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Director
Kedren Vaccines
vaccines@kedrenhealth.org

SUBMITTED WRITTEN TESTIMONY

UNITED STATES SENATE

COMMITTEE:
HEALTH, EDUCATION, LABOR & PENSIONS

FULL COMMITTEE HEARING:
EXAMINING OUR COVID-19 RESPONSE
AN UPDATE FROM THE FRONTLINES

JERRY P ABRAHAM, MD MPH CMQ
DIRECTOR, VACCINES PROGRAM
KEDREN HEALTH
Los Angeles

9th March 2021
Washington, DC

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JERRY P ABRAHAM, MD MPH CMQ

DIRECTOR, VACCINES PROGRAM
KEDREN HEALTH
South Los Angeles

biographical sketch:

Dr. Jerry P Abraham, MD MPH CMQ is a Harvard-Emory-University of Texas-USC-trained Family & Community Medicine Physician. a Global Injury Epidemiologist, and a Medical Quality Specialist, caring for patients in South Los Angeles at KEDREN HEALTH, a Historically Black Institution, which includes an Acute Psychiatric Hospital with an outpatient Mental Health outfit with field-based work, and a Federally Qualified Health Center FQHC Patient Centered Medical Home PCMH Primary Care Clinics.

Dr. Abraham also serves as the Director of the KEDREN Vaccines Program, which is committed to vaccinating a high volume of patients against COVID-19, as equitably distributed and administered, and with accurate and timely reporting back to the various jurisdictions including the California Department of Public Health CDPH.

From KEDREN 1.0 in South LA, where Dr. Abraham and his team vaccinate over 2,500 people per day, to date, they have vaccinated over 52,000+ people from the community thus far, removing every barrier standing in the way of his patients and their vaccine. KEDREN VACCINES plans to vaccinate 1,000,000 people in 100 days of this Biden-Harris Administration--with more vaccines, more hands to administer them, and more resources.

We are currently building additional vaccination networks in Watts (KEDREN 2.0) and Compton (KEDREN 3.0) and building a mobile fleet (KEDREN 4.0) to vaccinate the home-bound, housing insecure and people living in homeless encampments, the jail populations, among others, and along with planning KEDREN 5.0 MAX VAX LA LIVE AID-style Mass Vaccination events in partnership with black entertainers and black community leaders.

#WeCan and #WeWill We #WontStop #CantStop until everyone is vaccinated. #ThisIsOurShot Let's End This Epidemic one poke at a time. #NotADropToWaste #NotAMomentToLose #ARaceAgainstTime #AnArmsRace to get Los Angeles County Vaccinated...NOW!

executive summary

UNITED STATES SENATE
Committee on Health, Education Labor & Pensions

Full Committee Hearing:
Examining Our COVID-19 Response: An Update from the Frontlines

Jerry P Abraham, MD MPH CMQ
Director, Vaccines Program
KEDREN HEALTH

Across this country, the pandemic has exposed deep seated divides within our communities. Data from the Centers for Disease Control and Prevention (CDC) shows that Black and Latinx populations who contract this disease, are dying at twice the rate of other populations.

Nowhere is this fact more deeply felt than in Los Angeles where those living in poorer communities in South Los Angeles struggle daily with access to medical care amid the worst Pandemic in more than 100 years. This population is more likely to utilize public transportation, to struggle with limited access to mental health services, to have difficulties related to language and insecurity due to the lack of immigration documentation, and lastly, they usually lack medical insurance. This populations also suffers from higher rates hypertension diabetes, and obesity.

The point is that racial and ethnic, economic, lack of equitable access to healthcare and public health, and a whole raft of issues related to disparities have conspired to result in health outcomes that are different. While it is easy to unmask this effect related to vaccination rates, the same forces play out throughout the entire health care system. As the nation approached 500,000 deaths and mortality numbers were exceeding 3000 deaths per day, the community in South Los Angeles had to do something to ensure no one was left behind. At a time when many had lost hope, Kedren Community Health Center decided something had to be done to change this dynamic. We needed action at the local level where people live and work with the full participation and empowerment of the population. I call this the "Kedren Miracle" where a disenfranchised community pulled together under Kedren Community Health Center to build one of the most effective vaccination units in this Pandemic which continues to this day to serve as a model throughout the USA.

Over the last several months, we have been able to transform Kedren into a COVID-19 vaccination center serving the people of South Los Angeles. We have worked with the Los Angeles County of Public Health and received tremendous support from California Governor Newsom's Administration, including the CalVolunteers program, which has provided dozens of volunteers to help staff the clinic. We have also received support from the Americorps, American Red Cross, International Medical Corps, Salvation Army, Americares, among other official channels for volunteerism and service—hundreds of servicemembers help us serve over 15,000 members of the community every week—over 52,000 individuals have been vaccinated at Kedren thus far.

The Kedren Model – The Secret Sauce

Kedren Community Health Center is a federally qualified health center (FQHC) that provides quality, integrated health and behavioral health services to children, youth, adults and families irrespective of immigration status, residency, language, culture, gender, ethnicity, religion, sexual orientation or one's ability to pay. Annually, KCHC provides care for more than 100,000 patients. Kedren Community Health Center is a trusted care provider in South Los Angeles and has work exemplify some of the best practices for distributing the COVID-19 vaccine and breaking down barriers to accessing the COVID-19 vaccine for vulnerable individuals in South Los Angeles.

Kedren Community Health Center's Framework

Kendren Community Health Center has a robust framework for distributing COVID-19 vaccine effectively and efficiently to vulnerable populations, the aged and the disabled. It is a model built on trust at the most local level of the health system.

SUBMITTED WRITTEN TESTIMONY

UNITED STATES SENATE
Committee on Health, Education Labor & Pensions

Full Committee Hearing:
Examining Our COVID-19 Response: An Update from the Frontlines

Jerry P Abraham, MD MPH CMQ
Director, Vaccines Program
KEDREN HEALTH

Trustee, California Medical Association
Secretary, Los Angeles County Medical Association
Delegate, American Medical Association

Family & Community Medicine Physician
Global Injury Epidemiologist
Medical Quality Specialist

March 9, 2021
Washington, DC

Madame Chair Senator Patty Murray, Ranking Member Senator Burr, Senators, I would like thank the committee for this opportunity to discuss the paramount issue of the day; the COVID-19 Pandemic.

My name is Jerry Abraham, and I am a Family & Community Medicine Physician, a Global Injury Epidemiologist, and a Medical Quality Specialist practicing in South Los Angeles. I provide care to patients at Kedren Health, a FQHC community health center and acute psychiatric hospital serving low-income, diverse patient populations of South Los Angeles.

First, on behalf of Kedren Community Health Center and our President & CEO Dr. John Griffith, we extend the warmest thanksgiving and gratitude to each of you for inviting us to share our experience and perspective on the issue of healthcare service and public health delivery to underserved populations in this time of COVID-19.

Before I begin, we at Kedren want to acknowledge those local leaders who make it possible for our measured success. Governor Gavin Newsom and the State of California Department of Public Health, our Los Angeles County Board of Supervisors, specifically Supervisor Holly Mitchell, our local LA County Department of Public Health, and many City of Los Angeles officials including Mayor Eric Garcetti and Councilor Curren Price and of course our very own Congressional Representative Maxine Waters who represents us here in Washington, DC.

I would also like to begin by thanking the Biden Administration for their leadership in working with physicians and other providers across the country to address the COVID-19 pandemic. It has made a tremendous difference to have national leadership, transparency, and communication about the pandemic and the vaccination effort.

Across this country, the pandemic has exposed deep seated divides within our communities. Data from the Centers for Disease Control and Prevention (CDC) shows that Black and Latinx populations who contract this disease, are dying at twice the rate of other populations.

Nowhere is this fact more deeply felt than in Los Angeles where those living in poorer communities in South Los Angeles struggle daily with access to medical care amid the worst Pandemic in more than 100 years. This population is more likely to utilize public transportation, to struggle with limited access to mental health services, to have difficulties related to language and insecurity due to the lack of immigration documentation, and lastly, they usually lack medical insurance. This populations also suffers from higher rates hypertension diabetes, and obesity. For example, South Los Angeles has a rate of diabetes that is three times higher than the rate of diabetes parts of the state.[1] All of these challenges are contributing to the unequal and uniquely adverse medical outcomes from the Pandemic. According to recent data released in mid-February by the Los Angeles County Department of Public Health showed that among those who were vaccinated with at least one dose, only 5% were black, while 33% were white and 23% were Latino and 19.1% were Asian. Among black resident in Los Angeles 65 and above, only 24% of Black residents had received at least one dose of the vaccine compared to 42% of white residents 65 and up.

The point is that racial and ethnic, economic, lack of equitable access to healthcare and public health, and a whole raft of issues related to disparities have conspired to result in health outcomes that are different. While it is easy to unmask this effect related to vaccination rates, the same forces play out throughout the entire health care system. As the nation approached 500,000 deaths and mortality numbers were exceeding 3000 deaths per day, the community in South Los Angeles had to do something to ensure no one was left behind. At a time when many had lost hope, Kedren Community Health Center decided something had to be done to change this dynamic. We needed action at the local level where people live and work with the full participation and empowerment of the population. I call this the “Kedren Miracle” where a

disenfranchised community pulled together under Kedren Community Health Center to build one of the most effective vaccination units in this Pandemic which continues to this day to serve as a model throughout the USA.

Over the last several months, we have been able to transform Kedren into a COVID-19 vaccination center serving the people of South Los Angeles. We have worked with the Los Angeles County of Public Health and received tremendous support from California Governor Newsom's Administration, including the CalVolunteers program, which has provided dozens of volunteers to help staff the clinic. We have also received support from the Americorps, American Red Cross, International Medical Corps, Salvation Army, Americares, among other official channels for volunteerism and service--they help us serve over 15,000 members of the community every week.

During this phase of the vaccination effort, the limiting factor in our efforts has been vaccine supply. Like many parts of the country, the demand for vaccine has outpaced supply since the first vaccines were distributed in December. This has been particularly true in communities that look like our community, with an overwhelming majority of people of color, and those who get their health insurance from Medicaid. Studies have shown that Black and Brown communities have simply not gotten their fair share of COVID vaccines.

Through our advocacy efforts and by being loud, we at Kedren have been able to secure vaccines to serve over 15,000 people every week. That number is increasing, but we still have the capacity to do more. We stand ready to serve our community, and to help ensure Black and Brown people in particular don't get left behind when it comes to getting vaccinated.

Communities like ours are the ones that have been hit hardest by this pandemic. Residents in the communities around Kedren are far more likely to have been hospitalized or die from COVID-19 than in most other parts of the state. We will continue to be more exposed to risk if we cannot get enough people vaccinated against this deadly disease.

In recent days, the Newsom administration has adopted new guidance that will allocate a disproportionate share of the state's vaccine supply to communities that have higher concentration of high-risk patients. Using the Health Equity Index to guide vaccine allocations makes sense. When you fight a fire, you don't just sprinkle a little water around the entire fire. You aggressively attack the parts that are burning the hottest and pose the most immediate risk.

That same principle is now driving the Newsom Administration's approach to vaccine distribution. But it is not enough to just have vaccine in these areas. We need to make sure we have the people power, the communications outreach and the infrastructure necessary to get the shots into arms.

This can't be done by just using apps to make appointments at mass vaccination sites. While thousands of people have gotten their shots at mass vaccination clinics like the one at Dodger

Stadium in Los Angeles, if we rely only on these mass sites, we will have distorted and inequitable distribution of shots. The technology needed to navigate the state's vaccine appointment system can be confusing in particular to older patients. The ability to get to these sites requires the ability to take hours out of your day to be able to sit in line, limiting opportunities for those who have to work or single parents who have to care for their children. And of course, it requires use of a car. Even in Los Angeles, thousands of low-income people do not have their own car to be able to access a drive-thru mass vaccination site.

Over the next several weeks, it will be essential to build a network of community-based vaccine administrators. It will be important to involve physicians and other providers in every single community. The California Medical Association is working with the state's Third Party Vaccine Administrator to help build a network of community physicians and other providers to help the state achieve its goal of vaccine equity. As vaccine supply becomes less of an issue, it will be important to make the vaccine available for people in the community where they live through their local providers.

We also know there are high levels of vaccine hesitancy in our Black and immigrant communities. There are many historic reasons for this skepticism which we do not have to go into here. But it does underscore the added importance of getting vaccine into the hands of community providers. Many people have a personal relationship with their local physician or community clinic. When people utilize other health care services, we need to be able to vaccinate people as well. If people are in a place they know with a health care professional they trust, they are more likely to be able to talk through their vaccine hesitancy issues. Local physicians and others can help advocate for their patients to be vaccinated, and hear their concerns, while addressing them with science and compassion.

By late April, we fully anticipate going from a vaccine supply problem to a vaccine demand problem. If we truly want to bring an end to this pandemic, we will need a robust, and community-specific communications and persuasion strategy. Physicians will be an important part of that outreach, but we cannot do it alone. We need to build partnerships with trusted community leaders and create a high-touch, multi-faceted strategy to promote vaccine acceptance.

We have had our share of hiccups over the last several months. It is no small thing to create a statewide vaccination program for roughly 30 million adults. We know that many of the same problems we've seen in California are plaguing other parts of the country. Some of this is to be expected, but that does not mean we should be silent or accepting. We must continue to push for a faster and more equitable vaccine distribution at every turn.

We have learned a great deal since vaccinations began in December, and we share the Biden administration's optimism that we can get vaccines to those who want and need them by late spring/early summer. But we are also clear eyed about the challenges that lie ahead. With continued transparency and cooperation between federal, state and local governments, along

with health care providers and community leaders, we can meet those challenges head on and bring an end to this pandemic.

The Kedren Model – The Secret Sauce

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For example, one of the biggest barriers cited by patients attempting to become vaccinated has been the appointment registration process. Many seniors have had to rely on children, nieces, nephews or other friends who are more comfortable using the internet to schedule an appointment. In addition, many vulnerable residents lack access to reliable broadband or simply do not have the time to wait for appointments to become available. Kedren Community Health Center. Adding to the problem and due to the digital divide, many of the local residents do not have internet access, or own a computer, or even have access to a smartphone. We worked to develop a simplified system that allowed both appointed and walk ins, as system that used a combination of paper and "point of care" information collection that could be entered into the county's online database later. As a consequence, Kendren Community Health Center became one of only a handful of country affiliated vaccination facilities where walk ins are welcome.

Additionally, interpreters for almost every language spoken in South Los Angeles are available on-site. As of March 5, 2021, more than 12,000 people are vaccinated at our facility each week. One immediate outcome was that many – many of them Black and Latino healthcare workers who worked independently or in small practices where were exclude from that vaccination efforts of larger hospital system have received their vaccine doses at Kendren Community Health Center. I would like to add that although our Federally Qualified Health Center accounts for only a small fraction of the 100's of vaccinating organization in greater Los Angeles, we routinely account for nearly 10% of the COVID-19 vaccinations given within the county. It doesn't seem possible *that so few can do so much for so many*.

We have been relentless in this effort to save lives, much like Noah gathering people and animals before the great flood, Kendren Community Health Center has become a beacon for those trying to address the COVID-19 flood. Organizations organizations such as the Los Angeles County Department of Public Health, International Medical Corps, AmeriCorps, the faith-based community, and myriad of other organizations and donors, many from the community have come to our aid and are providing surge support and human resources to enhance this vaccination effort. The result is a small city of vaccinators, with temporary shelters, stockrooms, endless

deliveries of vaccine, needles and medical commodities. We have been so successful in promoting vaccination effort in our community model that we routine send a fleet of trucks to other vaccine sites throughout the city to take their unused vaccines!

Kedren Community Health Center's Framework

Kendren Community Health Center has a robust framework for distributing COVID-19 vaccine effectively and efficiently to vulnerable populations, the aged and the disabled. It is a model built on trust at the most local level of the health system.

Phase 1: Increase vaccination at fixed sites within the community

Phase 2: Expanding services and recruit additional vaccination sites

Phase 3: Develop Academic Partners to improve options for access and quality

Phase 4: Develop mobile vaccination teams for those Hardest to reach

Phase 5: Conduct mass vaccination events uniquely tailored to the population

I would like to speak to Kedren Community Health Center's Vision for a future where inequality in medical services doesn't force people in my community to wait at the end of the vaccine line to ensure their survival. We are on a mission to get as many people in the life boat as possible. We are targeting support to drive up vaccinations to over 1 million people in South Los Angeles and beyond this year in an equitable and culturally focused program able to reach those most at-risk. Second, we will not let this experience fade. We also have a dream that we have been able to work in a manner that will contribute to expanded healthcare infrastructure in our community when the pandemic subsides. Lastly, we hope that the heroic work of Kedren Community Health Center, and the work of our partners, will serve as an example of others seeking to address the problem of unequal access to health services in underserved, vulnerable, disabled, minority and at-risk populations during this Pandemic and beyond.

Thank you for this opportunity to testify before each of you today on this very important subject. I humbly respect your time and admire your serve to our nation. I am happy to answer any questions you may have.

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APPENDIX

supplemental materials & supporting documentation for the official Congressional record

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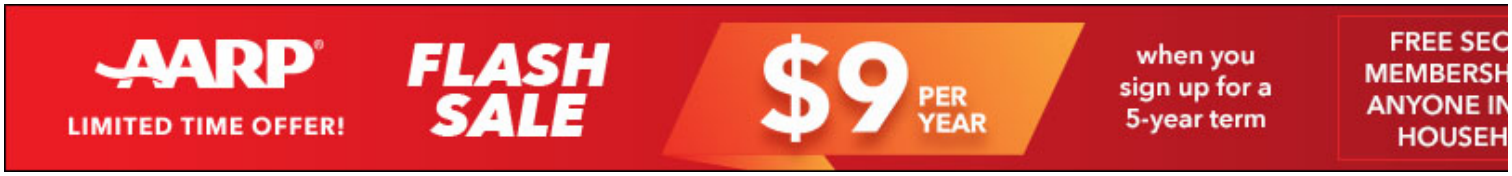
KEDREN VACCINE PROGRAM
MEDIA COVERAGE



How to Book a COVID-19 Vacci Appointment Without a Compu

Faith groups, libraries, Meals on Wheels all chipping in to help

by Deborah Schoch, **AARP (http://www.aarp.org)**, March 3, 2021 | Comments: 6

NOVANT HEALTH

A retired Army captain receives the COVID vaccine at a vaccination event at Park Expo conference cente
3,700 people received shots. It was a joint event of The Park Church and Novant Health, a major regional

En español (/espanol/salud/enfermedades-y-tratamientos/info-2021/cita-de-vacunacion-c
HLTH-TOSPA-TOGL-ES) | Sheron Gardner was determined to make COVID-19 vaccine appo
treatments/info-2020/coronavirus-vaccine-distribution.html) for herself and her partner. Bu
working computer, so she spent more than a week trying to sign up using the official New Yo

"It was horrendous," says Gardner, of Rochester, New York. "When I did get an appointment,
Many older adults seeking vaccines don't have computers (/home-family/personal-technolo
adults-computers-internet-access.html), she says, adding, "It's just not fair."

For the latest coronavirus news and advice go to AARP.org/coronavirus (/coronavirus/

Gardner and her partner finally got their vaccine doses by calling Lifespan of Greater Roche
provides information and services for older adults and caregivers. Lifespan has received a flo
a day — from clients seeking appointments.

The clients who call “don't have computers, or they didn't have the skills to troll the sites all t
spokesperson Mary Rose McBride.

Most states have now approved vaccinations for adults age 65 and older, prompting a scram
typically has to be done online, and many older adults are not connected. According to a 20
Center, 27 percent of adults age 65 and older do not use the internet (/home-family/person
subsidy-helps-broadband-internet-access.html).

In Colorado, older adults face the same challenges.

"We're seeing that big time,” says Eileen Doherty, executive director of the Colorado Geront
nonprofit that offers assistance and advocacy. “And it's all technology-driven."

So those older adults without computer access are struggling to make vaccine appointment
one phone number, then another, Doherty says.

One of her clients, Ralph Gean, a well-known musician who lives in the Denver suburb of Brc
computer or a car.

Out of the blue, Gean, 78, got a phone call from a hospital in Boulder, inviting him to come ge
uncertain about the safety of the vaccine but decided he would go ahead and get it.

Still, the hospital is a 25-minute drive from Gean's home. A Colorado Gerontological Society
and Gean received his first shot, with the second scheduled soon.

'Go Out to Where People Are'

Fresh ideas are needed to connect older adults to vaccines, says Lisa A. Cooper, M.D., an int
for Health Equity at the Johns Hopkins Bloomberg School of Public Health in Baltimore. “Go
Cooper says. “You can have the fanciest site, where it's all set up, and they're not coming.”

Cooper is encouraged by the use of mobile clinics to distribute vaccines (/health/conditions
2020/coronavirus-vaccine-research.html). And she suggests that churches can also help. Fo
drop off items at churchgoers’ homes can ask, “Say, have you had a vaccine shot yet?” and h

Libraries, too, are playing a role. Patt Saich, 81, of Diamond Springs, California, was startled t
asking if she and her husband, Gary Saich, 85, wanted vaccines. They do not own a compute

"Boy, did we jump on that,” says Patt Saich.

The call came from Kelly Jordan, a librarian with the Eldorado County Public Library System.
numbers of people who had called a county hotline earlier, seeking the vaccine, Jordan says.
librarians began making calls.

"I said, ‘Bless your heart,’ “ says Patt Saich, happy to report that she and her husband have n

In some areas, Meals on Wheels is connecting homebound clients with agencies to arrange

Racial Divide

The digital divide can be especially challenging for people of color. Only 57 percent of Latinc computers, compared to 82 percent of whites, according to another 2019 Pew study. (https: tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gap

"If you don't have that savviness in using technology, you're going to have to figure out a diff Cooper, who studies health disparities at Johns Hopkins.

At the nonprofit Kedren Community Health Center in South Los Angeles, more than half the who walk in, largely Black and Latino residents.

They don't need to bring a phone or identification, says vaccination director Jerry P. Abrahar We make the clinical judgment that they're over 65."

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In North Carolina, African Americans make up 21 percent of residents but 25 percent of COV (/health/conditions-treatments/info-2020/race-coronavirus-disparities.html). Yet they're ge (/health/conditions-treatments/info-2021/racial-disparities-covid-vaccine.html), according Francisco-based Kaiser Family Foundation.

Churches in the state have teamed up with Novant Health, a major regional health provider. provided its large expo and conference facility and helped get the word out for a major Febr 3,700 people received vaccinations.

One major hurdle is that many African Americans distrust the vaccine, a reluctance that has infamous federal study that tracked hundreds of Black men with syphilis without revealing th

Only 42 percent of Black Americans plan to get vaccinated, according to a December 2020 (https://www.pewresearch.org/science/2020/12/03/intent-to-get-a-covid-19-vaccine-rise research-and-development-process-increases/).

"Any digital strategy is going to be complicated by the divide that is historical," says Bishop C pastor at the Park Church.

The divide is also evident in Indian Country (/health/conditions-treatments/info-2020/choc coronavirus.html), says Larry Curley, executive director of the National Indian Council on Agi Albuquerque, New Mexico.

"They don't have access to the internet. Broadband isn't out there," Curley says. "When you
worthless." And Native Americans have their own history of unethical medical treatment by

Yet Native American nations are bridging that gap, with close to 575,000 doses of the vacci
Indian Health Service as of March 1, a rate higher than many states.

*Deborah Schoch is a contributing writer who covers health and science. A longtime journalist,
for AARP, The New York Times and KNBC-TV Los Angeles.*

More on Health

- COVID-19 vaccination appointment process must improve (/politics-society/advocacy/info-2021/improve-covid-vaccine-process.html)
- Getting a lifesaving COVID-19 vaccination (/health/conditions-treatments/info-2020/
- What to do if winter weather delays your COVID-19 vaccine appointment (/health/cor 2021/winter-weather-and-vaccine-appointments.html)

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Physicians tackle equitable vaccine distribution and misinformation

Watch the AMA's daily COVID-19 update, with insights from AMA leaders and experts about the pandemic.

AMA COVID-19 Daily Video Update

AMA's video collection features experts and physician leaders discussing the latest on the pandemic.

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Transcript

Unger: Hello, this is the American Medical Association's COVID-19 Update. Today we'll discuss equity challenges with vaccine distribution, and how two physicians are part of the solution. I'm joined today by Dr. Jerry Abraham, director of Kedren Vaccines at Kedren Health in Los Angeles, and Dr. Michael Knight, assistant professor of medicine at the George Washington University School of Medicine and Health Sciences in Washington D.C. Dr. Knight also serves as vice chair and National Medical Association representative on the AMA Minority Affairs Section Governing Council. I'm Todd Unger, AMA's chief experience officer, in Chicago.

Dr. Abraham, you are coming to us live from an actual vaccination center. This is a first for the COVID-19 Update. I want to talk to you first about your experience trying to correct the problem of equity in vaccine distribution. You in fact, at Kedren Health, couldn't secure at first vaccines and so you had to take matters into your own hands. Can you tell us what that was like?

Dr. Abraham: Sure. It kind of goes back to, historically, who we are. Kedren was started in the 1960s, during the Watts riots here in Los Angeles, especially when Black people had nowhere to go for mental health care, especially when in crisis. And during that time that's when 22 Black psychiatrists came together and formed Kedren. That's who we are, and that's kind of our mission ever since. We've been that beacon, that light on a hill.

And when COVID hit, we knew as early as March 2020, we had to be a part of the COVID testing strategies. So we supported the city and the county with that, and opened up to the public to test. And then December 2020, when the FDA met and then the EUA went through, we were looking around at each other and going where's our vaccine. Kind of like many of our patients are right now. And we started knocking on doors. And door after door, phone call after phone call, we finally realized we had been forgotten about. Something that has happened in the past for historically Black institutions, but we weren't going to focus on that, we were going to focus on the solutions. And we drove up there with our little Kedren minivan and we said, "Department of Public Health warehouse, we're not leaving until we got some." And they sent us on our way with a hundred vaccines.

These conversations started Christmas Eve Eve of 2020. By New Year's Eve Eve we'd

administered 50 doses into the arms of our own Kedron staff. We have 400 employees, but we knew that wasn't enough. We needed vaccines to help Black and brown essential workers who were shut out because they weren't a part of big systems. And so we did that. And then the next thing we said is, when seniors were eligible, we were going to do the same. So from those 50 first doses to over 40,000 today, that's kind of how we started. But that's part of our heritage, it's ingrained in our DNA. We've always believed you got to stand up and shout, and you've got to say, "Give me mine now." And that's the strategy we took with these vaccines.

Unger: That's amazing. Did you think when you got into this, you'd be strolling through a facility with Governor Newsom, showing him the extent of your efforts?

Dr. Abraham: No, that was really exciting. I think the truth is that, we went to the Department of Public Health and we said, "Do not give us these vaccines unless you are committed to giving us more, because it is not about us and just our staff." We had nurses and patients with COVID. We were highly disturbed that we, as a small little outfit and operation, had not received vaccines. And so, maybe that was the mistake I made, was to say, "Make sure you give us an endless supply." But that's kind of how it started was, absolutely, we were going to put on our oxygen mask, and they were going to turn to our neighbors, right and left, and make sure they got their oxygen masks on. And somehow, miraculously, now we're starting putting oxygen masks on all the planes that are flying.

And people took note. We don't have enough vaccines, we don't have enough help, we don't have enough resources. However, what we do really good with the very little that we've been given. Since 1960s, we do a lot with very little. And so with this very limited supply, we do a high volume of vaccines as equitably distributed and administered, and as accurately and timely reported back, so that planning, preparation and allocations can be made. And because of that, we continue to be rewarded with Moderna, and now with Pfizer, and with those snow storms, of course that's affected our cold supply chain, but we're very excited to see what's happening with Johnson & Johnson. And we're ready to take any vaccines that are given to us and get them into the arms of Angelenos. We've got to end this epidemic now.

Unger: Absolutely. Well, you've become kind of a high profile role model for a real commitment to getting vaccines to the most vulnerable. Are there any kind of tips, learnings, that you would like to share with other people across the country who are making a similar commitment?

Dr. Abraham: Sure. I think one of the greatest successes of our story is physician leadership, it's clinical leadership. And that our president, Dr. John Griffith, a clinical psychologist, and our board, and our chief medical officer, they made sure that there were no institutional barriers in the way from a doctor doing what we do best, which is caring, treating, diagnosing, and in this case, providing life-saving essential medicines, this COVID-19 vaccine. And they did exactly that, instead of check boxes and Zoom meetings, they said, "Go with God, do good and do well." And that is exactly what me and my team have done.

The next piece is that we have wed clinical leadership, the physician leadership, with clinical operations. There is complete shared decision-making between me and my work husband, Mr. Sonny Tran. And all day long, you'll see us lock in step, they're getting tents up, I'm getting medicines out, and that's really a big part of our secret sauce here at Kedren.

Unger: That's fantastic. Dr. Knight, I've seen a lot of you on social networks. You've taken a really proactive approach to address misinformation and vaccine hesitancy, by documenting your own journey in getting the vaccine. Can you tell us about the decision you made? Why did you make that decision, and why do we need more physician voices talking about vaccines now?

Dr. Knight: Sure. This pandemic has really taken a toll on our country, but particularly in marginalized and minoritized community. Obviously, I'm a part of the African American community, and when the COVID-19 pandemic first started, people said this would be the great equalizer. And unfortunately, those of us that know real medicine know that that was never going to be the case. The communities that have continued to deal with the burden of disease, chronic disease, infectious diseases, unfortunately, again, were disproportionately affected by COVID-19.

A part of that was also a pandemic of misinformation, a infodemic, if you will. And that started off in the spring. And I even heard it within my patients, my family members, about ways to avoid COVID, ways to treat COVID, that were not really scientifically sound. And that's when I started being very proactive, getting on social media, talking and dispelling some of the myths, and really connecting patients to factual information. Also, understanding that it's easy to believe things, what you see online, with something that is new. So we're not telling patients, "No, you're totally wrong for believing this," but saying, "How can I empower you as a patient to be proactive and identify real information?"

So when I heard the vaccines were coming, I said, "This is our opportunity to get this to our community." And once again, the false information started, and I said, "You know what? I'm going to be front of the line. I'm getting my vaccine. I'm going on camera." I've documented my journey. I posted on YouTube, posted on Facebook. People started sharing it and talking about it. Our local television station here in Washington, D.C., picked it up as well. And I had patients contacting me like, "Dr. Knight, I just saw you on TV. Now I'm definitely going to get the vaccine."

And it's an opportunity for us to say, go forward. One thing I said in my interview was, "You know what, let me be your guinea pig, okay? I will get it. Okay. Let's have a conversation." And that's what we have to do. Let's not blame patients who have doubts. It's okay to have doubts, but let's counter that with integrative and intentional actions to really address misinformation.

Unger: So, we are seeing concerning levels of vaccine hesitancy in the Black community. Do either of you have any kind of experience or tips that you have found successful in countering that high level of misinformation and hesitancy?

Dr. Abraham: Dr. Knight, if I could jump in really quickly, I just want to applaud you for doing what you did. That's exactly what we need to do. We need to roll up our sleeves, and get our shot as publicly as we possibly can. On camera if we can. We've had Black pastors and bishops come and get their vaccines, and live stream it to their congregants. We've had Black doctors come, and now their medical assistants, and their patients are proud to get their shot. So I can't thank you enough. And that really is the solution.

First and foremost, I just have to strongly... and just cry, do not confuse lack of access to vaccines for Black and brown hesitancy. And that really is a big part of some of the data that we see, is "What shot? I was never offered a shot."

And then just as Dr. Knight pointed out, being able to engage and to educate, and then vaccinate...Black, brown, white, or yellow, whoever you are, as Dr. Knight just mentioned, there are many reasons to be afraid of new technologies, of mRNA vaccines. You mentioned the word guinea pig. This is not Tuskegee. This is not Henrietta Lacks. There were Black people in the study, and the National Medical Association had eyes watching every step of the way. And we applaud them for providing that assurance to our Black and brown community that this is by no means... In fact, this is your shot, your taxpayer funded shot. And when it is your turn, you're going to roll up your sleeves and get your shot.

So that's what we have to say is when you spend the time, as Dr. Knight just mentioned, when you really answer people's questions, legitimate ones, when you tell them that we don't exactly have all the information or all the right answers, but this is what we know today. I promise you, and we've seen that less than 1% hesitancy in the Black and brown health care workforce here at Kedren, less than 1% hesitancy in the Black and brown seniors that have come through. What they do instead is they come here proudly, roll up their sleeves and get their shot. And then they'd go out there and they bring us 10 more. And that's how we end this epidemic.

Unger: Fantastic. I can't see it or hear it in the background, but I hear that you have created kind of a special atmosphere at your vaccine center, to make it either less scary, or more enjoyable. What is that like?

Dr. Abraham: Well, we are just so excited to be a part of the solution. We're smiling, we're dancing, we're air high fiving and hugging. We just want to get back to normalcy. We want to get back to work, get back to school, get back to loving our loved ones, hugging and kissing and seeing grandma again. And in order to do that, we have to do this. So yes, we blast dance music, and we are dancing and moving. And we're just really having a good time, because everyone here knows that a part of the solution, every volunteer, every patient, everyone who comes her and interfaces with us is helping end this epidemic. And that's the energy and joy we feel.

We believe that, just like #ThisIsOurShot, we are all together creating a movement, an optimistic movement, that the day of this pandemic is numbered. And we are at

war with COVID-19, and we are winning. So you better believe everyone is excited, and we're so happy to be here every day, doing our part. We just ask that everybody does theirs, wear your masks, socially distance, and when it's your turn, roll up your sleeves and get your shot.

Unger: Well, I can feel the energy. Dr. Knight, a lot of the efforts that you've been making are in lockstep with an organization that you founded nearly nine years ago to improve health in urban communities. Can you tell us more about that Renewing Health Foundation?

Dr. Knight: Sure. So the Renewing Health Foundation was founded in 2012, actually, when I was an intern in internal medicine there in New York City. And after medical school, I've been very involved with the Student National Medical Association, and other organizations that were doing health education programming. And when I went to residency, I'm from New York City, so I was coming home, I was in my community. And even though I was very, very early in my training, I said, "What can I do to get into the community?" And I knew I needed a 501(c)(3), so I can get some funds. I knew I needed to be able to build a community and a team. And so we founded the Renewing Health Foundation.

Since that time, we have worked extensively to address chronic disease, breast cancer, a number of issues that have affected African American community. And specifically also COVID-19. And I want to quickly mention something that Dr. Abraham brought up. When we talk about vaccine hesitancy, I think a lot of times we focus on, "Well, why don't these group of individuals trust us, as the medical field?" Instead, we should be thinking, "Well, what about the medical field is fostering this trustworthy issue, right? How can we become more trustworthy?"

And you are giving examples of what's being done at Kedren Health to engage with the community. When they walk into a facility and see individuals who are from their community, who look like them, who have been invested, not just coming when it's time for us to spend some grant dollars, but have actually put down roots in the community and build that care. Some of the data has shown that patients are much more likely to accept the vaccine from providers that they have relationships with. And so that is what we want to do, talk about building trust, because there's a lot of things that have happened in the past. And there are a lot of things that are still happening, that decrease the trust that patients may have in the health care system. As providers, as physicians, we need to be on the front lines of addressing that.

Unger: That's fantastic. Well, Dr. Abraham, your operation up and running, a role model for people across the country. How do you see yourself expanding from here?

Dr. Abraham: Yeah, that's really exciting. What I've described as Kedren 1.0, that includes that pre-registration, getting the right people in the door, registering and checking them in. It includes the vaccination itself. It includes the reporting, and all of the supply chain, and then that clinical leadership I mentioned, clinical ops.

That's 1.0.

We're building a site closer to Compton now. That's 2.0, that will create and build public health infrastructure that we hope long lasts and outlives COVID. We need that public health infrastructure in this country. We need preventative medicine, and we need high quality primary care.

Then at the MLK Community Hospital and the Charles Drew University Campus, we're building Kedren 3.0, another main nerve center. But we really know that it's not these nerve centers that are effective, it's really roots in the ground. And so what we can do is build Kedren 4.0, a fleet of mobile ice cream trucks, where we take these vaccines out into the community, to the home bound, to the vulnerable, to the community center, to the church, to the library, the rec center. That's how we're going to get this vaccine out en masse.

And then lastly, Kedren 5.0, the mass vaccination events where we're going to make it #TheCoolShot, we're going to bring the celebrities, and the entertainers and the leaders, and we're going to engage, and we're going to educate. And we're going to create a Live Aid-like event where people come, roll up their sleeves, get their shot, so we can get on with our lives. And I think that's really the response, that's really the antidote, that's really the life-saving essential shot-in-the-arm, this whole country and society needs right now.

But to everything Dr. Knight said, I wanted to say, "Amen, and preach brother, because you are right on about everything." We're going to get there, and it's through that grassroots network. It's really meeting people where they are. It's not telling them to come to where we are, it's really understanding why, and where we got to where we are, and let's focus onto those solutions and we'll get there.

Unger: Well, Dr. Abraham, I loved that statement you made about not confusing hesitancy and access, and it sounds like you are really taking the vaccine to where people are. And that's such a smart idea.

Well, last question for both of you, many practices have been left out of the early vaccination efforts, with much of the supply going to large health systems and pharmacies. What's your advice to physicians who want to get involved, and be part of this effort? Dr. Knight, why don't you start?

Dr. Knight: Sure. I think it's unfortunate, some of the limitations that have been out there for physicians who have stakes in the community and don't have access to vaccines. We know that large academic centers, large medical systems, are not equitably placed in the community. There are many areas of Washington, D.C., for example, where most of our hospitals are located. And there are parts of our city that, unsurprisingly, are also where many of the marginalized communities live, that don't have such access. However, what is there, are doctors offices that have been there for decades that don't have access. So I definitely understand why we have a centralized approach, but as physicians, within our organizations, such as the AMA, we have been advocating at the state, local and county level, to have better access to our practices in an organized way. Yes, we got to be careful about

supply. We have to make sure that the vaccines are getting to the right people. But we have to be able to empower our medical centers, our small physician practices, who want to get involved, to be able to do that.

Dr. Abraham: Yeah, I'd say, first and foremost, crisis is danger plus opportunity. And we know that luck is preparation plus opportunity. So really for me, that preparation, and I can't say this strongly enough, it's the time I have invested in organized medicine, but more importantly, what organized medicine has invested in me. My ability to speak publicly, my ability to speak with decision-makers regularly, my ability to understand medicine and stay up-to-date, my ability to know that I'm not alone, and I'm in the community of physicians and physician leaders who we will figure this out. All of those things were blessings of my involvement in my Los Angeles County Medical Association, my California Medical Association and our AMA, and that is critical.

And so I hope that everybody hearing this is not, "How did this little Kedren-that-could...?" Or, "Dr. Abraham in South LA is a one-off." No, it's because we've been preparing since that very first day of med school, probably even well before that, as pre-meds, that we have learned to take on challenges. We've figured out how to practice good, sound medicine. And we've learned how to tell that story to others. So that all those barriers that stand in our way, our colleagues, our politicians, our bureaucrats, understand, "Get those barriers out of the way, because Dr. Abraham and Kedren need to vaccinate."

And so that's where I would really say the message here is that everyone can do it, but build those relationships with your Department of Public Health, and your local jurisdictions and your authorities. Know your policy makers, get involved in organized medicine, so you're not alone and you feel connected. And when you don't know what to do next, just like I did, I reached out at every level, and along the way, every one of my organized medicine colleagues came with me. And so this is all of our success. And when we end this epidemic, it's because we all did it together.

Unger: That's fantastic. Well, I would like some of your energy and passion put in a bottle and given to me, along with my COVID vaccine, whenever I'm able to get that. I just want to say, thank you so much, Dr. Abraham, Dr. Knight, for everything that you're bringing to the table, for your leadership, and for doing what you're doing right now. It's just amazing.

Well, that's it for today's COVID-19 Update. We'll be back with another segment shortly. In the meantime, check out ama-assn.org/COVID-19 for more information about COVID. Thanks for joining us, and please take care.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.

LOS ANGELES

Kedren Community Health Center steps up to help South L.A. after seeing racial disparities in COVID-19 vaccine distribution

The South L.A. clinic says it has struggled to ensure doses are getting to the communities that need them most.

By: Emilie Fu, Nicholas Cassol, Anthony Gharib, Victoria Westover, Avery Anderson, Olivia Tyler, and Bianca Bueno

March 5 at 4:12 PM

As Los Angeles continues its vaccine rollout, many Angelenos are rushing to distribution sites in search of a sense of relief. But for many South Los Angeles residents, getting their shots has proved to be more challenging due to the racial disparities in vaccine distribution.

At Kedren Community Health Center, located 10 minutes away from USC's University Park campus, health officials said they have seen the racial inequities firsthand.

"It's not fair because we're all grasping for scraps, and I think that it puts underserved and vulnerable communities pitted against one another. East L.A. and South L.A. are not at war for this vaccine," said Dr. Jerry Abraham, the director of Kedren Vaccines at the center. "We're all trying to help our communities and it is frustrating to feel that it is harder for us to get this precious lifesaving, essential medicine."

According to the Los Angeles County Department of Public Health, communities such as Brentwood, Culver City and South Pasadena have more than 20% of their populations vaccinated despite low COVID-19 cases. On the other hand, areas such as South L.A. have less than 10% of the population vaccinated, despite being home to some of the communities hardest hit by COVID-19.

California has already administered more than 10 million vaccines as of March 4, and officials announced March 3 that the state allocated an additional 400,000 for hotspot communities. One primary neighborhood the new policy targets is South L.A., according to data released by the Los Angeles County Department of Public Health.

The state's decision to earmark vaccines for underserved communities came after the Los Angeles Times released an explosive report in late February that found some people were using codes that the state intended to be for those most in need to get vaccine appointments early.

Amelian Kashiro Hamilton, a 37-year-old Los Angeles resident who received the vaccine from Kedren, posted an Instagram video that received over 1,000 likes to spread awareness about the work Kedren is doing to ensure that Black people have priority in receiving the vaccine.

Hamilton not only informed viewers when, where and how to get the vaccine in her post, but she described her frustration with the large number of people not from the South L.A. community who were waiting in line to receive the vaccine.

"A lot of people were just kind of disregarding the Black bodies that were there and moving forward and asking to get ahead," Hamilton said. "It just kind of gave this very elitist energy, this occupying energy that was really triggering to say the least, to see that invasiveness."

Kedren was originally founded in 1965 with a mission to provide comprehensive patient care for children, transitional aged youth, and people with mental health difficulties. When the vaccine was developed, Abraham said he decided to transform Kendren into a vaccine distribution center to serve the South L.A. community.

The clinic now serves as a primary distribution site for the vaccine, and has vaccinated over 9,000 people and counting since February.

“Everyone in this county needs a shot, but they need to wait their turn,” Abraham said. “We need to make sure that the vaccines go to where the hotbeds, where the heat maps, where the highest infection rates, hospitalizations, ICU admissions, ventilation rates and fatality rates are highest. Unfortunately, that is not someone who’s isolated and holed up in their home.”

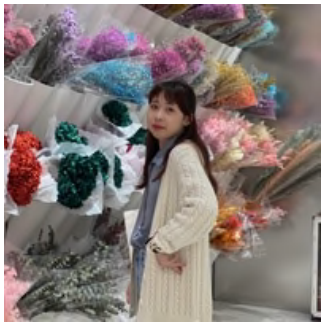
Earlier this year, the health center was featured in the Los Angeles Times after receiving an extra 600 vaccine doses and working well past closing hours on a Friday night to distribute them. Kedren was praised for getting the vaccine out to those who didn’t have access to a computer or internet to schedule an appointment and allowing walk-ins.

In a March 3 news release, the county addressed the issue of vaccine accessibility due to technological barriers. “Los Angeles County continues work mitigating barriers and increasing access to vaccines to eligible residents and workers in the hardest hit communities,” stated the release. The county also described efforts to work with community leaders and organizers to help people navigate the online registration interface and allow onsite registration.

Abraham said that despite the controversy and difficulty for minority groups to get the vaccine, everyone should be able to get one, but at the right time and the right place.

“Doesn’t change the fact that those people too deserve vaccines, ideally when it is their turn, ideally, they don’t have to come to Kedren to get them because Kedren is here to support our community and our community needs to be first in line at Kedren for the vaccines that we’ve been allocated,” he said.

The county also said on March 2 that while COVID-19 vaccines remain limited, “when Johnson & Johnson doses come into L.A. County, a vaccine that is 100% effective in preventing COVID-19 hospitalization and death, we are hopeful this will improve vaccine supply.”



About **Emilie Fu**

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FDA approves emergency use of Johnson & Johnson vaccine

By **United Press International** - February 27, 2021

Physician assistants prepare syringes from a vials of the Moderna vaccine for local residents waiting in line to receive a COVID-vaccination shot at the Kedren Community Health Center in South Los Angeles Feb. 16. Photo by Jim Ruymen/UPI

Feb. 27 (UPI) — The Food and Drug Administration granted emergency use authorization to Johnson & Johnson's single-dose COVID-19 vaccine Saturday.

The announcement follows a Friday endorsement from the FDA's advisory panel on vaccines.

The vaccine is the third approved for use in the United States to inoculate against the novel coronavirus, which has killed more than 500,000 people in the United States and 2.5 million people worldwide.

Only a few million doses will be shipped to states in the days immediately after authorization, b production is expected to ramp up in coming weeks, with 20 million doses due to be delivered b the end of March and 100 million total in the first half of the year, according to Johnson & Johnson.

The new vaccine has a lower efficacy rate — 66% overall and 72% in the United States in preventing moderate to severe cases of COVID-19 — than the Pfizer and Moderna vaccines already in use.

In June the FDA said it would approve emergency use authorization of any vaccine shown to be more than 50% effective in clinical trials — a rate comparable with the seasonal flu shot releas each fall.

“Don’t get caught up, necessarily, on the number game, because it’s a really good vaccine, and what we need is as many good vaccines as possible,” Anthony S. Fauci, the government’s top infectious disease expert, said Saturday. “Rather than parsing the difference between 94 and 7 accept the fact that now you have three highly effective vaccines. Period.”

But it has practical advantages over the others: it can be administered in one shot and does no have to be kept frozen, making it easier to distribute to rural areas and to doctor’s offices and community clinics that do not have freezers.

United Press International

COVID-19

Vaccines Heading to L.A. Held Up by Winter Storms; Appointments Postponed

By City News Service

February 19, 2021

News & Community

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Up Next

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Mistrust Among Homeless Population Slows COVID-19 Vaccination Push in North America

Cal State L.A. Vaccine Site Now Open | Feb. 17

New Vaccination Site Brings LAUSD Closer to the Classroom, but Teachers Insist It’s Too Soon

State to Expand COVID Vaccines to Those with High-Risk Health Conditions

Medical workers load syringes with the Moderna Covid-19 vaccine to be administered by nurses at a

vaccination site at Kedren Community Health Center, in South Central Los Angeles, California on Feb. 16, 2021. | APU GOMES/AFP via Getty Images

By City News Service

February 19, 2021

News & Community

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LOS ANGELES (CNS) - Los Angeles' city-run vaccination sites will be closed today and all appointments rescheduled due to supply delays caused by winter storms throughout the nation.

“Severe weather across the country has disrupted travel and shipping nationwide, including delaying the delivery of our vaccines,” Mayor Eric Garcetti said Thursday while announcing the closures. “Our city is ready toadminister COVID-19 vaccines swiftly, safely and equitably — and as soon as doses arrive in Los Angeles, we will get them into people's arms immediately.”

Two shipments of vaccines heading to Los Angeles were held up due to grounded flights and icy roads:-- 26,000 doses that were supposed to arrive Tuesday are in Kentucky; and-- 37,000 doses intended to be used for next week's appointments are in Tennessee.

Weather-related delays of vaccine shipments have also forced the closure of vaccination sites in Orange County and are causing delays in vaccinations in San Diego County.

However, Los Angeles County officials said their sites have not been affected by any weather-related issues, and will remain open as scheduled. The Los Angeles County sites are administering only second doses of the two-dose regimen for people in need of

their second shot.

Garcetti said the city's mobile vaccination efforts will continue on Friday.

“One thing we won't pause on, even in the face of terrible weather and logistical challenges like these, is our commitment to equity. And even as we have to close down for a day those large vaccination sites, our mobile equity sites, those vans and those vehicles that are going out into communities to make sure, especially in hard-hit, high-density, low-income communities of color, we will continue to vaccinate tomorrow (Friday) and Saturday,” Garcetti said during his COVID-19 briefing Thursday.

The 12,500 people who had appointments scheduled at Los Angeles city-run sites Friday will receive a notification by text, email or phone that their appointment is postponed, according to Garcetti's office.

However, dozens of people showed up at the Dodger Stadium site for their previously scheduled appointments, apparently unaware of the closure, some saying they never got a cancellation text or email, according to a tweet from a KTLA5 reporter.

People whose appointments need to be rescheduled will be prioritized for new appointments once the city receives vaccine supply and receive a notification about their automatically rescheduled appointment.

“We are collaborating closely with the city of Los Angeles to ensure the vaccination distribution process is as smooth as possible,” said Dr. Sujal Mandavia, chief medical officer of Carbon Health, which coordinates the city's vaccination efforts.

“Second-dose appointments will be prioritized, and it is our intent to administer those second doses within the CDC-recommended time frame of 42 days after the first dose.”

The latest disruption comes less than a week after the city closed its vaccination sites last Friday and Saturday after exhausting its supply of first-dose Moderna vaccines.

Prior to running out of vaccines, the city received only 16,000 new doses for the week, while it was administering an average of 13,051 doses per day.

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CALIFORNIA

Column: Of course, Californians misused vaccine codes. The system is designed for cheating

Vehicles line up at a COVID-19 vaccination site at Cal State Los Angeles. The site was chosen for its proximity to Latino and Black neighborhoods that have been hit hard by the pandemic and are trailing other L.A. neighborhoods in terms of vaccinations. (Al Seib / Los Angeles Times)

By ERIKA D. SMITH | COLUMNIST

FEB. 24, 2021 10:32 AM PT

If there has been one constant in California's roller-coaster rollout of its COVID-19 vaccination program, it has been the cheaters. The vaccine chasers — many of whom have the luxury of working from home — who aren't yet eligible under the state's rules, but still exploit every angle to get themselves shots, often hogging doses meant for vulnerable Angelenos.

And as my colleague Julia Wick reported, they've struck again — this time intentionally or ignorantly using what were supposed to be secret access codes to

unlock blocks of appointments that had been set aside online for seniors living in hard-hit, largely Black and Latino neighborhoods.

This embarrassing blow to the state's often touted mission to distribute vaccines "with an equity lens" prompted Gov. Gavin Newsom to offer up a less-than-inspiring solution Tuesday.

"We're going to go away from group codes to individual codes," he said at a news conference, explaining that a community organization's group code was responsible for outsiders snagging appointments at a vaccination site at the Ramona Gardens public housing complex in Boyle Heights. "We're hopeful that we can work out the bugs."

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But what if these openings for abuse, which also has been rampant at the Cal State Los Angeles and Oakland Coliseum sites, aren't "bugs"? What if they're unfortunate features of the way California's vaccination program is designed — and whom it is designed for?

CALIFORNIA

Vaccine access codes for hard-hit Black, Latino communities improperly used in other L.A. areas

Feb. 23, 2021

What if the problem that needs solving by Newsom isn't the order in which people can book their appointments online, but rather the fact that people have to get online at all?

To dismiss these concerns — increasingly voiced by those working on the ground in underserved neighborhoods even as Newsom resorts to techno-babble about getting every county on My Turn, the state's online scheduling system — is to dismiss the massive digital divide in California and the needs of those stuck on the wrong side of it.

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Consider that just last year, as L.A. Unified was trying to figure out how to do remote learning, USC researchers found that 1 in 4 households in Los Angeles County with school-age children didn't have broadband internet access or a laptop or desktop computer.

Unsurprisingly, most of those 250,000 or so households were in South and East Los Angeles — neighborhoods with high numbers of Black and Latino essential workers who are getting sick and dying from COVID-19 at disproportionately elevated rates.

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These also are the neighborhoods where Black and Latino seniors are having a nearly impossible time scheduling appointments to get vaccinated.

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According to recent data from the L.A. County Department of Public Health, only about 9% of the residents in South L.A. and southeast Los Angeles County have gotten their first dose. Meanwhile, 25% or more have in wealthier areas, including Century City, Beverly Crest, Pacific Palisades and La Cañada Flintridge.

And, as is the case in many counties in California, the rate of at which white and Asian seniors have been vaccinated in Los Angeles is much higher than among those who are Black, Latino or Native American.

CALIFORNIA

New map shows deep inequities in L.A.'s COVID-19 vaccine rollout

Feb. 20, 2021

Pat Strong-Fargas, a pastor at Mt. Salem-New Wave Christian Fellowship Church, is one of the people in South L.A. who has been working to reverse that trend. It's hard, she said, because seniors are often wary of a vaccine they don't understand, but even more than that, they lack or don't understand the technology required to make an appointment.

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"Without having Wi-Fi, some should have smartphones, but don't. Some still have flip phones," said Strong-Fargas, known to most as Pastor Pat. "And then a lot do not have tablets, and the ones who do are fearful. They feel intimidated by the technology."

She reflected on her own experience of trying to book an appointment online.

"Somebody said do it after 12. And then somebody told me to do it early in the morning and on the weekends," Strong-Fargas said. "I tried all of that and it did not work — and I'm not afraid of technology. So just imagine people who are fearful."

Now, when she hears from seniors who want to get vaccinated, she doesn't even mention using the My Turn website or calling the county for an appointment, knowing some have reported sitting on hold for hours. Instead, she gets their names

and passes them along to the office of L.A. City Councilman Curren Price, who has begun staging pop-up vaccination clinics in local parks.

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I've written before about the staff at Kedren Community Health Center resorting to workarounds to ensure Black and Latino seniors can get vaccinated. A broader array of community groups, churches and nonprofits are doing the same, increasingly working with elected officials to create their own lists of seniors who want to get vaccinated and setting up their own separate databases for appointments.

CALIFORNIA

Column: How a South L.A. doctor is beating the system and distributing vaccines equitably

Jan. 29, 2021

Price, for example, has been encouraging people in his council district to call his office to schedule a time to get the vaccine, instead of trying to use the My Turn website. His staff has been passing out fliers and going door to door, and bringing seniors to the pop-up vaccination sites via private buses when necessary.

“Rather than stay online or waiting to get a phone call back or log onto a computer that they might not have or to get into a vehicle that they don’t have to travel across town, we’ve tried to make it very easy,” Price said.

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This is just one example of why achieving true equity in distributing COVID-19 vaccines will be much harder than the governor making a few tweaks to the state’s vaccination program and opening new sites.

Rather, it will require true cultural competency, as well as a willingness to listen and understand the needs of vulnerable people. It also could require a fundamental revamping of the vaccination program in some neighborhoods of some cities.

Because creating secret access codes — even moving to individual codes — will do little to eliminate racial disparities when the intended recipients lack internet access and are scared of technology.

Just like opening drive-through vaccination sites in underserved Black and Latino neighborhoods — another frequent point of criticism — isn’t going to help when many residents who need to be inoculated can’t drive or don’t have a vehicle. It’s just an invitation for more vaccine gentrification.

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Erika D. Smith is a columnist for the Los Angeles Times writing about the diversity of people and places across California. She joined The Times in 2018 as an assistant editor and helped expand coverage of the state's housing and homelessness crisis.

NEWS

Are White 'Vaccine Chasers' the Reason People of Color Aren't Getting Their COVID-19 Shots?

BY **JESSICA GOODHEART AND ANGELIKA ALBALADEJO** ON 2/25/21 AT 4:52 PM EST

NEWS CORONAVIRUS LOS ANGELES CALIFORNIA VACCINE

Why aren't vaccines reaching the hardest-hit Los Angeles communities? Registered nurse Emily Enos attempts to extract an extra dose of the Moderna COVID-19 vaccine outside the Los Angeles Mission on February 10, 2021 in Los Angeles, California.

MARIO TAMA/GETTY IMAGES

This story is co-published with Capital & Main

Veronica Sance was irate. For days, she'd been monitoring the sidewalk in front of a prime South Los Angeles COVID-19 vaccination site, Kedren Community Health Center. And she did not like what she was seeing.

"I was here on Thursday, Friday and Monday, and I was the only African American in the standby line," a situation she described as "horrendous." After securing a dose of the vaccine for herself, the 60-year-old activist who lives nearby returned the following week with a sign: "Go home vaccine chasers! Leave our vaccines alone!" On this particular day, the line of people willing to wait hours for unclaimed vaccines included a smattering of Asians, Latinos, African Americans, as well as whites.

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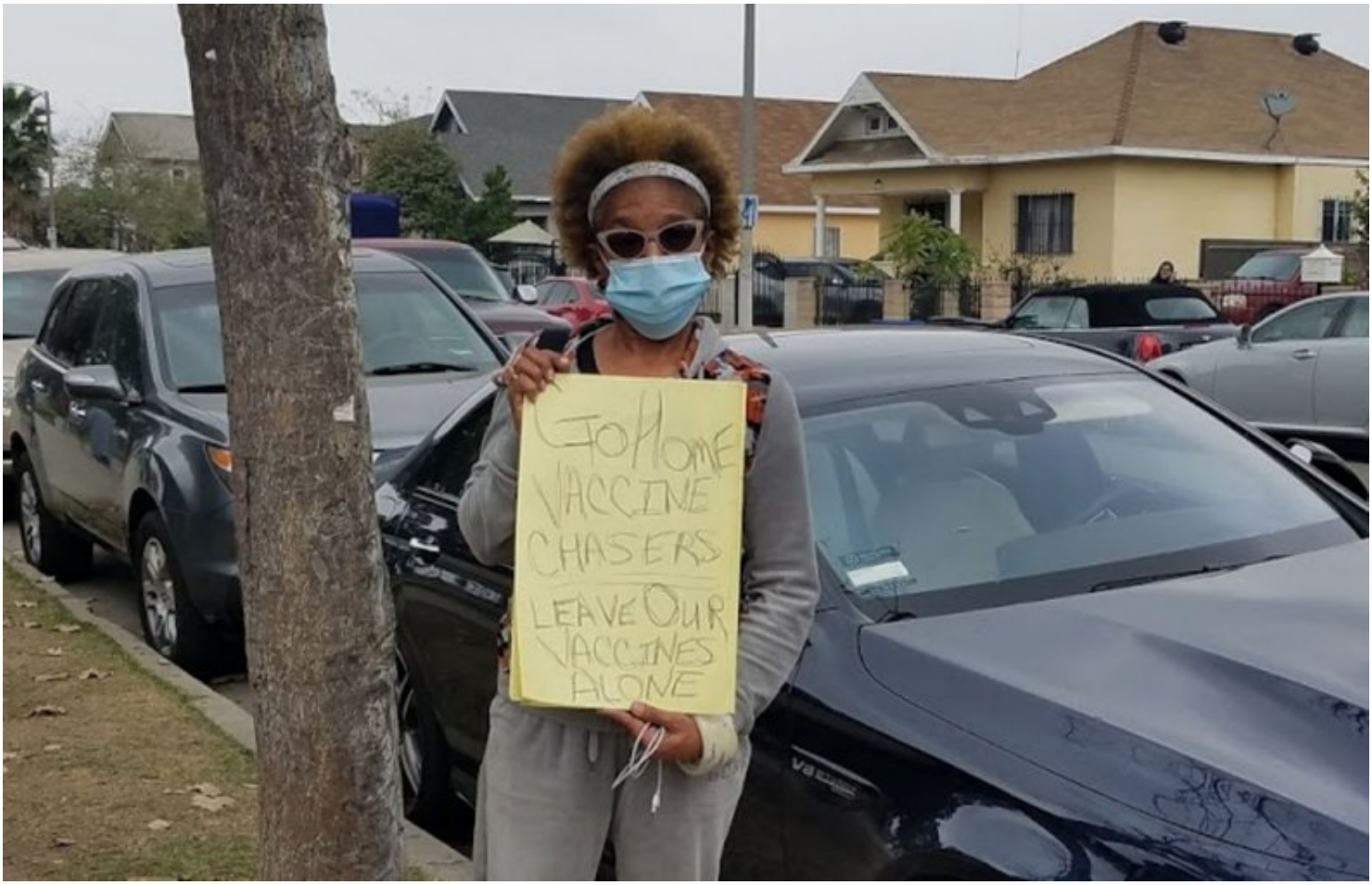
But for weeks, mostly white people with portable lawn chairs and time to spare had claimed those spots, she said. "How do they know and we don't know?"

The sight of those young, white "vaccine chasers" camped out in the Vernon Central neighborhood was jarring in a region where the coronavirus has hit Black and brown residents the hardest. But ensuring that the Kedren's standby line better reflects the surrounding neighborhood won't be enough to rectify the inequities in Los Angeles County's COVID-19 vaccine distribution. The county's effort involves meting out an ever fluctuating supply of doses to a sprawling region of 10 million people. Kedren has administered thousands of vaccines, and by all accounts has gone the extra mile to reach those most at risk of contracting and dying from COVID.

The big question in L.A. County is: Why are the Angelenos who are dying most from COVID-19 being vaccinated at such low rates? Case in point, in the neighborhood surrounding Kedren, only 5.5 percent of residents have been vaccinated. Meanwhile in the affluent community of Bel-Air, 19 miles away, 30 percent of people have been vaccinated. This may be in part because the

South L.A. neighborhood skews younger, making fewer of its residents eligible for the vaccine, despite the fact that the COVID-19 death rate in Vernon Central has been more than 10 times that of Bel-Air. (To date, California has prioritized vaccinating older people, along with health care workers and residents of skilled nursing facilities.)



Veronica Sance monitored the sidewalk in front of a prime South Los Angeles COVID-19 vaccination site--and didn't like what she saw.

JESSICA GOODHEART/CAPITAL&MAIN

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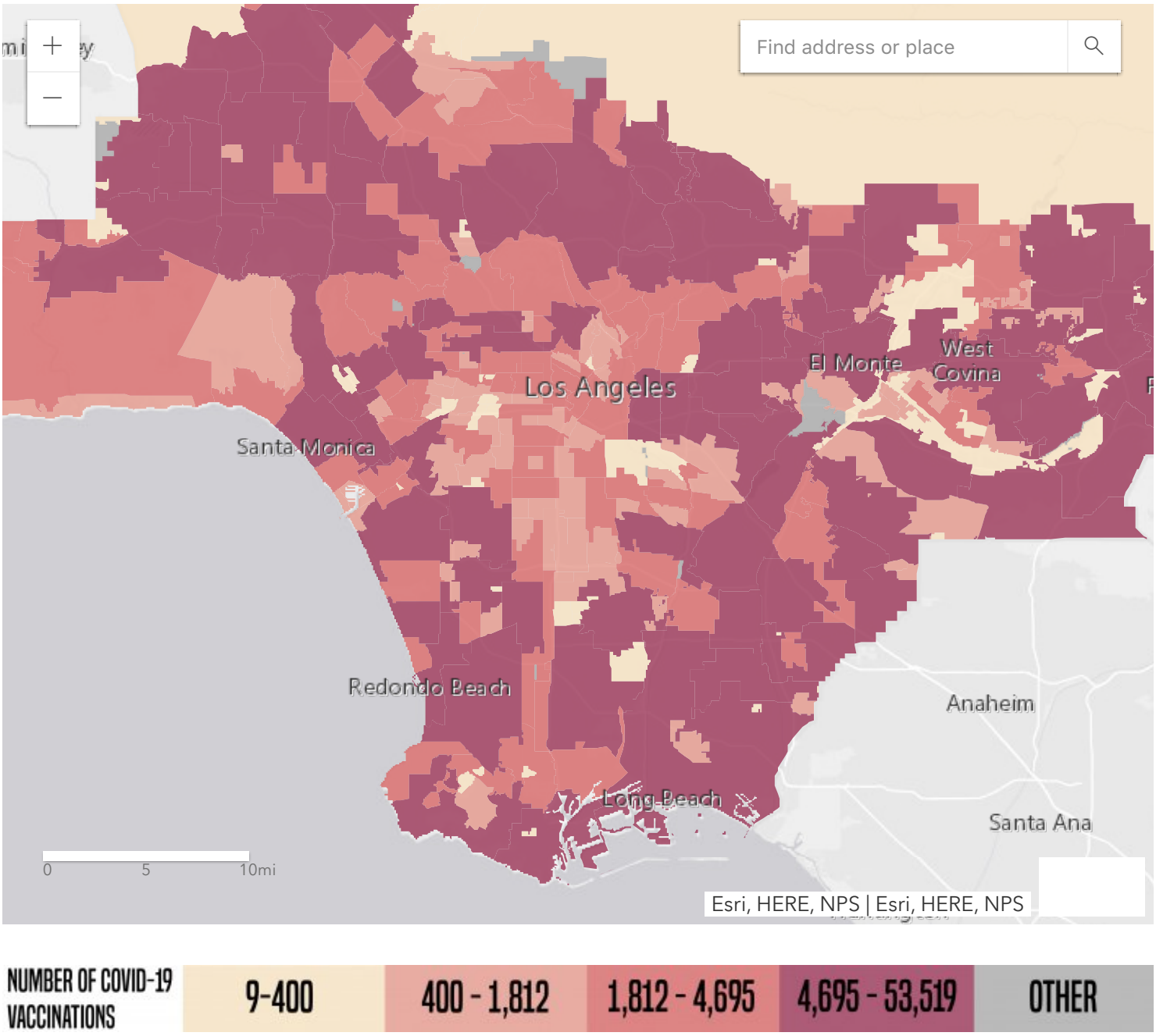
While COVID-19 case and death rates are declining across all groups after L.A.'s devastating winter surge, Latinos and African Americans continue to get sick and die at much higher rates than white and Asian Angelenos, who are

being vaccinated at higher rates. Latinos in the county have been almost three times more likely to die from COVID-19 than whites.

Click on interactive map below to view COVID-19 vaccinations distributed in Los Angeles County.



Recommendations for fairly distributing vaccines were developed as far back as October of last year, when the National Academies of Sciences, Engineering

and Medicine provided local and national leaders with a framework for dealing with the anticipated scarce supply. In November, California created a Community Vaccine Advisory Committee to make sure "the vaccine is distributed and allocated equitably." Yet when the vaccines arrived in mid-December, Los Angeles County lacked the ability to reach deeply into the communities that had been most affected, advocates told *Capital & Main*.

"It always seems like we're five steps behind, instead of being proactive," said Charisse Bremond-Weaver, the president and CEO of the Brotherhood Crusade, a grassroots group in South Los Angeles. Although the county knew that vaccines were coming, it did not set up the systems for coordinating appointments in a way that supports the folks who are the most vulnerable or who might not be technologically savvy, Bremond-Weaver said.

Instead, the county focused on standing up large vaccination sites, like those at Magic Mountain and Dodger Stadium, which facilitated the speedy vaccination of thousands of people but were only accessible by car with online registration.

This strategy of prioritizing volume over targeted communities has left many of those most in need by the wayside. "The inequities we saw with respect to cases, hospitalizations and deaths have been reflected so far in the vaccine administration. This is completely unacceptable," said Los Angeles County Supervisor Hilda Solis at a February 2 virtual press conference.

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Fauci Says Vaccine Rollout Isn't Failing Black Community Despite Challenges

Mass vaccination sites are logistically easy to roll out, said Steven Wallace, a professor at the University of California, Los Angeles, Fielding School of Public Health. But "taking the vaccine to where the people are is the most effective way of reaching those harder to reach populations," he said. And county officials agree.

Paul Simon, chief science officer at the Los Angeles County Department of Public Health, told *Capital & Main* during a virtual press conference that "early on, it was such a limited supply, and such great pressure to get folks

vaccinated as quickly as possible so we weren't holding on to the vaccine, that I think we did prioritize volume." But, the county "pivoted as quickly as possible to making sure that [we had an] equitable distribution," he said.

Now, the local government is launching partnerships long sought by community organizations to bring outreach and services to the most affected neighborhoods. Last week, the county's public health department started sending mobile teams to vaccinate elderly Angelenos in senior centers and housing developments, and began coordinating ride-share services to bring seniors to existing vaccine sites, according to a February 17 press release.

The County is also tapping community health workers to go "block by block" to provide information about the vaccine. Ten additional vaccination sites were added in East and South Los Angeles earlier this month. With vaccines in short supply last week, the county was prioritizing sending first doses to health centers, pharmacies and other providers in COVID-19 hot spots, according to Simon.

Bremond-Weaver's Brotherhood Crusade is one of the community groups

involved in the county's newest outreach program, dubbed the County COVID-19 Community Equity Fund. She told *Capital & Main* that it was meant to launch before the winter surge and vaccine rollout but hit delays. "With bureaucracy it can be a little slow, and that is our concern," Bremond-Weaver said. "By the time the county or city institute a contract, you're already months behind."

Rhonda Smith, executive director of the California Black Health Network, says an education campaign should have begun before the vaccines rolled out, one that dealt with the reluctance to get vaccinated among African Americans and other communities of color who have faced discrimination in the health care system. "There would be a different mindset and attitude about it because people would know and have more confidence, but that didn't happen," she said.

Felipe Escobar is the organizing director for Pacoima Beautiful, a nonprofit organization that serves one of the hardest hit communities in the county. He agrees that more of a running start on education likely would have helped. He began educating his own parents, who are in their 50s, during the Christmas holiday and reached out to Pacoima Beautiful members in January. He's battling concerns about the safety of the vaccine and misinformation that's ricocheting on social media, especially among young people.

Mostly, though, the seniors Escobar works with are anxious for the peace of mind that will come with a vaccine. When he spoke to *Capital & Main* in early February, he had just helped a senior get his first shot at California State University, Northridge. "He'd been on the phone for three hours." Pacoima Beautiful was also in the midst of hiring five people in order to reach a target of helping 200 people a month get access to shots.

The 56-year-old Watts Labor Community Action Committee (WLCAC) has also been participating in an L.A. city funded program to connect its homebound seniors with vaccines, particularly those located in COVID-19 hot spots. Some contend with a lack of family support systems, transportation challenges and low digital literacy. "Many seniors report they are frustrated and gave up making appointments for the COVID vaccine online," Phyllis Willis, senior director for older adult programs-senior services at WLCAC, wrote in an email.

It's easy to see how even painstaking outreach to vulnerable seniors, like Pacoima Beautiful and WLCAC are doing, is no match against a privileged and plugged-in population of more affluent residents with all-day internet access, a car and a willingness to brave one of the large vaccination sites.

But it would be a mistake, too, to paint any demographic group as a monolith. Many African Americans and Latinos have eagerly lined up for vaccines and some of them feel a special responsibility to cajole and coax others to follow

their lead. Ann Jackson, a 75-year-old South Los Angeles community leader, got a ride to Dodger Stadium from a younger friend in late January and was awed by the massive operation that involved thousands of orange cones. "I drove around and around and around and around until I got to the station where we were given the shots," she said. "When we finally got up to get the shot, I didn't feel anything."

Her friend, Pat Payne, 73, has been taking more of a wait and see approach. But she plans to get the Moderna vaccine from her provider, Kaiser, in the next couple of weeks. Both women have been touched by COVID-19. Jackson's cousin, a retired barber who continued to cut hair during the pandemic, was hospitalized with COVID-19. "Everyone at the barbershop has it," Jackson said.

Vaccine supply will likely remain tight for some time, even as new and more infectious variants potentially take hold. By March 1, teachers, food service workers and other frontline workers will enter the line for shots in California. By March 15, the state will open eligibility to people 16 to 64 with health conditions that put them at high risk for hospitalization and death. These newly

eligible groups will be competing with the county's seniors, 57.5 percent of whom have yet to receive the first of two required vaccine doses.

But there is a light at the end of the tunnel. Many more vaccines are expected to come on line in April, and they should be universally available by the end of July, according to President Joe Biden, who spoke at a televised town hall in Milwaukee last Tuesday.

In the meantime, the question is whether those most at risk will get prioritized access to early vaccines. Thus far many states have not done a good enough job of getting vaccines to those most impacted by COVID-19, Ashish Jah, dean of Brown University's School of Public Health and an expert on pandemics, said during a recent event. Jah doesn't believe the answer lies in creating more rules about who can get the vaccine. "The more complex you make the rules, the more people with resources and connections can figure out how to [comply with] those rules," he said.

Instead, the strategy needs to rely on local leaders and organizations to help overcome vaccine hesitancy and logistical barriers, he added. "Use a ground

game that uses local community resources, as a way to make sure that people who have color actually have much, much better access."

An effective ground game at scale costs money and is not yet in place, according to Simon from the Los Angeles County Department of Public Health. "It's going to really require not just our department getting more funding, but a commitment across multiple sectors to really make this work," he said.

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THE CORONAVIRUS CRISIS

Race Versus Time: Targeting Vaccine To The Most Vulnerable Is No Speedy Task

February 23, 2021 · 5:00 AM ET
Heard on Morning Edition

YUKI NOGUCHI

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At a Kedren Community Health Center vaccine clinic in South Central Los Angeles this month, 89-year-old Cecilia Onwytalu (center) signals she's more than ready to get her immunization against COVID-19.

Apu Gomes/Getty Images

Early in the pandemic, San Diego County recognized its COVID-19 relief efforts needed to reach its large Latino population, and set up a task force in June to lay out plans — well ahead of when vaccines became available.

Last month, it opened its first vaccination sites where the target population lives and works: Close to the Mexican border. But the people who showed up for appointments were white, more affluent, and didn't live there.

"Even by physically locating the centers down south, a lot of those appointment slots are taken up by people that are from the north of the county and more technologically savvy," says Dr. Christian Ramers, a member of the county's task force, and an executive at Family Health Centers of San Diego, which runs a network of 23 primary care clinics serving mostly minority and poor populations.

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Biden Administration Recruits Community Clinics To Help Solve Vaccine Inequities

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OPINION: Moral Tragedy Looms In Early Chaos Of U.S. COVID-19 Vaccine Distribution

Ramers says Latino people make up a third of San Diego's population, but account for about half of COVID-19 hospitalizations and deaths. And to date, only 15% received at least one dose of vaccine. So San Diego, like the rest of the country, is living a COVID-19 paradox: Those needing vaccine most aren't getting as much of the limited supply as the numbers suggest they should be getting.

"The challenges in ensuring equity are just very, very large," Ramers says. "And even despite having our eyes on the ball, the numbers don't really satisfy anybody."

The Biden administration set twin goals of trying to vaccinate people of color and others most vulnerable to COVID-19, and doing so swiftly. This week, the federal government will start supplying more vaccine to community health centers, whose patients tend to be minorities, homeless and the poor. But what those centers are learning is that speed and equity do not necessarily go hand in hand.

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Vaccinating Homeless Patients Against COVID-19: 'All Bets Are Off'

In some cases, health centers say, technology is a barrier, because appointment systems are too complex, or because they require a smart phone.

In many cases, the competition for the vaccine appointments is just too fierce. Jim Mangia, CEO of St. John's Well Child and Family Center in South Los Angeles, says his clinic had to hire 20 security guards at $12,000 a month to manage traffic and disputes among its long lines of vaccine seekers. Many of those in a line hoping to get leftover shots at the end of the day have come from wealthier parts of town, though the clinic generally serves the less well off. (During one incident, Mangia says, someone in line spit at a guard for moving an 82-year-old Black woman to the front.)

The biggest hurdles to vaccination are rooted in the realities of life for racial minorities and the working poor. They make up a large share of public-facing essential workers. Transportation may be a problem, or their daytime schedules may not allow time to hunt for appointments, or stand in line. They might be undocumented or lack insurance.

Many, Ramers say, are still waiting to meet with their doctor or religious leader to ask

questions, or get further assurance that vaccination is safe, both medically and legally.

NATIONAL

Many Latinos Are Hesitant To Get A COVID-19 Vaccine

SHOTS - HEALTH NEWS

'Trusted Messengers, Trusted Messages': How To Overcome Vaccine Hesitancy

"Hesitancy is not just one thing," Ramers says he's found. Many patients he hears from want to know how the vaccine might affect cancer treatment, or other medicines they're taking or their allergies.

Those conversations take time — and that clashes with the other major goal of vaccination: Speed.

Ramers says California started cutting back shipments when vaccinators don't administer shots quickly.

"There's immense pressure on using the vaccines as quickly as possible, and that tends to favor these mass vaccination sites, which really don't have the ability to target the communities that need it," he says.

That inequity should come as no surprise, given the existing racial disparities across the medical system, says Dr. Georges Benjamin, longtime executive director of the American Public Health Association.

While a great deal of effort went into developing a vaccine, Benjamin says, "we really haven't had a well financed, well-structured national effort to get into communities that we knew would be more hesitant and were disadvantaged by all of those social issues."

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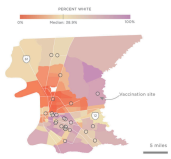
'You Can't Treat If You Can't Empathize': Black Doctors Tackle Vaccine Hesitancy



THE CORONAVIRUS CRISIS

Across The South COVID-19 Vaccine Sites Missing From Black And Hispanic Neighborhoods

The vaccine rollout is happening, he notes, as the country wrestles with racial disparity across public health — from policing to food insecurity. Disparities in vaccination are hard to track in the data, because race information is available for only 55% of those who have received doses. But among the states that do gather race data, disparities show up in early vaccination numbers.

The U.S. now has an opportunity to prove that it is shifting priorities, and trying to bridge those age-old gaps, says Harald Schmidt, an assistant professor of medical ethics at the University of Pennsylvania.

"The longer-term implication of how we dealt with social justice will be very powerful — so we do have to get this right," Schmidt says.

"Getting it right" for Dr. Suzanne Lagarde requires constantly evaluating what works at Fair Haven Community Health Care, in New Haven, Conn., where she is CEO.

Her center abandoned an online appointment system the Centers for Disease Control and Prevention helped set up called the Vaccine Administration Management System, for example, because it made no sense to her mostly Latino patients. She says it asked 14 difficult questions, phrased only in English: "One of them," Lagarde says, "is, 'Have you ever had an allergic reaction to polyethylene glycol?'

Instead, the clinic announced it would begin booking appointments by phone, and take questions there. But within half an hour, 300 calls from people all around the state crashed the phone system — as well as the backup answering service. So now,

Lagarde is rethinking her approach, again.

"I envision ultimately even going literally knocking on doors — because I think it might take that," she says. She hopes to vaccinate not just the patients the clinic knows, but also many thousands of others who've never sought care.

That, again, will take time.

"I need to get to the folks who are not getting into the big hospital systems," Lagarde says. "It's much more time intensive, but they're both needed — and as a country, we need to do both."

covid-19 vaccine coronavirus pandemic race and health racial disparities community health

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Buscan voluntarios para asistir a centros de vacunación de áreas más vulnerables

Los organizadores señalaron que algunas de estas personas podrían recibir la vacuna contra COVID-19.

Por Norma Ribeiro y Elizabeth Chavolla • Publicado el 05 de marzo del 2021 • Actualizado a las 7:00 pm del 05 de marzo del 2021

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los centros de vacunación, pero además algunos hasta podrían recibir la vacuna.

Los organizadores dicen necesitar voluntarios que ayuden con la logística, registración y también a los que tengan entrenamiento en el área de la medicina o cuidado de la salud para que ayuden a colocar las vacunas.

“Hoy estamos lanzando una campaña de voluntarios”, dijo Josh Fryday, director de servicios de California.

Miles de voluntarios se necesitan en todo el estado de California, a medida que se van abriendo más centros de vacunas y cada vez más personas son elegibles.

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“Es muy importante tener voluntarios porque nuestras personas mayores necesitan ayuda para la registración. Tenemos más de 200 voluntarios diarios aquí”, dijo Jerry Abraham, director del programa de vacunas de la clínica Kedron Health.

Victoria Ramírez es una voluntaria en el centro de vacunas, y dijo que fue la mejor decisión que pudo haber hecho.

“Estoy aquí en este momento tan histórico que estamos haciendo con la misión de ayudar a las personas”, dijo Ramírez.

Y gracias a que habla español, Ramírez ha podido ayudar especialmente a muchos hispanos en el sur de Los Ángeles, una de las comunidades más impactadas.

“Siendo latina, quiero ayudar a las personas afectadas como los latinos y las demás personas”, señaló Ramírez.

Quienes donen su tiempo en labores de logística, registro de pacientes, educación comunitaria o vacunación, si es que tienen entrenamiento médico, hay posibilidades de que también reciban la vacuna.

“Yo me pude vacunar y ya recibí la segunda dosis”, agregó Ramírez.

Cualquiera que quiera unirse a este esfuerzo para salvar vidas, debe preferiblemente ser mayor de 18 años y puede registrarse a través de la página myturnvolunteer.ca.gov

"Necesitamos toda la gente que pueda ayudar", dijo Fryday.

Los organizadores dijeron que los voluntarios que no tiene entrenamiento en áreas médicas pueden ayudar de otra manera. Entra aquí si desea más información.

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11:38 a.m. ET, March 2, 2021

Nearly 70% of Americans want to get a Covid-19 vaccine as soon as the can or already have, poll shows

From CNN's Naomi Thomas

A nurse picks up a Moderna Covid-19 vaccine that is ready to be administered at a vaccination site at Kedren Community Health Center in Los Angeles on February 16. Apu Gomes/AFP/Getty Images

A nurse picks up a Moderna Covid-19 vaccine that is ready to be administered at a vaccination site at Kedren Community Health Center in Los Angeles on February 16. Apu Gomes/AFP/Getty Images

Nearly 70% of Americans are likely to get the vaccine as soon as it is available to them or have already gotten it, according to new poll results from Axios-Ipsos published Tuesday.

The poll found that 68% of Americans said that they were likely to get the vaccine as soon as it was available, or have already gotten it.

The number of Americans saying they're not at all likely to get the vaccine – 21% – remains essentially unchanged since January, but the number saying they're not very likely to – 10% – has decreased by nine points since earlier in the year, according to the poll conducted Feb. 26 to March 1 and based on a nationally representative probability sample of 1,088 adults age 18 and up.

People with a college degree and Democrats expressed the greatest interest in getting vaccinated.

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< Vaccine Distribution: An Equity Challenge

March 2, 2021 · 4:00 AM ET

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MADDIE SOFIA, HOST:

You're listening to SHORT WAVE from NPR. Maddie Sofia here with NPR science reporter Pien Huang. Hi, Pien.

PIEN HUANG, BYLINE: Hey, Maddie.

SOFIA: So last time we had you on the pod, it was back in November, and you were giving us this little sneak peek into how COVID-19 vaccines might be distributed in the U.S. Do you remember that, Pien? Do you remember November?

HUANG: Wow.

(LAUGHTER)

HUANG: (Laughter) Like, that was a really long time ago. I mean, the last time we talked, the country was still in a limbo over who would be president. There were no COVID vaccines that had been authorized, and that was just three months ago, but it

feels like a whole lifetime.

SOFIA: We were so young. We were so young. So...

HUANG: Babies.

SOFIA: So, OK, Pien, vaccine distribution - big picture - how's it going?

HUANG: Well, the vaccine rollout got off to a rough start under President Trump. And for President Biden, one of his big priorities has been to try and speed it up.

SOFIA: Yeah.

HUANG: His administration set an early goal for his first 100 days. Here's Biden speaking on December 8, 2020, describing his administration's COVID-19 plan.

(SOUNDBITE OF ARCHIVED RECORDING)

PRESIDENT JOE BIDEN: A hundred million shots in the first 100 days, and we'll follow the guidance of science to get the vaccines to those most at risk.

HUANG: And that would have been one million a day. And now the country is actually at 1.4 million shots a day, so we're actually on track to hit and even to surpass that 100 million goal. And now, the Biden administration is also focusing on equity in vaccine distribution, meaning that the populations most impacted in this pandemic should be getting those shots.

SOFIA: Right.

HUANG: Here's Dr. Marcella Nunez-Smith, chair of Biden's COVID-19 Health Equity Task Force, at that same event.

(SOUNDBITE OF ARCHIVED RECORDING)

MARCELLA NUNEZ-SMITH: It is our societal obligation to ensure equitable access to

testing, treatments and vaccines, equitable support for those who are hurting and equitable pathways to opportunity as we emerge from this crisis and rebuild, including for those most marginalized communities.

SOFIA: Right. I mean, we've covered this on the pod before - communities of color, specifically Black and Latino, you know, some folks in tribal nations - all of these groups have been hit disproportionately hard by the coronavirus.

HUANG: Yeah, and members of these communities are more likely to become infected and die from the virus. They're at high risk because of factors like age, poor health, job requirements, crowded living conditions and other long-term health care disparities. But there's real concern that in the push for speed, we're not fully addressing the issue of equity, and we're leaving our most vulnerable communities behind.

(SOUNDBITE OF MUSIC)

SOFIA: So today on the show - getting COVID vaccines out quickly and equitably. This is SHORT WAVE, the daily science podcast from NPR.

(SOUNDBITE OF MUSIC)

SOFIA: OK, Pien, we are talking vaccine equity in the pandemic. And just a quick note, we are focusing just here in the United States for this episode. So let's start with some top-line numbers. Three COVID-19 vaccines have been authorized for emergency use in the U.S., one very recently. How many people have actually been vaccinated so far?

HUANG: Well, since vaccine distribution started in mid-December, around 50 million people have gotten at least one dose of a COVID-19 vaccine. That includes about 25 million people who've gotten two doses, which means they've been fully vaccinated with either the Pfizer or Moderna vaccines. And that's some real progress over the past two months. Still, just around 8% of the total U.S. population has been fully vaccinated, so there's still a long way to go.

SOFIA: Yeah, I mean, do we have any demographics on who the people who got the

vaccine are? Like, do we have any data on race or ethnicity?

HUANG: Well, last week, I spent some time at a CDC conference, which was online, and a bunch of public officials talked about it, including Dr. Marcella Nunez-Smith, who we heard from earlier.

(SOUNDBITE OF ARCHIVED RECORDING)

NUNEZ-SMITH: People of color are getting vaccinated at rates below their representation in the general population. We know these challenges reflect longstanding, deeply rooted systemic realities.

HUANG: But here's the thing - the data that she's talking about is still pretty limited. You know, so far, race and ethnicity data have only been collected for about half of the shots given out.

SOFIA: Wow, only half? That's - I mean, that's a little bit frustrating. That's not enough data.

HUANG: Yeah, it's really not. And the Biden administration has pointed this out themselves, and they acknowledge that it's pretty abysmal. Dr. Rochelle Walensky, she's head of the Centers for Disease Control and Prevention, and she says the problem is coming from a couple different directions.

(SOUNDBITE OF ARCHIVED RECORDING)

ROCHELLE WALENSKY: Individuals may choose not to report. It may not be required of or requested by providers. And some providers, as well as jurisdictions, have restrictions on data sharing.

SOFIA: So some of these data gaps are due to the fact that we have inconsistent systems around data gathering, which, you know, is something that has been happening quite a bit with this pandemic.

HUANG: Yeah, that's certainly part of it. And there's reasons why people might not want to share their personal information about race and ethnicity, especially people of color. You know, the federal government has a long history of exploiting and underserving minority communities...

SOFIA: Yeah.

HUANG: ...And that extends to this day. But now, there are government officials saying that it's up to them to try and convince people that it's important to give their information. Here's Nirav Shah, a health official in the state of Maine.

(SOUNDBITE OF ARCHIVED RECORDING)

NIRAV SHAH: In public health, what gets measured gets managed. And if we measure the right things, then we will manage the right issues. If we measure the wrong things, then the data that we collect that may not bear a resemblance to current present public health challenges is actually what we will end up managing.

HUANG: Yeah, so early on in vaccine distribution, the only metric that was available was the number of doses sent out and the number of doses administered, which basically measured speed.

SOFIA: Right.

HUANG: And so if the Biden-Harris administration wants to achieve both speed and equity with vaccine distribution, they're going to have to get more comprehensive data on race and ethnicity to get a handle on the problem.

SOFIA: Yeah. I mean, I want to talk about what the Biden administration is doing specifically to address this issue of vaccine equity. But first, let's talk about some of the ways the general rollout has put vulnerable communities at a disadvantage because that's definitely happening.

HUANG: Yeah. And to be honest, it's been hard for everyone, including health

reporters, to keep up with the changes that are happening daily and weekly with vaccine distribution. I mean, every single state has its own rules about who qualifies and how to sign up. Obviously, that confusion is compounded if the information isn't coming to you in the language you speak or if you don't have access to computers and email. And even for people who may have read up on how to book an appointment, it's taken them hours to actually research and book one. So if you don't have time to figure that out and if you don't have access to transportation or time off work to get to an appointment, in most places, you probably haven't been able to get vaccinated yet.

SOFIA: Yeah, I mean, that's when you know for sure that you want the vaccine.

HUANG: Exactly. And Dr. Christian Ramers - he's a physician and executive at Family Health Centers of San Diego - he points out that people also have questions that are very specific to their own circumstances, and they want those answered before they feel like they can make an informed decision to actually get vaccinated. Here he is speaking to my colleague, Yuki Noguchi.

CHRISTIAN RAMERS: Hesitancy is not just one thing. And in many cases, they're very unique to their own situation, like I just got treated for cancer or I'm on a certain medication or I've had an allergy in the past.

HUANG: And those are, you know, questions that will be answered most likely from talking one on one with a medical professional or some other trusted person, which, again, if you're part of an underserved community, is hard to access if you don't have the time to seek out those answers. You know, it would be much easier if the vaccines and the resources were coming directly to you.

SOFIA: Right, right. OK, so, Pien, what has the Biden administration specifically announced or done to address vaccine equity?

HUANG: So at that CDC conference, Dr. Marcella Nunez-Smith acknowledged that this is a huge issue, and it's not going to be easily solved.

(SOUNDBITE OF ARCHIVED RECORDING)

NUNEZ-SMITH: We must attend to the underlying social and structural drivers as we look ahead to building resilience into our recovery. What we do believe, though, is that the way we get America vaccinated and the emphasis we place on reaching our hardest hit communities, that's just as important as hitting the goals for the number of people vaccinated.

HUANG: So their strategy to get to those goals basically amounts to increasing a couple different things - No. 1, the number of vaccines available; No. 2, the number of people giving out vaccines; and No. 3, the number of places people can get vaccinated. And specific to equity, they've launched a few FEMA-supported mass vaccination sites. These are huge operations set up in stadiums and parking lots that are aiming to give out 6,000 shots a day. And they're putting some of these in places that score high on something called the Social Vulnerability Index.

SOFIA: Right, which is a CDC measurement of how vulnerable a community is based on social factors like poverty, for example.

HUANG: They've also started sending vaccines directly to community health centers, which serve around 30 million people overall, many of whom are rural or belong to minority groups or are low income. And these centers can also offer outreach in different languages and support for signing up.

SOFIA: I mean, are they also leaning on nonmedical sites, too? I mean, like, I know working with community leaders and partners can be especially effective.

HUANG: Yeah. Well, they're also talking about sending out mobile vaccination trucks to job sites and setting up clinics in local churches and high school gyms and YMCAs, you know, those nonmedical sites that you were talking about. And these local community clinics might not be serving thousands of people a day, but they will make the vaccine a lot more available and convenient for people in those communities to get.

SOFIA: Gotcha.

HUANG: So the Biden administration is really trying to take a both/and approach. They're supporting mass vaccination sites to get a lot of people vaccinated quickly, and they're also realizing that some people will take more time and more effort to reach, so they're also trying to figure out ways to gather better data and target underserved areas.

SOFIA: OK. So, you know, most of what we've been talking about today, Pien, is how the government is handling this, which I, you know, would argue is the most important facet. But, I mean, is there a sense of individual responsibility here? I know there are a bunch of stories out there about people line jumping or, like, going into communities outside their own to get vaccines.

HUANG: Yeah. We have all heard those stories, and it's hard to say how much it's happening, but it does make people feel like the system isn't working, you know. And what bioethicists have said to me is that cheating happens for sure, but it's probably not happening enough to undermine the system overall.

SOFIA: I mean, is that all kind of a short-term problem? I mean, there's a huge demand - right? - at this point and not enough supply. But the hope is that, you know, in the coming weeks or months, the situation will change as vaccine manufacturing and distribution ramp up even further, right?

HUANG: Yeah, and that's been the hope all along. I mean, for weeks now, we've been hearing about a flood of vaccines that will be coming online in the near future that will make it less cutthroat to get a vaccine appointment. And we're not there yet, but there are some promising signs. The government has now ordered a total of 600 million doses of Pfizer and Moderna vaccines to be delivered by the end of July, which is enough to cover 300 million people. And that's more than all the adults in the U.S.

SOFIA: Right. Right. Plus, we've got the newly authorized J&J vaccine, which will eventually make a difference.

HUANG: Right. And getting all these shots in arms is really urgent right now because we're kind of in a race between vaccinations and variants, which means that the more people you protect right now, the fewer people will catch the virus and the fewer chances the virus will have to keep mutating in ways that might make it evade the vaccines and the treatments we've developed. So that's why it's still super, super important to keep up the other measures that prevent the virus from spreading - double masking, staying physically distant. You know, we're all excited about vaccines, but health experts are saying right now that in the middle of this vaccination campaign is not the time to let up our guard.

SOFIA: OK, Pien Huang, we appreciate you, as always. Thank you for coming on the show.

HUANG: Thanks so much, Maddie, appreciate you, too.

SOFIA: This episode was produced by Thomas Lu, edited by Viet Le and fact-checked by Rasha Aridi. The audio engineer for this episode was Gilly Moon. Thanks for listening to SHORT WAVE from NPR.

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Thursday, March 4, 2021

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U.S. President Biden says the latest COVID-19 relief bill could provide resources needed in speeding up vaccination rollout in the U.S. CGTN America was granted access into a community health center in Los Angeles. Take a look at how this

Efforts Are Being Raised for Vaccine Equity for Essential Workers

Beyond supply and demand issues, the *LA Times* has been looking into COVID-vaccine equity and how to make sure all those who qualify for inoculation have proper access. According to L.A. County Public Health Data, cities where more than 25% of the population is vaccinated, are in wealthy areas. While in South L.A. and less affluent neighborhoods, only 9% are inoculated.

What You Need To Know

- **Beyond supply and demand issues, the *LA Times* has been looking into COVID-vaccine equity and how to make sure all those who qualify for inoculation have proper access**
- **According to L.A. County Public Health Data, cities where more than 25% of the population is vaccinated, are in wealthy areas. While in South L.A. and less affluent neighborhoods, only 9% are inoculated**
- ***LA Times* reporter Erika Smith had seen the disparity of vaccine access for essential workers when she hired movers who were essential workers who were not qualified to get the vaccine under state guidelines at least until next month**
- **Smith met City of Refuge L.A. Pastor Noel, he said that he went to get vaccinated to make a point to his congregation that the vaccines are safe**

LA Times Columnist Erika Smith volunteered at the Kedren Community Health Vaccine Center in South L.A. and spoke to both patients and workers on-site.

Before becoming a vaccination site, Kedren only provided mental health services, but the area decided to administer vaccines because of the lack of access in South Los Angeles.

“Right now, there are only so many vaccination sites in South L.A., which of all neighborhoods in L.A. County, has many essential workers, and that is where people are getting sick and dying the most. It tracks that there have not been many people going out to these sites, but the sites that do exist are drawing people from other parts of the county and city who cannot get appointments in other sites," said Smith.

"It is a weird scenario at Kedren Health, where you have people in line who are from the community and are 65 and older, waiting for their appointments. Still, then you also have this line of vaccine chasers for people who do not have an appointment but are hoping and waiting that there will be some leftover doses at the end of the day. Then some people are scheduling appointments online that do not live anywhere near South L.A. They chose to go to Kedren Health because it may have more appointments than Dodger Stadium or some of the other vaccination sites."

Smith had seen the disparity of vaccine access for essential workers when she was moving apartments.

“As somebody who lives by herself, I could not move a lot of heavy furniture by myself, so I ended up hiring a few people to help, and they were both essential workers under the age of 65. They had multiple moving appointments that day; they had PPE, and they were wearing masks and everything. But they were not qualified to get the vaccine under state guidelines at least until next month. It is one of those things where there is so much debate of who should get the vaccine next.”

The people exposed the most are the ones at the end of the line when it comes to vaccine access.

“I think the biggest argument about vaccine equity is whether we should be vaccinating people based on age. Or should we vaccinate them based on several other criteria, whether it is your age and the fact that you may be an essential worker? Is it about where you live? Do you live in a household with several different people? So, in some way, one person’s job becomes a risk for a whole lot of people. And that has been the story for South L.A., which is why you see the numbers that you do regarding the number of cases and deaths in that region,” added Smith.

There is great effort to get out into the community and raise awareness about the importance of vaccines.

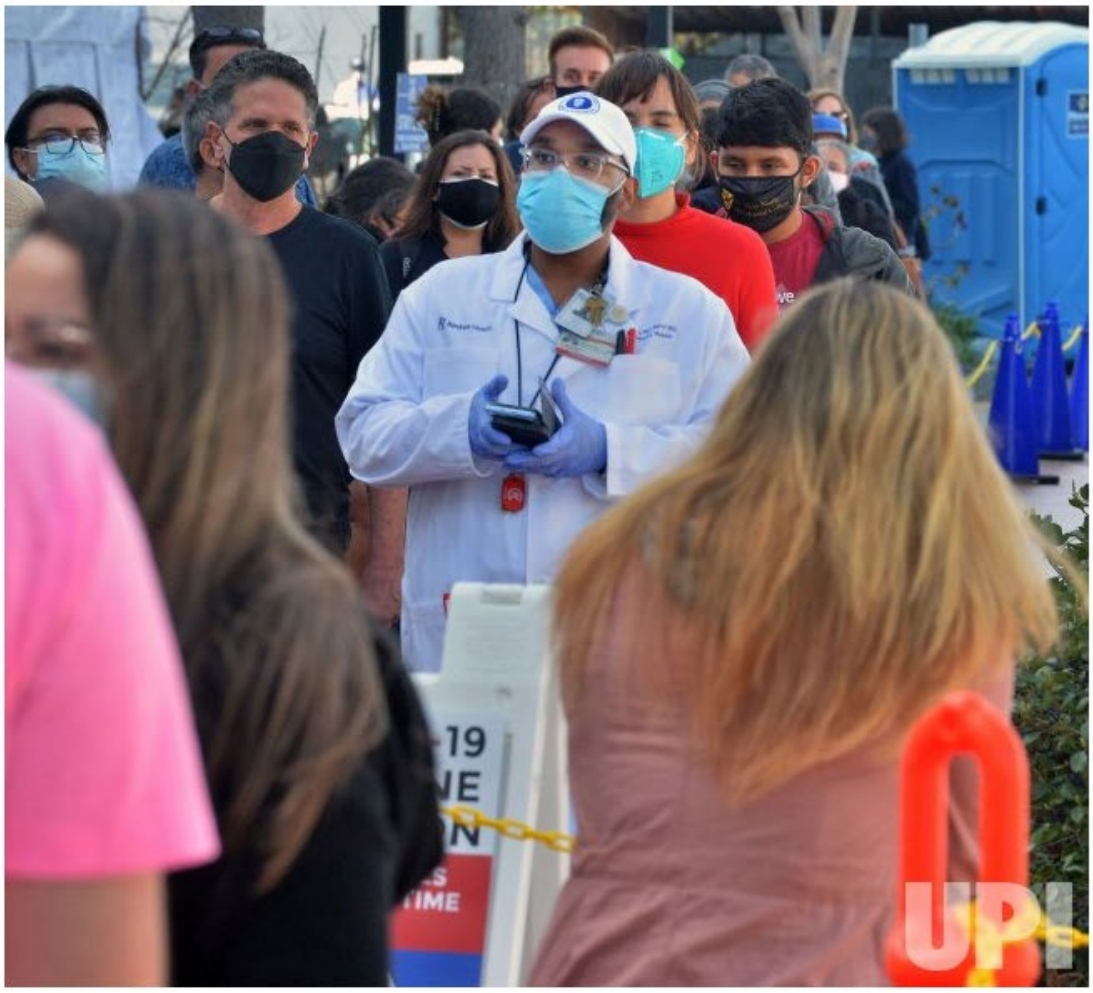
“I met Pastor Noel, and he is a pastor at City of Refuge L.A. in Gardena, and he had come to get vaccinated but to make a point to his congregation about the vaccines being safe," said Smith. "He told me about his congregation members who believe conspiracy theories and do not want to get vaccinated. So, he wanted to go out there and demonstrate the importance of doing it."

Pastor Noel also said there needs to be more dedication to vaccine equity because that will stop the virus.

“I think this idea that we can have the Westside of the County vaccinated and leave South L.A. to fend for itself is not going to work. We have people from South L.A. who are working as essential workers on the Westside and other parts of the county. So leaving people to continue to get sick and die is eventually going to affect everyone. As a city and county, if we cannot agree that we should let other people go first who need it most, we need to understand that we are all at risk. The longer that the people who are essential workers and more vulnerable are at risk of COVID-19, all of us are at risk as well.”

UPI

Focus on South L.A. Doctors Fighting Vaccine Inequities



Dr. Jerry P. Abraham stands amongst local residents waiting in line to receive a COVID-19 vaccination shot at the Kedren Community Health Center in South Los Angeles on Tuesday, February 16, 2021. To boost vaccination among people of color, L.A. county plans more sites, better messaging and access to transit. Black, Latino and Native American seniors are being vaccinated at lower rates than other groups. Photo by Jim Ruymen/UPI

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Focus on South L.A. Doctors Fighting Vaccine Inequities

A physician assistant prepares a syringe from a vial of the Moderna vaccine for local residents waiting in line to receive a COVID-19 vaccination shot at the Kedren Community Health Center in South Los Angeles on Tuesday, February 16, 2021. To boost vaccination among people of color, L.A. county plans more sites, better messaging and access to transit. Black, Latino and Native American seniors are being vaccinated at lower rates than other groups. Photo by Jim Ruymen/UPI

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Focus on South L.A. Doctors Fighting Vaccine Inequities

A local resident receives a COVID-19 vaccination shot at the Kedren Community Health Center in South Los Angeles on Tuesday, February 16, 2021. To boost vaccination among people of color, L.A. county plans more sites, better messaging and access to transit. Black, Latino and Native American seniors are being vaccinated at lower rates than other groups. Photo by Jim Ruymen/UPI

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Focus on South L.A. Doctors Fighting Vaccine Inequities

A physician assistant picks up a syringe prepared with the COVID-19 Moderna vaccine from a tray for a local resident waiting to be inoculated at the Kedren Community Health Center in South Los Angeles on Tuesday, February 16, 2021. To boost vaccination among people of color, L.A. county plans more sites, better messaging and access to transit. Black, Latino and Native American seniors are being vaccinated at lower rates than other groups. Photo by Jim Ruymen/UPI

Local residents wait in line to receive a COVID-19 vaccination shot at the Kedren Community Health Center in South Los Angeles on Tuesday, February 16, 2021. To boost vaccination among people of color, L.A. county plans more sites, better messaging and access to transit. Black, Latino and Native American seniors are being vaccinated at lower rates than other groups. Photo by Jim Ruymen/UPI

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South Los Angeles seniors have been able to show up at Kedren Community Health Center to get a COVID-19 vaccine without an appointment. Dr Jerry Abraham who runs the clinic has been spearheading an initiative to fast-track inoculations for the elderly, Latino and Black citizens, footage from Thursday shows.

South LA COVID vaccine standby line sparks racial equity debate

Stella Kim and James Cannon arrived at Kedren Community Health Center at 5 a.m. to wait in the standby line for COVID-19 vaccines. With about 30 people in front of them, they felt they had a 50% chance of getting a shot that day.

Kedren Community Health Center primarily serves Black and Latino Angelenos who have been disproportionately affected by the pandemic. And right now, it's a COVID-19 vaccine distribution center.

Every day, dozens of people form an unofficial standby line on the sidewalk outside.

6 a.m.

Before the sun rises, there are already about 30 people in line. At the front is Michael Jansen. He and his teenaged son arrived from Silverlake at 7:30 the night before. He brought food, entertainment, panchos and tarps for the rain that morning, and a tent to sleep in. It's not his first rodeo.

"We started on a whim, we just heard about it through a text, someone saying, 'Hey, there's extra vaccine.' We're like, 'Okay, it's leftover vaccine, it's not hurting anyone, it's leftover,'" he says.

It's his sixth time standing in this line, hoping to get lucky. "I feel like it's a civic responsibility to get a shot in your arm as quickly as possible. I would hate for things to get thrown out," he says.

Kedren opens every day at 8 a.m. When it closes at 4 p.m., vaccines that didn't get used during the day could go to people camping in tents or sitting in lawn chairs outside.

After Jansen is a man named Ben. He wants to be identified only by his first name. Many people in line are entertainment industry workers or company founders, and they worry about friends and colleagues knowing that they're traveling to Kedren Health to wait for a leftover vaccine.

"I haven't seen my family in a while, and they're in Florida, and they're doctors and they're vaccinated. And so I would like to eventually — once I'm immunized — travel and see them," Ben says.

Ben, who chose to withhold his last name for privacy reasons, arrived at Kedren Community Health Center at 10:30 p.m. to secure a spot in the COVID vaccine standby line for the next day. He slept in a tent he bought for $20. Photo by Caleigh Wells.

Ben lives in Venice. Other people in line hail from Encino, Hollywood and Hancock Park. They're passing the time on their laptops or tablets.

Most people in the queue are white, so they're conspicuous in the Historic South Central neighborhood of LA, where 97% of residents are Latino or Black, and the median household income is less than $40,000.

12 p.m.

By noon, the line resembles a lively tailgate party. Some people brought bluetooth speakers. One group brought a card table and is playing Settlers of Catan.

Stella Kim has the day off from her job in retail. She came at 5 a.m. and brought a Nintendo Switch and plenty of snacks.

"Being able to have that peace of mind is invaluable, and since we don't really know when it's going to be our turn," she says. "I fully recognize that we're privileged enough to be able to sit here all day long. Not a lot of people can spend that time to do that," she says.

Kim learned about the line through word of mouth. There are also local Facebook groups and websites that publicize where leftover vaccines are available, and they're growing in popularity.

There's a sense of camaraderie. Some of the people who have been here before recognize each other and have become friends.

Closing time

Around 3:30 p.m., a half hour before the clinic closes, the vibe changes. All at once, they pack up their tents and lawn chairs and face the front gate. The backyard barbecue has become a single-file queue. Everyone at the front is nervous but excited.

“I’m pretty sure we’ll give seven of them at least,” says a woman in scrubs to the people at the front. “You’re really close.”

Meanwhile, a steady stream of cars drives up and drops off people who are almost all Black and Latino and under age 65.

This group stands to the left of Kedren’s gate, while frustrated overnight campers are to the right. All have their eyes on the doors, waiting for someone in scrubs to tell them there’s a shot inside for them.

The people in line get uncomfortable. “They’re kind of here under another pretense, thinking they can cut the line,” says Ben.

Victoria Sance watches the scene. She waited in the standby line and got her shot last week. But she keeps coming back.

“I was the only Black person in the line. What’s wrong with that picture, lady? If all these white people know, how come the Black people in the community don’t know that there's been extra vaccine?”

She says she’s designated herself as a sort of poll watcher for this standby line.

“If all these white people from these affluent neighborhoods are coming east of the 110 freeway … yes it’s legal for them to line up, but is it morally legal for them to come take our vaccines?”

People in line begin to heckle Sance. “Tell us where to stand,” calls one of them. Because yes, there are unofficial standby lines in Encino and West Hollywood, but Kedren Health is known for having more leftover doses.

5 p.m.

An hour after the clinic closes, about 30 people from the local community who arrived later are escorted inside.

Kedren Health Center officials have been watching this scene for days, and finally they decided to do something different. People from the neighborhood — the 90011 zip code — got to go first. Everyone else in the standby line had to wait.

The head of vaccine distribution, Dr. Jerry Abraham, says the clinic is doing what it can to serve those at highest risk for getting COVID-19.

“Our neighbors here at Kedren are a 80-90% predominantly Spanish-speaking Latinx community. Why are they not getting through?” he asks. “90011: That’s a zip code with a very high heat map for infection rates. There’s a clear reason why they might be able to walk through or skip ahead or be prioritized.”

Abraham has heard from community members angry when they see white people waiting for vaccinations.

“There are those tensions that exist, and we are doing everything we can to be peacemakers and to get this vaccine out as quickly and as safely as we can. And we want to avoid conflicts between the groups that are finding their way outside.”

Outside Kedren, the sun has set and it’s getting cold. Finally, the doctor comes out to the standby line. He says he waited and stayed late to make sure every last vaccine was used that day. And then he announces that none were available for the people in line.

Within minutes, the line dissipates. Ben stays behind to pack up the $20 tent he bought the week before.

He says he understands why Kedren prioritized the neighborhood residents, but he’s frustrated by the unpredictability of it all.

“It doesn’t feel like there’s much consistency to what’s going on here. It feels like people trying to get backstage at a concert, and some people know the DJ, and some don’t.”

He says after 19 hours on this sidewalk, he’ll go home to catch up on the work he didn’t get done sitting in his tent all day. He’s not sure yet if he’ll come back or if it’s time to give up and wait his turn.

CAPITAL & MAIN

Vaccines Are Not Reaching Hardest Hit Los Angeles Communities

Why are whites more likely to get their shots when people of color suffer more from COVID-19?

Entrance to Kedren Community Health Center's vaccination site. (Photo: Jessica Goodheart)

Veronica Sance was irate. For days, she'd been monitoring the sidewalk in front of a prime South Los Angeles COVID-19 vaccination site, Kedren Community Health Center. And she did not like what she was seeing.

"I was here on Thursday, Friday and Monday, and I was the only African American in the standby line," a situation she described as "horrendous." After securing a dose of the vaccine for herself, the 60-year-old activist who lives nearby returned the following week with a sign: "Go home vaccine chasers! Leave our vaccines alone!" On this particular day, the line of people willing to wait hours for unclaimed vaccines included a smattering of Asians, Latinos, African Americans, as well as whites.

But for weeks, mostly white people with portable lawn chairs and time to spare had claimed those spots, she complained. “How do they know and we don’t know?”

The sight of those young, white “vaccine chasers” camped out in the Vernon Central neighborhood was jarring in a region where the coronavirus has hit Black and brown residents the hardest. But ensuring that the Kedren’s standby line better reflects the surrounding neighborhood won’t be enough to rectify the inequities in Los Angeles County’s COVID-19 vaccine distribution. The county’s effort involves meting out an ever fluctuating supply of doses to a sprawling region of 10 million people. Kedren has administered thousands of vaccines, and by all accounts has gone the extra mile to reach those most at risk of contracting and dying from COVID.

The big question in L.A. County is: Why are the Angelenos who are dying most from COVID-19 being vaccinated at such low rates? Case in point, in the neighborhood surrounding Kedren, only 5.5% of residents have been vaccinated. Meanwhile in the affluent community of Bel-Air, 19 miles away, 30% of people have been vaccinated. This may be in part because the South L.A. neighborhood skews younger, making fewer of its residents eligible for the vaccine, despite the fact that the COVID-19 death rate in Vernon Central has been more than 10 times that of Bel-Air. (To date, California has prioritized vaccinating older people, along with health care workers and residents of skilled nursing facilities.)

While COVID-19 case and death rates are declining across all groups after L.A.’s devastating winter surge, Latinos and African Americans continue to get sick and die at much higher rates than white and Asian Angelenos, who are being vaccinated at higher rates. Latinos in the county have been almost three times more likely to die from COVID-19 than whites.

Recommendations for fairly distributing vaccines were developed as far back as October of last year, when the National Academies of Sciences, Engineering and Medicine provided local and national leaders with a framework for dealing with the anticipated scarce supply. In November, California created a Community Vaccine Advisory Committee to make sure “the vaccine is distributed and allocated equitably.” Yet when the vaccines arrived in mid-December, Los Angeles County lacked the ability to reach deeply into the communities that had been most affected, advocates told Capital & Main.

“It always seems like we’re five steps behind, instead of being proactive,” said Charisse Bremond-Weaver, the president and CEO of the Brotherhood Crusade, a grassroots group in South Los Angeles. Although the county knew that vaccines were coming, it did not set up the systems for coordinating appointments in a way that supports the folks who are the most vulnerable or who might not be technologically savvy, Bremond-Weaver said.

Instead, the county focused on standing up large vaccination sites, like those at Magic Mountain and Dodger Stadium, which facilitated the speedy vaccination of thousands of people but were only accessible by car with online registration.

This strategy of prioritizing volume over targeted communities has left many of those most in need by the wayside. “The inequities we saw with respect to cases, hospitalizations and deaths have been reflected so far in the vaccine administration. This is completely

unacceptable," said Los Angeles County Supervisor Hilda Solis at a February 2 virtual press conference.

Mass vaccination sites are logistically easy to roll out, said Steven Wallace, a professor at the University of California, Los Angeles, Fielding School of Public Health. But "taking the vaccine to where the people are is the most effective way of reaching those harder to reach populations," he said. And county officials agree.
Paul Simon, chief science officer at the Los Angeles County Department of Public Health, told Capital & Main during a virtual press conference that "early on, it was such a limited supply, and such great pressure to get folks vaccinated as quickly as possible so we weren't holding on to the vaccine, that I think we did prioritize volume." But, the county "pivoted as quickly as possible to making sure that [we had an] equitable distribution," he said.

Now, the local government is launching partnerships long sought by community organizations to bring outreach and services to the most affected neighborhoods. Last week, the county's public health department started sending mobile teams to vaccinate elderly Angelenos in senior centers and housing developments, and began coordinating ride-share services to bring seniors to existing vaccine sites, according to a February 17 press release.

The County is also tapping community health workers to go "block by block" to provide information about the vaccine. Ten additional vaccination sites were added in East and South Los Angeles earlier this month. With vaccines in short supply last week, the county was prioritizing sending first doses to health centers, pharmacies and other providers in COVID-19 hot spots, according to Simon.

Bremond-Weaver's Brotherhood Crusade is one of the community groups involved in the county's newest outreach program, dubbed the County COVID-19 Community Equity Fund. She told Capital & Main that it was meant to launch before the winter surge and vaccine rollout but hit delays. "With bureaucracy it can be a little slow, and that is our concern," Bremond-Weaver said. "By the time the county or city institute a contract, you're already months behind."

Rhonda Smith, executive director of the California Black Health Network, says an education campaign should have begun before the vaccines rolled out, one that dealt with the reluctance to get vaccinated among African Americans and other communities of color who have faced discrimination in the health care system. "There would be a different mindset and attitude about it because people would know and have more confidence, but that didn't happen," she said.

Felipe Escobar is the organizing director for Pacoima Beautiful, a nonprofit organization that serves one of the hardest hit communities in the county. He agrees that more of a running start on education likely would have helped. He began educating his own parents, who are in their 50s, during the Christmas holiday and reached out to Pacoima Beautiful members in January. He's battling concerns about the safety of the vaccine and misinformation that's ricocheting on social media, especially among young people.

Mostly, though, the seniors Escobar works with are anxious for the peace of mind that will come with a vaccine. When he spoke to Capital & Main in early February, he had just helped

a senior get his first shot at California State University, Northridge. “He’d been on the phone for three hours.” Pacoima Beautiful was also in the midst of hiring five people in order to reach a target of helping 200 people a month get access to shots.

The 56-year-old Watts Labor Community Action Committee (WLCAC) has also been participating in an L.A. city funded program to connect its homebound seniors with vaccines, particularly those located in COVID-19 hot spots. Some contend with a lack of family support systems, transportation challenges and low digital literacy. “Many seniors report they are frustrated and gave up making appointments for the COVID vaccine online,” Phyllis Willis, senior director for older adult programs-senior services at WLCAC, wrote in an email.

It’s easy to see how even painstaking outreach to vulnerable seniors, like Pacoima Beautiful and WLCAC are doing, is no match against a privileged and plugged-in population of more affluent residents with all-day internet access, a car and a willingness to brave one of the large vaccination sites.

But it would be a mistake, too, to paint any demographic group as a monolith. Many African Americans and Latinos have eagerly lined up for vaccines and some of them feel a special responsibility to cajole and coax others to follow their lead. Ann Jackson, a 75-year-old South Los Angeles community leader, got a ride to Dodger Stadium from a younger friend in late January and was awed by the massive operation that involved thousands of orange cones. “I drove around and around and around and around until I got to the station where we were given the shots,” she said. “When we finally got up to get the shot, I didn’t feel anything.”

Her friend, Pat Payne, 73, has been taking more of a wait and see approach. But she plans to get the Moderna vaccine from her provider, Kaiser, in the next couple of weeks. Both women have been touched by COVID-19. Jackson’s cousin, a retired barber who continued to cut hair during the pandemic, was hospitalized with COVID-19. “Everyone at the barbershop has it,” Jackson said.

Vaccine supply will likely remain tight for some time, even as new and more infectious variants potentially take hold. By March 1, teachers, food service workers and other frontline workers will enter the line for shots in California. By March 15, the state will open eligibility to people 16 to 64 with health conditions that put them at high risk for hospitalization and death. These newly eligible groups will be competing with the county’s seniors, 57.5% of whom have yet to receive the first of two required vaccine doses.

But there is a light at the end of the tunnel. Many more vaccines are expected to come on line in April, and they should be universally available by the end of July, according to President Joe Biden, who spoke at a televised town hall in Milwaukee last Tuesday.

In the meantime, the question is whether those most at risk will get prioritized access to early vaccines. Thus far many states have not done a good enough job of getting vaccines to those most impacted by COVID-19, Ashish Jah, dean of Brown University’s School of Public Health and an expert on pandemics, said during a recent event. Jah doesn’t believe the answer lies in creating more rules about who can get the vaccine. “The more complex you make the rules, the more people with resources and connections can figure out how to [comply with] those rules,” he said.

Instead, the strategy needs to rely on local leaders and organizations to help overcome vaccine hesitancy and logistical barriers, he added. “Use a ground game that uses local community resources, as a way to make sure that people who have color actually have much, much better access.”

An effective ground game at scale costs money and is not yet in place, according to Simon from the Los Angeles County Department of Public Health. “It’s going to really require not just our department getting more funding, but a commitment across multiple sectors to really make this work,” he said.

LA Progressive

Big Pharma Shouldn't Control Covid-19 Vaccines

At a recent virtual gathering of parents and faculty at my children's school, one parent who is a teacher and therefore eligible to receive a COVID-19 vaccine mentioned that she got her first Pfizer shot at a local pharmacy, and when she asked about a leftover dose that could be given to her husband rather than thrown away, her husband got lucky. The rest of us parents eagerly took down the drug store's information and called about leftover doses after the meeting. Better for the vaccines to be dispensed than thrown into the trash, was our logic. But the pharmacist, perhaps tired of being hounded about extra doses, informed us they would no longer give them out to those who weren't currently eligible.

It's the vaccine Hunger Games. Or, as the creator of the Minneapolis Vaccine Hunter Facebook group told the New York Times, "It's like buying Bruce Springsteen tickets."

In the private Los Angeles Vaccine Hunter Facebook group in which I lurked for a few days, both as a bona fide member and as a journalist, I observed Southern Californians sharing tips about how to obtain leftover doses at Kedren Community Health Center in South Los Angeles, a private clinic serving a vulnerable community. Vaccine hunters reminded one another to be polite and considerate to the community they obviously did not hail from, and some even said they made a donation after getting their shots. Obtaining leftover doses requires standing in a separate line, sometimes for hours, with no guarantee of getting a vaccine. Many fear being judged.

There is shame and blame all around. There are accusations that those who are privileged are cutting ahead of others. There is disappointment and unfairness. In January, journalists like me were included in an early "tier" of eligibility in California, classified as essential workers under "Communications and IT." As a daily television and radio show host, I am required to come into contact with at least one staff member daily. News reporting cannot stop. And yet by February, the eligibility had disappeared as Los Angeles County reconfigured its eligibility tiers.

In the meantime, my husband, a work-from-home scientist, is classified as an "educator" because he is employed by a university. Although in-person classes will not resume until the fall on many campuses, he and others like him are eligible to get the vaccine now simply because county authorities decided so. As one vaccine hunter asked on Facebook, why are we "letting the government dictate who gets to live or die, and labeling who is essential and who is not essential to society"?

And yet, even for those who are eligible, finding a vaccine has turned into a blood sport. The conservative Wall Street Journal recommends that elderly Americans who may not be tech-savvy should simply "Recruit a College Kid with Tech Skills and Patience," to navigate the "bewildering field of online portals and limited supplies."

So far in California, most of those who need vaccines the most have not received them. According to the Associated Press, "African Americans have received 3% of vaccine doses while they make up 6% of the state. Latinos, who make up 39% of the state, have received 17% of doses." Meanwhile,

Republican-led states like Texas and Mississippi are ending all quarantine and safety requirements, well before vaccination rates are at safe levels.

Given the extreme difficulty in obtaining a vaccine, authoritative exhortations by officials "to get a shot if it's offered to you" and to set aside any guilt about who deserves it and who is cutting in line ignore the real problem: we live in a nation where health care is considered an individual privilege by way of employment, not a right. Health care in the United States is considered an industry where profits are a critical priority over the delivery of care.

At the heart of the desperate stampede to obtain vaccines is one simple dilemma: there aren't enough vaccines against COVID-19 being produced. Variants of the virus are developing faster than nations are able to inoculate their populations, and plummeting infection rates in the U.S. have now leveled off.

Part of the problem is that former President Donald Trump, who quietly got vaccinated recently and wants all the credit for vaccine development, last year turned down the chance to purchase additional Pfizer vaccines beyond the first 100 million doses. After President Joe Biden threatened to invoke the Defense Production Act to force Pfizer and Moderna to produce more vaccines, the companies agreed to sell more doses faster than had been agreed upon.

Also showcasing that governments can indeed force private companies to do what is needed, Biden more recently brokered a deal with the pharmaceutical company Merck to produce extra doses of a new vaccine developed by Johnson & Johnson. Merck is being paid handsomely with $268.8 million of taxpayer funds. Biden has also invoked the Defense Production Act to help the company obtain the supplies it needs. Had Trump last year used the might of the U.S. government against these private companies, we might not be fighting to sign up for vaccines today.

Pharmaceutical companies whose vaccines were funded by massive public investments still refuse to share their intellectual property with the world. The Open COVID Pledge, created by a group of academics and scientists to make virus-related technology freely available, has urged corporations to prioritize public health over profit. But notably absent from the pledge's list of signatories are Pfizer, BioNTech, Moderna, Johnson & Johnson, or Merck.

The United States and other nations where these pharmaceutical companies are based could force them to share the life-saving information, especially because doing so keeps all of us safe. Unless nations stop all international travel across borders, hoarding vaccine technology from the rest of the world will not help anyone. The old adage of "no one is safe until everyone is safe" applies especially well to the pandemic.

Journalists with the Associated Press say they found three factories on three continents that could begin manufacturing "hundreds of millions of COVID-19 vaccines on short notice if only they had the blueprints and technical know-how." Except that such "knowledge belongs to the large pharmaceutical companies who have produced the first three vaccines."

Instead of blaming and shaming one another over the frustrating lack of vaccine availability and the individual race to obtain it, Americans ought to turn their gaze to the companies that are manufacturing the products. Pfizer and Moderna have earned near-mythical status for the life-saving

vaccines, but it behooves us to remember that these private entities were paid handsomely to do their job and cannot be allowed to hold humanity hostage over their profits.

Los Angeles Times

Why wealthy spots like Beverly Hills, San Marino have the highest COVID vaccination rates

Syringes filled with COVID-19 vaccines await use at Kedren Health in Los Angeles. (Jason Armond / Los Angeles Times)

Striking inequities are emerging in the COVID-19 vaccine rollout, with residents of wealthy areas receiving far more vaccinations than those in poorer neighborhoods, data show.

Los Angeles County's wealthiest and more predominantly white cities have a far greater percentage of residents vaccinated for COVID-19 than its poorest regions, home to large Black and Latino populations.

"The findings clearly indicate very significant inequities in the distribution of vaccine to date," said Dr. Paul Simon, chief science officer for the Los Angeles County Department of Public Health. "These inequities are unjust and unacceptable and demand renewed efforts to address them."

A Times analysis found that areas hardest hit by the pandemic have the lowest vaccination rates. In South L.A., only 1 out of 24 people are vaccinated — a low rate for L.A. County — while 1 in 6 coronavirus tests come back positive.

Simon said one of the biggest barriers to vaccinations has been the appointment registration process.

"The websites have been flooded with folks trying to get an appointment. And so those people who have the luxury of time can spend, literally in some cases, hours, I'm sad to say, working to try to get an appointment," Simon said. Many seniors have relied on their children, nieces, nephews or other friends who are more comfortable using the internet to help get them an appointment.

In addition, the use of so-called mega-POD (point of distribution) sites in the county — such as the Forum and Pomona Fairplex super sites — has been criticized. They're off-putting for those trying to avoid large crowds, critics say, and the demographic served often doesn't reflect the county's poorer residents.

Simon said the strategy of using massive sites was done to dispense vaccinations quickly and has been successful in that regard. "We're using more than 90% of our supply within four days of receiving it," he said. "But those big mega-PODs don't necessarily work so well for these underserved communities."

Distributing the vaccine is considered the center of efforts to finally bring COVID-19 under control. But demand has far outstripped the limited supply.

Los Angeles County recorded its 20,000th death from COVID-19 on Tuesday, a tragic milestone that came as California's cumulative death toll neared 50,000 and as the national death toll passed 500,000 Monday.

But those tallies come amid a dramatically improving picture. Daily coronavirus case counts in Los Angeles County are reaching lows not seen since early November, during the first few weeks of the autumn-and-winter surge. L.A. County recorded an average of 2,000 cases a day for the seven-day period that ended Tuesday, down 87% from early January, when there were more than 15,000 new cases a day.

L.A. County recorded about 120 deaths a day on average over the past week, half as much as during the peak in early January, when 241 deaths a day were recorded.

Black and Latino communities have been hit disproportionately hard by COVID-19, and experts say it's essential the vaccine get distributed there as quickly as possible.

According to the most recently available data, Latino residents of L.A. County are dying from COVID-19 at triple the rate of white and Asian American residents. For the 14-day period that ended Jan. 30, the average daily COVID-19 death rate for Latinos in L.A. County was 33 per 100,000 residents; for Black residents, it was 14 deaths per 100,000; and for white and Asian American residents, it was 11 deaths per 100,000.

Rich vs. poor communities

According to the data released by the L.A. County Department of Public Health, cities and neighborhoods where 25% or more of the populations had received at least one dose of vaccine included Cheviot Hills, Century City, Bel-Air, Beverly Crest, Beverly Hills, Rolling Hills Estates, Encino, Pacific Palisades, San Marino, Palos Verdes Estates, La Cañada Flintridge, Brentwood, Sierra Madre and Rancho Palos Verdes.

But areas with 9% or less of the population vaccinated included broad swaths of South L.A. and southeast Los Angeles County, including the cities of South Gate, Paramount, Lawndale, Lynwood, Maywood, Hawaiian Gardens, Huntington Park, Bell Gardens, Bell, Compton and Cudahy; the Antelope Valley; and other L.A. neighborhoods, including Koreatown, Hollywood and North Hollywood, Little Armenia, Wilmington, Westlake and Thai Town. Avalon, on Santa Catalina Island, also reported a vaccination rate of less than 9%.

Neighborhoods and cities with less than a 10% vaccination rate included Harbor Gateway, Pacoima, Hawthorne, Little Bangladesh, Pico-Union, Inglewood, South El Monte, Boyle Heights, East L.A., Temple-Beaudry and Van Nuys.

Overall, neighborhoods around L.A. County with the lowest vaccination rates were South L.A., East L.A., several regions of the San Gabriel Valley, the eastern San Fernando Valley, the Antelope Valley and several areas near the ports of Los Angeles and Long Beach.

Other imbalances

There is also a gender imbalance among those who have been vaccinated: 59% are female, while 41% are male.

And Black and Latino residents are being vaccinated at a substantially lower rate compared to their proportion of the population: Among vaccines given to L.A. County residents 16 and older, 33.5% have been given to white residents; 23% to Latinos; 19% to Asian Americans; and 5.2% to Black residents. Of L.A. County's population of residents 16 and older, 46% are Latino and 9% are Black.

L.A. County officials also calculated by race and ethnic group the percentage of seniors who had received at least one dose of vaccine: 42.5% of people 65 and older.

But among racial and ethnic groups, there was wide variation. White seniors were most likely to have received at least one dose, with 42.8% of all white seniors receiving the vaccine; 39.4% of Asian American seniors also had received at least one shot. But only 24% of Black seniors, 29.3% of Latino seniors and 31.7% of Native American seniors had received at least one dose.

Trying to fix the problems

Strategies that officials have proposed to get more vaccine to members of underserved communities include reserving appointment slots for residents of those areas; expanding mobile vaccination units to serve seniors and others with limited mobility; dispatching community health workers to help residents schedule appointments; and expanding transportation services for those in need.

Authorities also are sending more vaccines to healthcare providers in underserved communities, such as clinics and pharmacies.

Officials are allocating an additional 6,000 to 7,000 vaccine doses for residents of South L.A. and 1,000 to 2,000 in the Antelope Valley, Simon said. New vaccination sites will be prioritized in areas with the lowest vaccination rates.

L.A. City Councilman Marqueece Harris-Dawson, who represents South L.A., has been critical of how vaccinations have been distributed. At a City Council meeting in January, he expressed concern about the initial government strategy of routing vaccines to large sites such as the Forum in Inglewood. He said his constituents were “not going to anyplace with big crowds of people” and criticized the demographic makeup of those receiving shots at the venue as not representative of the neighboring community, an observation confirmed by others, including Simon.

Harris-Dawson and others have encouraged the use of mobile vaccine clinics and the practice of routing vaccines to clinics that have a trusted reputation in the community.

Although officials also plan to step up efforts to combat misinformation about the safety of the vaccines, which data have shown to be very safe, Simon said he believed the larger problem right now was lack of access to the vaccine. There are many more Black seniors who desperately want to get the vaccine but have so far been unsuccessful at getting appointments, Simon said.

LOS ANGELES SENTINEL

Observing the Success of the Co-Pilot Initiative of Vaccination Distribution in Impacted Communities

California State Governor Gavin Newsom arriving to Kendren Hospital. (Betti Halsell/L.A. Sentinel)

California State Governor Gavin Newsom visited the vaccine distribution center found at the Kendren Hospital in Los Angeles, CA. Observing their protocols, the governor highlighted its success and stated that there should be hundreds more replicated, but in the current vulnerability of the state, every county is facing a different saturation of challenges that Newsom is looking to face head on.

On February 3, Newsom and the Biden administration announced a pilot partnership to open community vaccination centers in Oakland and Los Angeles. The Governor dissected the issues happening across the state are unique in each community and call for specific solutions. Newsom spoke of a new age of humility stemming from this; the solution is found within the alignment of the community and the organizations that look to serve the public.

The directive is in direct collaboration with the Federal Emergency Management Agency (FEMA), they will provide resources and federal staffing support to new vaccination centers. Using the states "MyTurn" online system, the mission behind these co-piloted facilities is to expand the rate of vaccination in California, "in a effective and equitable manner," focusing on high-risk communities, according to the released press information from the governors office.

The coronavirus pandemic has been an impetus for accelerated progress and social change. The role of racism in the quality of one's life, has been seen vividly through data and research that italicize demographics most susceptible to the virus.

There is a zoomed in lens, magnifying underrepresented and impacted communities and location of vaccination centers have become a key factor in treating the imbalance of resources found within the health care system.

Quoting the official press release, Newsom stated, "In the fight against COVID-19, partnership is key, especially when it comes to reaching Californians in underserved areas," Governor Newsom continued, "These new sites will help us get available supply to some of the California communities most in need…"

It was 11 a.m. on Tuesday, Feb. 15, the line for vaccinations traveled down the block, snaking around to the corner intersection of Avalon Blvd and 42nd Place. People of all ages and ethnicities were standing, funneling through the maze to get to Kendren Community Health Center, where COVID-19 vaccine shots were being administered. Some were there for the very first time and were nervous about the experience, others familiar with the process, stood ready for their second dose of the COVID-19 vaccination.

After a tour of the Kendren facilities led by Dr. Jerry P. Abraham, Newsom sat with L.A. Sentinel and stated, "This is great, this is amazing—I mean it's a model and it needs to be replicated hundreds of times." The governor spoke in full transparency of the challenges behind doing that, this type of organization depicted at Kendren Hospital is greatly needed across California.

California State Governor Gavin Newsom visited the vaccine distribution center found at the Kendren Hospital in Los Angeles, Ca.

Newsom mentioned the shared responsibility of the nation and how America has been shaken, abruptly woken up to the core issue of racial inequity hemorrhaging the resources in impacted communities. Coming into this level of awareness, location has played a significant role in vaccine distribution.

Newsom broke down the strategy behind the placement of resources includes a "healthy place index;" the analysis of social economics for over 200 communities and a close look at their equity index level, it all plays a critical role when deliberating the priority of supplies, amplified health care assistance, and vaccines.

Looking directly at the vaccinations and the hesitation found among the population, Governor Newsom highlighted the African American community, he stated, "The African American community in particular, understandably, is a community that has very strong opinions, historically around the issue of vaccinations."

Recent data shows people who identified as White are the majority of those vaccinated at 32.6 percent, followed by Latinx 15.8% percent, and 2.8 percent are Black.

Newsom recognizes the concept of trust has been broken through a dark past Black Americans have encountered in this nation's medical system, causing a deep resistance to the vaccination. With this in mind, the governor stated, "We have to meet people where they are."

The Governor shared the feeling of last year being a heavy and enduring season, various communities have been brought to their lowest means of living. He stated, “We are at a point where there’s truly a bright light at the end of this tunnel—it’s just a few months away, but we are also at the zenith of exhaustion.”

The nation developed racially charged phobias, escalated levels of anger, and exercised radical behavior throughout this pandemic, it has been a massive weight for all levels of government, as they look to carry out their civic duty in serving the public who are in dire need of a remedy.

The governor stated,” When you look at the solution for any problem, you have to start from the bottom, up— in communities, culturally competent in language, and recognize in every way, shape, and form, one size does not fit all.”

Newsom enlisted the word of the year is humility, there is a new understanding of seeing each other and caring for one another, superseding any social difference that is found in this nation. Newsom reflected on what this pandemic has done to his perspective and the amplified call for a solution in racial inequality.

Governor Newsom stated, “What drives me is what I believe is represented in our values.” The governor reflected on his strategy going into his position 25 months ago, he wanted California to be for all.

He stated, “I feel a deep responsibility and weight to connect to those values and to advance them.” Newsom has the mindset of collaboration and to build a framework that seeks inclusivity in legislation and connection to the people the state government has sworn to protect.

Newsom closed with the following statement, “This year has been humbling, and it has exposed the best and the worst—and its also a year of such profound energy and that energy was manifested in terms of how this nation responded, in some parts, the rest of the world responded like to George Floyd and the energy that we are now placing the issues of equity…”

UPI

COVID-19 cases pass 28 million in U.S., deaths near 500,000

Local residents wait their turn to receive a COVID-19 vaccination shot at the Kedren Community Health Center in South Los Angeles on Tuesday. To boost vaccination among people of color, L.A. county plans more sites, better messaging and access to transit. Photo by Jim Ruymen/UPI | License Photo

Feb. 20 (UPI) -- COVID-19 cases in the United States passed 28 million and deaths were only few thousand from 500,000 as the nation ramps up vaccination distribution after bad weather hampered distribution.

Infections reached 28,076,756 according to tracking by Johns Hopkins through Saturday, a rise of 71,510. And fatalities are at 497,648, an increase of 1,844.

Since the first case was announced in the state of Washington on Jan. 21, 2020, cases have averaged 70.722.

After reaching a peak of 299,786 on Jan. 2, infections have subsided. On Monday the cases were 53,970, the lowest since 49,307 on Oct. 18.

It took 13 days to climb one million and it was nine days from 26 million to 27 million.

Also, hospitalizations have dropped dramatically to 59,882 through Friday, the lowest since 62,119 on Nov. 10, after a high of 132,474 on Jan. 6, according to The COVID Tracking Project.

And fatalities also have been subsiding but not quite as dramatically as hospitalizations and cases.

On Friday, the increase was 2,706 compared with a record 4,401 on Jan. 12. Since the first death was announced on Feb. 29, they have averaged 1,394. On Monday it was 941, the lowest since 898 Nov. 29.

Until last week, New York had recorded the most deaths except for the beginning when the virus' U.S. epicenter was in Washington state.

But California is now No. 1 with 48,825, including a U.S.-high 481 Saturday.

New York is at 46,703, including 110 Saturday. The state only counts confirmed deaths though New York City also includes probable cases.

A distant third is Texas with 41,213, including a 227 rise Friday followed by Florida at 29,692, including 218 Friday; Pennsylvania in fifth at 23,480 with 67 increase.

California leads in cases with 3,435,186, including 6,668 Saturday. Texas is third at 2,583,617 with an increase of 6,586 Friday as the state contends with a massive power failure from cold weather. Florida ranks third with 1,863,707 with an increase of a U.S.-high 7,280. The only other states with more than 2 million are Illinois at 1,172,824 with a 1,922 increase and New York with 1,572,175, including 7,692 reported Saturday.

Because of the winter storm, vaccine distribution has been hampered.

But "things are getting back to normal," Andy Slavitt, a senior adviser to the White House Covid-19 response team, told CNN on Friday.

He said states will be receiving more vaccines they "have ever received before because we're going to be shipping this week's doses and next week's doses."

About 1.85 million Americans received vaccinations on Friday. This is above the goal of 1 million vaccinations per day before Joe Biden became president on Jan. 20.

On Biden's inauguration, the U.S. administered nearly 1.5 million shots with the seven-day average for the previous week about 966,000 shots a day.

In all, 41,977,401 people have now received at least one dose of the vaccine and 17,039,118 people have been fully vaccinated since the first shot on Dec. 14, according to CDC data Friday.

That means 12.6% of the U.S. residents have received at least one shot. Most of them have been administered to medical personal and people 65 and older.

In all, 78.1 million doses have been distributed to states.

During a White House news briefing earlier Friday, Slavitt said that there is a backlog of about 6 million Covid-19 vaccine doses due to bad weather, which has affected all 50 states. That includes more than 2,000 vaccine sites are located in areas with power outages and unable to receive doses.

California has had the most vaccines administered at 6,964,603, followed by Texas at 4,542,622 and Florida at 4,198,4512, according to the CDC.

COVID-19

Get the latest information from the CDC about COVID-19.

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Learn about vaccine progress from the CDC

U.S. COVID-19 cases and deaths decline

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The U.S. has reported its lowest daily infection rate since October, but more contagious variants of the coronavirus are spreading. CBS News' Errol Barnett spoke with Dr. Jerry Abraham, director of vaccine programs at Kedren Health, about what we need to do to stay on this downward trend.

SPECTRUM NEWS 1

Los Angeles Times

Column: Black people still aren't getting COVID vaccines. This pastor isn't having it

People arrive at Kedren Community Health Center, a site for COVID-19 vaccinations. (Jason Armond/Los Angeles Times)

In his dark sunglasses and face mask, with a yellow beanie perched atop his head, Noel Jones tried to blend in with the crowd as he shrugged off his jacket and got his shoulder ready for the needle.

But he was recognized almost immediately.

"I've been watching you since forever," a woman gushed as Jones fumbled with the paperwork for his COVID-19 vaccine at Kedren Community Health Center in South Los Angeles. "You have spoken into my life via the television for years. For years!"

Her words seemed to prove what Jones had just been telling me. That, as the well-known bishop and senior pastor of City of Refuge Church in Gardena, he was in a powerful position to help reverse the stubborn racial disparities that have, thus far, dogged California's rollout of the vaccines.

As of Sunday, white residents had received 32.7% of the 5.7 million doses that had been administered statewide, compared with 16% for Latino residents, 13% for Asian residents and 2.9% for Black residents, according to new data from the California Department of Public Health. The rest went to people who identified themselves as other or multiracial or who didn't state a race.

Jones wants more Black Angelenos to get vaccinated, as we are among the most likely to contract and die of COVID-19 along with Latinos.

"That's why I'm coming forward," he said. "I think it would be good for me to take the lead."

I've spent enough time in Black churches to know the crucially important role they play in distributing accurate information to the public — not to mention in dispelling conspiracy theories. And although I'm not particularly religious, I also understand why Black people — long the subjects of medical racism — would trust the advice of a pastor who they've known for years over that of a doctor they just met.

The pandemic has forced churches across California to keep their doors shut for much of the last year. For some, that has meant losing loyal congregants who lack internet service and, therefore, have been unable to watch sermons online. For others, the shift to streaming solely on social media has allowed them to actually expand their congregations.

City of Refuge is one the churches that has grown and Jones has used the opportunity to speak to more people about the dangers of COVID-19 and the safety of vaccines. In fact, the biggest reason he wanted to get vaccinated was to set an example for his congregation of 20,000, and for the hundreds of others who also now watch him online every Sunday.

Too many members are reluctant to get vaccinated, he said, despite the risks they face. They insist that the vaccines are "evil," he said, and that the coronavirus was manufactured and that Donald Trump had something to do with it.

"It's just the same old conspiracy stories. There's no proof for any of that," said Jones, 71, who also happens to be the brother of model and actress Grace Jones. "So what I do is I go in and say, where's the proof? Let's talk reality."

I'll admit, I was somewhat surprised that Jones would choose Kedren Health, a relatively small vaccination site in one of L.A.'s most neglected neighborhoods, as the place to wield his considerable star power. But I shouldn't have been.

The reputation of this mental health hospital that's punching above its weight as a vaccination site has only grown since I was there in January interviewing director Dr.

Jerry P. Abraham about his mission to get more doses to the many vulnerable Black and Latino residents of South Los Angeles.

Dr. Jerry P. Abraham, right, director of vaccine programs at Kedren Health, oversees another day in which hundreds of people line up in hopes of receiving the COVID-19 vaccine. (Jason Armond/Los Angeles Times)

There's an almost cult-like following of fans now. If you think of the vaccination "super site" at Dodger Stadium as a chain restaurant, with service that's efficient but inflexible, then Kedren Health would be a family-owned soul food restaurant, a place where the kitchen might run out of stuff from time to time, but everyone knows the service is always personal.

It's one reason I decided to start volunteering here.

On my first day, the day Jones showed up, a staffer told me about woman who was so moved by Kedren Health's mission of equity that, after being vaccinated, she started going door to door in South L.A., dragging her neighbors back to get vaccinated.

Many others, I learned, have become evangelists for the vaccination site among their Black and Latino friends and relatives.

Compton residents John and Pearl Samuels told me they heard about it from their daughter, who, in turn, heard about it from a friend. Louise Jackson of Inglewood, who arrived at Kedren Health with her husband, Keith, had a similar story. They had been trying for weeks to make appointments to get vaccinated without success.

"The only thing about it is that there's not that many of us here," said Louise Jackson said of other Black people.

Jones, who also heard about Kedren Health through a friend, agreed.

“We need to come,” he said looking around, “because the percentages are off.”

On Sunday morning, days after his vaccination, Jones stood behind the pulpit as usual, staring into a camera and searching for a way to get through to his most obstinate congregants watching on their screens.

“I’m opening with the mask,” he said, “because it’s important for us to still remember that we are coming out of a pandemic. They’re reopening very slowly. Don’t think that’s going to happen overnight. We still have months to go.”

He then talked about Rev. Frederick K.C. Price, the televangelist who founded the Crenshaw Christian Center megachurch in South Los Angeles. He died from COVID-19 on Feb. 12 after spending several days in the hospital. He was 89.

“We should pray for them,” Jones said of the Price family, “that the Lord will just put his arms around them and comfort them again. (It’s) one of the cornerstones of the churches in this city for years and years. He has blessed people all over the world. And we must pray for his family. That is a tremendous loss.”

Weeks ago, the city converted the parking lot of Crenshaw Christian Center from a COVID-19 testing site into vaccination “super sites,” hoping to provide more access for Black and Latino residents in hard hit South L.A.

It’s one step in the right direction. But there need to be more.

“The vaccine is out and things are changing, as we can see,” Jones said. “But at the same time, we have to continue to be careful, continue to follow the rules, because many people are still caught between taking the vaccine not taking the vaccine. And it’s going to be touch and go here because there’s so much distrust in our country, and so much distrust in the people who have been in charge for years.”

San Francisco Chronicle

California's positivity rate drops sharply, a promising indicator for reopening

3 of 4

California Governor Gavin Newsom talks to a person that got inoculated with the Moderna Covid-19 vaccine at a vaccination site in Los Angeles on Tuesday. California's positivity rate has plunged since December — a good sign.

Apu Gomes / AFP via Getty Images

California's coronavirus numbers continue to show signs of improvement.

The percentage of coronavirus tests that came back positive over the past seven days — a closely watched indicator for reopening the economy — has dropped to 3.5%. That's down from over 11% a month ago.

Hospitalizations for coronavirus patients have dropped 38% over 14 days, and the rate of infection in the state has fallen to 0.65 — meaning each infected person infects fewer than one other person.

“That’s the lowest I’ve seen it,” said Dr. Tomás Aragón, the director of the California Department of Public Health, at a meeting of a state vaccine advisory committee on Wednesday. “That’s really good news.”

The falling transmission rate could help more counties soon advance from California’s purple — or most-restrictive — reopening tier to the slightly-less-restrictive red tier, in which indoor dining at 25% capacity and other activities are allowed.

On Wednesday, Santa Clara County Health Officer Dr. Sara Cody said she expects the county to move into the red tier soon, though she did not have an anticipated date.

“It’s difficult to know,” she said. “We are encouraged by the case rates, which have continued to decline since the first week of February.”

But, she cautioned, virus variants may cause another surge.

While vaccinations are ramping up across the state, there are still not enough to meet demand.

Gov. Gavin Newsom said that some mass vaccination sites that opened across the state recently cannot operate at capacity. Some have temporarily closed, including the Moscone Center in San Francisco.

“We are throttling back many of those sites because of constraints on supply,” Newsom said Wednesday as he visited a vaccination clinic at a packinghouse in Coachella (Riverside County), an area that’s home to many farmworkers — where he also announced additional funding for a program that puts farm and food processing workers up in hotels if they contract the virus and have no place to isolate.

At the current pace doses are being administered, most Californians will have to wait until June or July to be vaccinated, Newsom said.

Under recent revisions to state guidelines, medical marijuana workers — including those involved in growth, transportation and distribution as well as more direct medicinal roles — and veterinarians now will have priority access to vaccines.

However, although both groups are now technically eligible under state guidelines, they will not necessarily get immediate access from individual counties, which often limit vaccinations to a subset of eligible people, such as those 65 and older, due to insufficient vaccine supplies.

Santa Clara County officials announced on Wednesday that they will expand vaccine accessibility to teachers, child care providers, emergency responders and food and agriculture workers on Feb. 28. Until then, the county will focus on vaccinating those 65 and over, pending vaccine availability.

Office of the Governor of California @CAgovernor · Feb 16

Today we visited Kedren Health, which was founded in 1965 to support the mental health needs of South LA.

It's currently serving as a #COVID19 testing & vaccination site. Its dedicated physicians, nurses, & volunteers are ensuring the community has access to available vaccines.

UPI

New COVID-19 cases, deaths tick up in U.S. amid Biden vaccine push

Residents receive a COVID-19 vaccine on Tuesday at the Kedren Community Health Center in South Los Angeles, Calif. To boost vaccination among people of color, Los Angeles County plans more sites, better messaging and access to transit. Photo by Jim Ruymen/UPI | License Photo

After days of declines, new coronavirus cases and deaths across the United States increased slightly on Tuesday, according to updated data from Johns Hopkins University.

The data Wednesday shows there was an addition of about 62,400 COVID-19 cases nationwide on Tuesday, an increase of about 8,000 cases from the previous day.

Before the new figure, national cases had declined for four straight days. Despite the rise in new cases, the figure remains well below the average for November, December and January.

The relative increase was slightly more pronounced for coronavirus-related deaths in the United States on Tuesday. The data show almost 1,800 new deaths on Tuesday, about 900 more than the previous day.

Since the start of the pandemic, there have been a total of 27.8 million COVID-19 cases in the United States and about 488,200 related deaths, according to Johns Hopkins.

The slight uptick in cases and deaths came on the same day the Biden administration promised to increase vaccine distribution to states and pharmacies -- and President Joe Biden promised during a town hall event in Milwaukee Tuesday night that the vaccine will be widely available in July.

Biden noted that the vaccines from Pfizer and Moderna -- and the possible addition of another more stable single-dose vaccine from Johnson & Johnson -- should diminish the virus "considerably" and allow Americans to move toward normalcy by the end of the year.

Since December, about 55.2 million vaccine doses have been administered in the United States and 71.7 million doses have been distributed, according to the latest figures from the Centers for Disease Control and Prevention.

Fauci says a Covid-19 vaccine could be needed annually

Medical worker Robert Gilbertson loads a syringe with the Moderna Covid-19 vaccine at a vaccination site in Los Angeles on February 16. Apu Gomes/AFP/Getty Images

Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, said it's "possible" that the Covid-19 vaccine could become a yearly vaccine, like the flu shot.

“We hope we can contain this particular outbreak and all of its ramifications throughout the world in a way that doesn't have the ... cycling of various versions of the virus so that you have to address it differently each year,” Fauci said in an interview with Spectrum News' Lisa McRee on Tuesday.

Fauci also said that it's “entirely conceivable” that scientists are already working on a universal coronavirus vaccine that would address all the variants.

There are a number of new variants that have emerged recently.

The Guardian

Latino and Black Americans see lowest Covid vaccination rates, new data shows

Analysis reveals just 3% of Latinos and 4.5% of Black Americans have received shots despite facing disproportionate harm from virus

▲ Just 3% of Latinos and 4.5% of Black Americans have received a vaccine shot, compared with 9.1% of white Americans and 7.7% of Asian Americans. Photograph: Apu Gomes/AFP/Getty Images

Latino and Black Americans are being vaccinated against Covid-19 at the lowest rates despite suffering disproportionately high levels of serious complications and deaths, new analysis reveals.

Only 3.5% of Latinos and 4.5% of Black Americans have so far received a vaccine shot compared with 9.1% of white Americans and 8.6% of Asian Americans, according to state figures analysed by APM Research Lab.

Indigenous Americans have the highest inoculation rate so far, with 11.6% (one in nine) already having received at least one dose. News of the relatively fast vaccination rollout in Indian Country comes shortly after the Guardian revealed that Indigenous Americans are dying from Covid faster than any other community in the US.

Analysts warn that the available data is extremely patchy due to poor reporting by many state health departments, but that the trend strongly suggests that access to the Covid vaccines has so far been inequitable.

“Unfortunately, despite the fact that we know Covid-19 has had very disparate impacts, about half of all states currently fail to provide vaccination data by race and ethnicity,” said Craig Helmstetter, managing partner of APM Research. “In the states that are providing data, Black and Latino Americans are lagging far behind Asian, white and indigenous Americans.

It was several months into the pandemic that cities and states began releasing racial and ethnic breakdowns of Covid hospitalizations and deaths. A year on, almost half a million Americans have died, yet we still do not know the ethnic background of one in 10 people killed by the virus.

The vaccination rollout got off to a very slow start in the US, hampered by the Trump administration’s inadequate preparation and logistical support for states, as well as chronic underinvestment in public health capacity. The pace has picked up, with more than 1.6m doses now being administered every day, according to the Centers for Disease Control.

Joe Biden’s national Covid strategy promises to put equity at the heart of the vaccination programme, as his team strives to meet a campaign promise to get 100m doses into arms in his first 100 days in office.

As of 12 February, only 24 states and the District of Columbia had published comparable data about the number and share of their racial and ethnic communities who have received one or both Covid-19 vaccine doses. New York and Illinois, two of the six most populous states, are among those that had not released comparable ethnicity data, making it impossible to track whether promises to ensure equitable access are being kept.

Still, the emerging data suggest that states are failing to deliver equitable access to ethnic minorities.

In Florida, just over 3% of Latino and Black residents have received at least one dose of the vaccination compared with almost 9% of white Floridians. In Texas, 2.8% of Latino residents have received a shot compared with 3.6% of Black residents, 7.2% of white residents and 9.7% of Asian American residents.

In Virginia, 30.5% of indigenous Americans have been vaccinated compared with 5.9% of Black residents and 5.3% of Latinos. Recent polls suggest vaccine hesitancy is low among indigenous Americans compared with other groups. In Washington, 18.5% of Indigenous Americans have received at least one dose compared with just 5% of Black residents, 3.1% of Latino residents and 8.5% of white residents.

Based on the current data, the District of Columbia and Pennsylvania have vaccinated the fewest Latino and Black residents.

More data and better data is needed, but analysts say that disparities in vaccination rates may be partially explained by ethnic differences in priority groups. The oldest have been prioritized by all states, and the white population is significantly older than other ethnic groups.

Race to vaccinate: African Americans being left behind in the US

In the US, the Covid-19 vaccine programme is being rolled out, but the shots are not getting into the arms of many people who need it most, particularly Black Americans. They make up just 13 percent of the US population, but account for more than 15 percent of Covid-19 deaths. And desite promises to increase equality in the wake of the Black Lives Matter movement, little has been done to improve vaccine access in disadvantaged neighbourhoods where the majority of essential workers live. Our Los Angeles correspondents Valérie Defert, Pierrick Leurent and Ryan Thompson report.

CNN health

Covid-19 cases have declined sharply. Experts say these factors will determine how the pandemic unfolds

A grim new forecast confirms what experts have been warning amid declining Covid-19 cases and hospitalizations: when it comes to the pandemic, the United States is not yet out of the woods.

Another 130,000 Americans are projected to die of the virus over the next three and a half months, according to the latest model from the University of Washington's Institute for Health Metrics and Evaluation.

And while Covid-19 numbers may be trending in the right direction now, there are four key factors that will determine how the next few months unfold, the institute said in a briefing accompanying its model.

The first two will likely help the pandemic numbers continue a downward trajectory: increasing vaccinations and declining seasonality -- the pattern of lower transmission that's likely in the US during the spring and summer months.

"Two factors, however, can slow or even reverse the declines that have begun," the IHME team said.

One of those factors is the spread of the B.1.1.7 variant, which was first identified in the United Kingdom and experts warned could become the dominant strain in the US by spring. Data from the US Centers for Disease Control and Prevention released Sunday shows more than 1,173 cases of the variant have so far been detected across 39 states.

Another key factor, according to the IHME team, is "increased behaviors that favor Covid-19 transmission."

"Transmission has been contained over the winter through mask wearing, decreased mobility, and avoidance of high-risk settings such as indoor dining," the team said. "As daily case counts decline and vaccination increases, behaviors are likely to change towards increased risk of transmission."

That's why experts say now is not the time for the US to let down its guard, even as a growing list of governors loosen Covid-19 restrictions.

CNN Medical Analyst Dr. Leana Wen said Sunday that declining numbers were good news. "But I'm also very worried about these variants, because we have seen in other countries what happens when there is explosive spread of these more contagious variants," Wen said on CNN's "Inside Politics."

"I think it's really critical for us to ramp up vaccinations as much as we can, and in the meantime, do our best to continue with masking, physical distancing -- these other measures that we know to be really important in controlling the spread of infection."

In addition to the B.1.1.7 variant, the CDC said Sunday 17 cases of the B.1.351 Covid strain initially seen in South Africa have been found across seven states and in Washington, DC. There are also two cases of the P.1 strain first linked to Brazil -- one in Minnesota and one in Oklahoma -- it said.

The agency said the data did not represent the total number of such cases circulating in the US but just those that have been found by analyzing positive samples.

A nurse administers a Covid-19 vaccine at Kedren Health on Thursday in Los Angeles.

Los Angeles Times

Governor admits problems with vaccine rollout in Latino and Black communities

Gov. Gavin Newsom acknowledged Sunday that state and local health officials have stumbled in distributing the COVID-19 vaccine equitably among Latino and Black communities in California.

Speaking at a mobile vaccination clinic in Inglewood, Newsom said the state needs to "do more and do better" to provide outreach and set up vaccine sites directly in the communities that have been hit hardest by the virus.

"We're not doing enough. We need to do significantly more programs like this," he said. "We've got to get people back to work. We've got to get people back into church. And we've got to get people back into school."

Of the 7.3 million doses administered in California, 2.9% have gone to Black residents, 16% to Latinos and 13% to Asian Americans, compared with 32.7% to white people, according to state data.

Those disparities are reflected to some degree in L.A. County, where 24% of Black residents 65 and older have received at least one dose of the vaccine, with Latino seniors at 29% and Asian American seniors at 39%, compared with 43% among white seniors, according to county public health data.

Meanwhile, the COVID-19 death rate for Latinos is triple that of white people in the county, with a daily rate of 48 deaths per 100,000 residents compared with 16 deaths per 100,000 residents for white people, according to county data from mid-January. Black residents were dying at a rate of 23 deaths per 100,000 people.

Newsom, who is facing a recall campaign with nearly 1.1 million signatures, sought to illuminate the state's efforts to vaccinate "hard-to-reach" and "disproportionately impacted" communities by visiting two sites Sunday, including the one in Inglewood and another in Boyle Heights.

"We recognize our responsibility to do more," he said, commenting on a range of initiatives his office is involved in across the state. "We're focusing on farmworkers. We're down at Coachella Valley on an equity coalition collaborative focusing on farmworkers and pop-up sites in partnership with ranchers and with farm managers."

L.A.'s Eastside, which is predominantly Latino, has suffered from among the highest rates of coronavirus infection in the county. Inglewood has also seen a high case rate among its majority Latino and Black population, with 1 in 9 residents becoming infected, according to county public health data.

Only about 250 people were scheduled to be vaccinated Sunday at each of the mobile clinics Newsom visited, located at Faithful Central Bible Church in Inglewood and Ramona Gardens Recreation Center in Boyle Heights. The doses of the Pfizer-BioNTech vaccine came directly from the federal government as part of the allotment for the mass vaccination site at Cal State L.A. run by the Federal Emergency Management Agency and the Governor's Office of Emergency Services.

There was plenty of demand at the Inglewood site, with about 70 people forced to join the waitlist due to limited supply, said Bishop Kenneth C. Ulmer of Faithful Central Bible Church. He said those who were invited to make an appointment included members of his church and the surrounding community who are 65 or older.

State Sen. Steven Bradford (D-Gardena) spoke at the event, asserting that the main barrier to vaccinating more people in the Black community is lack of access, not fear of the vaccine.

"It's an awareness issue," he said, noting that a recent vaccination clinic at Kedren Community Health Center in South Los Angeles seemed to draw more people from outside the area than from within the neighborhood.

"Three hundred people were in line. Five of them were African American. People were from Rolling Hills, Beverly Hills. How did they get the word out?" he said. "They seemed to know more than we do, so we have to do a better job of getting the word out."

Newsom said in terms of raw numbers, California has now surpassed the number of vaccinations administered in Israel, which has the highest vaccination rate in the world. But California still has a long way to go in improving its per capita vaccination rate, hampered by a shortage in supply coming from the federal government.

Severe winter storms across the U.S. impeded the delivery of 702,000 doses of the Moderna vaccine to California in recent days, Newsom said. Those delays forced officials to shut down several mass vaccination sites, including Disneyland and Dodger Stadium.

In Los Angeles, all six city-run vaccination sites, including Dodger Stadium, will resume operations Tuesday, according to the mayor's office.

Los Angeles Times

New state report breaks down vaccine distribution by age, race, gender, and shows disparities

Hundreds of people lined up last week to receive the COVID-19 vaccine at Kedren Community Health Center in South Los Angeles. (Jason Armond / Los Angeles Times)

White Californians so far have received 32.7% of the first available doses of the COVID-19 vaccine, compared with 16% for Latinos, 13% for Asians, 2.9% for Black people and 0.3% for Native American populations, according to a new state report that provides a snapshot of vaccine distribution.

The new data from the California Department of Public Health for the first time break down vaccine recipients by age, race, gender and location. Due to limited supplies, healthcare workers, long-term-care residents and people 65 and older make up the largest portion of those who have received a first dose.

As of Sunday, 8,051,475 vaccine doses have been delivered to distribution sites across the state, and 5,768,684 doses have been administered. More than 8 million additional doses have been shipped.

Seniors top the list of those who have received a first dose of the vaccine, at 54.7%; followed by people ages 18-49, at 28.7%; and those ages 50-64, at 16.6%, according to the report. Women represent the majority of those who have received the vaccine, at 58.5%, compared with men, at 41.1%, and those who either declined to state gender or identified as transgender or other, at 0.4%.

The state data are also broken down by county, with disparities varying from one region to another.

For example, in Los Angeles County, the new report shows, Latinos have received 23.2% of the available vaccine doses; whites, 21.9%; Asian Americans, 14.6%; Black people, 4.1%; and Indigenous populations, 0.1%. By comparison, in San Diego whites have received 42.3% of the available vaccine; Latinos, 14.1%; Asians, 10.8%; Black people, 1.9%; and Indigenous populations, 0.5%.

But some Los Angeles County health officials and activists have argued that the vaccines are not being effectively targeted in communities hardest hit by the pandemic. Doses have instead gone to large vaccination centers, such as Dodger Stadium, or healthcare providers such as Kaiser Permanente.

They point out that Black, Latino and Asian populations make up a large proportion of the county's essential workers and that many in those communities may not have access to health insurance, transportation or computers needed to register for vaccinations and therefore are being left behind.

"The playing field is not level right now," said Dr. Don Garcia of Clínica Romero in Boyle Heights, near downtown Los Angeles.

The state data don't tell the whole story, he said. Although Latinos appear to be vaccinated at better rates than others in L.A. County, it matters who in the community is being treated.

"I'm in that [23%]," Garcia said. "I got the vaccine without desperation … and my patients cannot get vaccinated. That is the health inequity we are talking about."

His clinic recently received 100 vaccines for its 12,000 mostly Latino patients, many of whom lack legal status and work in the service industry. Since March, the rate of coronavirus-positive results among those being tested at the clinic has been consistently at 40%. That's quadruple the seven-day average positive-test rate for L.A. County overall, which was at 9.99% on Saturday.

The number of Latino residents in L.A. County who are dying daily from COVID-19 on average, over a two-week period, has skyrocketed: 40 deaths per 100,000 Latino residents. That's nearly triple that of white residents, a segment of the population that sees an average of 14 deaths per 100,000.

Most of the Latinos who are dying are older and, in many cases, among the region's large immigrant population. In many cases, they may not be aware of their options, and this affects the larger community.

"We're talking about the *abuelitas, tios* and *tias,*" Garcia said. "We're talking about the immigrants, the undocumented."

In South L.A., Dr. Jerry Abraham is grappling with similar inequities at Kedren Community Health Center. In a matter of weeks, the clinic has managed to create a model to better distribute the vaccine doses as equitably as possible.

"When I look at those numbers," Abraham said, "you better believe Kedren makes up a big portion of that 2.8%" of vaccines given to Black people.

The clinic started with 100 doses, which it administered to healthcare providers at Kedren and elsewhere. It has since worked to eliminate barriers for the elderly, those who don't speak English and those who lack transportation by having volunteers and interpreters help patients register for the vaccine.

The clinic now gets 6,000 vaccine doses weekly but has been seeing up to 2,000 people daily.

"We're in a literal arms race to find every expiring dose throughout the county," Abraham said. "We never have enough vaccines."

Both Garcia and Abraham say a key element to equitable vaccine distribution is taking vaccines to people in their homes and communities via fleets of mobile vaccination units.

"When you have a fire, you bring the water to put out the fire," Garcia said. "We're on fire. We're the blue flame."

The worst wave of the pandemic crested in early January. At that point, the state was recording nearly 45,000 new coronavirus cases a day.

That figure has tumbled since then — to an average of 11,180 daily cases as of Thursday, according to data compiled by The Times.

That's still more than three times the average daily caseload California saw before the surge occurred. And there is now the presence of new and highly contagious coronavirus variants throughout the state.

On Saturday, Los Angeles County public health officials confirmed 3,254 new coronavirus cases and 197 related deaths. To date, the Public Health Department has identified 1,164,769 coronavirus cases across L.A. County and a total of 18,984 deaths.

"The cases are coming down, but they still remain high," said L.A. County Health Officer Dr. Muntu Davis. "And so people need to understand that, even though they're coming down, the risk of running into someone with COVID-19 who may not know it is still very high."

California is adding 4 million to 6 million more people to the eligibility list for the COVID-19 vaccine, but officials warn that actually getting inoculated will remain a frustrating process as long as chronic shortages in supply remain.

Starting March 15, people ages 16 to 64 who are disabled or at high risk for morbidity and mortality from the coronavirus will be eligible for vaccination. That will bring the total number of Californians eligible to 17 million to 20 million.

But with supplies so limited, ultimately it will be up to local providers to decide who gets the vaccine immediately, with medical workers, first responders, people 65 and older, teachers and essential workers all vying for shots.

Physicians Garcia and Abraham said they hoped their communities would get the vaccine supplies they needed as soon as possible.

"We are used to being forgotten about," Abraham said. "We are used to having to do a lot with very little. We do this every day, COVID or no COVID."

Los Angeles Times

California adds millions to COVID-19 vaccine eligibility list but frustrating waits, shortages loom

Hundreds of people receive the COVID-19 vaccine at Kedren Health on Thursday in Los Angeles. (Jason Armond/Los Angeles Times)

California is adding 4 million to 6 million more people to the eligibility list to get the COVID-19 vaccine, but officials warn that actually getting inoculated will remain a frustrating process as long as chronic shortages in supply remain.

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But with supplies so limited, ultimately it will be up to local providers to decide who gets the vaccine immediately, with medical workers, first responders, people 65 and over, teachers and essential workers all vying for shots.

“We’re all frustrated,” said Dr. Paul Simon, chief science officer for the Los Angeles County Department of Public Health. “We know we could do much more if we had available doses.”

“Reprioritizing who gets doses does not get us more doses, and that’s what we need,” added Kat DeBurgh, executive director of the Health Officers Assn. of California.

Shortages reign

Some parts of California have had to hold off on vaccinating certain eligible groups in the face of insufficient shipments, while others have had to cut back on how many people receive a first dose to ensure there are enough shots available to give people their required second dose.

In Los Angeles, some vaccination sites that were already slated to close Friday due to supply shortages ran out of doses sooner than expected and had to start turning people away Thursday.

Of the 219,700 doses that arrived this week, more than half will be needed to provide second shots, according to Simon.

“That is simply to fulfill our commitment to make sure that everyone that received first doses three to four weeks ago will get a second dose,” he said during a briefing Friday. “But there will be a large number of doses available as first doses. It will be less than 50%, but still a significant number.”

The priority for what first doses are available, he added, will be communities that have been hardest hit by the pandemic “to make sure that we’re reaching those at greatest risk.”

Health officials throughout the state say that their capacity to dole out vaccines far outstrips the number of doses that are available at this point. In L.A. County, for instance, Simon said providers could likely administer up to 600,000 doses a week if they had the supply.

8.1 million doses delivered

So far, about 8.1 million vaccine doses have been delivered throughout California, and nearly 5.3 million have been administered, according to data compiled by The Times.

There is hope that an influx of inoculations is on the way. President Biden announced Thursday that his administration has secured a total of 600 million doses, split evenly

between Pfizer and Moderna, to be delivered by the end of July. That would be enough to fully vaccinate the roughly 260 million people eligible for the shots nationwide.

“We can’t move fast enough,” Gov. Gavon Newsom said earlier this week. “We’re sober; we’re mindful of the scarcity that is the number of available vaccines in the United States of America. Nonetheless, we are not naive about our responsibility here in the state of California to move these vaccines out of the freezers and into people’s arms.”

Shortages of the vaccine have become a chronic problem. Los Angeles vaccination sites that were slated to close Friday due to supply shortages ran out of doses sooner than expected and had to turn people away Thursday.

The shortage compounded growing concerns about vaccine supplies amid a week already mired in unpredictability, with Los Angeles Mayor Eric Garcetti on Wednesday calling vaccine supply issues “an enormous hurdle in our race to vaccinate Angelenos.”

“We’re vaccinating people faster than new vials are arriving here in Los Angeles, and I’m very concerned right now,” Garcetti said.

Simon said he hopes many of the county’s providers “will be vaccinating their own patients, will understand the medical conditions that their patients have” and that “the implementation would be relatively straightforward.”

But he added during a briefing Friday, “it will also require, I think, very clear definitions of who is eligible under this new phase.”

“It certainly means that there’s even more urgency now to getting a greater supply of vaccine,” he said.

Data showing vaccination rates by community reveal inequities in L.A. County, health officials acknowledge

Registered Nurse Ebony Thomas administers a COVID-19 vaccine to Cecilia Onwytalu, 89, at the Kedren Community Health Center in South Los Angeles on Feb. 16, 2021. (Apu Gomes / AFP / Getty Images)

Releasing new data, Los Angeles County health officials acknowledged Friday that Latino and Black residents continue to be vaccinated at a significantly lower level than whites and Asian Americans, a disparity the county's vaccine chief called "unjust and unacceptable."

More than 1.6 million doses of COVID-19 vaccine have been administered across L.A. County, but disparities continue to mar the vaccine rollout, according to county data released Friday.

The figures released by the county Department of Public Health show that less than 25% of Black residents age 65 and over, roughly 30,000 people, have received at least one dose of the COVID-19 vaccine. That's an increase of 18% from Feb. 9, when only 3.5% of Black residents had been inoculated, the county data show.

Meanwhile, about 29% of eligible Latino seniors have received the shot, a 14-point jump from earlier in the month.

On the other hand, nearly 43% of white senior residents have received at least one shot, as have roughly 39% of Asian Americans, the latest data show.

The county has been redoubling its efforts ever since local health officials pointed out steep inequities in vaccine access, especially among seniors in communities of color.

During a virtual briefing Friday, Dr. Paul Simon, the county health department's chief science officer, presented the latest data and a map of vaccination rates across the county, which show that the problem persists.

"There are marked inequities in vaccination coverage across the county," Simon said. "The findings are deeply concerning and provide further illustration of the deeply rooted health inequities that exist in our society."

When mapped, the latest data show glaring disparities in vaccination rates by neighborhood. Those who live in some of the wealthiest neighborhoods in L.A. County are receiving the vaccine at a much higher rate than lower-income communities of color, the data show.

Cities and neighborhoods with 25% of residents or more already inoculated with at least one dose of the vaccine include Bel Air, Beverly Hills, Bradbury, Brentwood, Century City, Cheviot Hills and Rolling Hills Estates.

By contrast, areas with the lowest coverage rates — 9% or less of residents vaccinated — included South L.A. and East L.A., several parts of the San Gabriel Valley, the east San Fernando Valley and the Antelope Valley, as well as several pockets near the ports and below West Hollywood, Simon said during Friday's news conference.

The chief science officer acknowledged that an important limitation in the data, however, is that the percentage vaccinated is "based on the total population in each city and community," not how much of the region is eligible right now, e.g. 65 and older, or a frontline health care worker.

"Despite these limitations, the findings clearly indicate very significant inequities in the distribution of vaccine to date," Simon said. "These inequities are unjust and unacceptable and demand renewed efforts to address them."

Simon said the county is planning a number of steps to address the inequities, such as prioritizing more doses for vaccine providers with the lowest vaccination coverage rates and reserving more vaccine appointments for residents in those under-served communities.

Issues with vaccine supply also remain, Simon added, although the county-operated vaccination sites were largely spared from the weather-related delivery problems that forced the Los Angeles city vaccination sites to close this week.

COVID-19 vaccine slow to reach L.A. County communities hit hard by pandemic

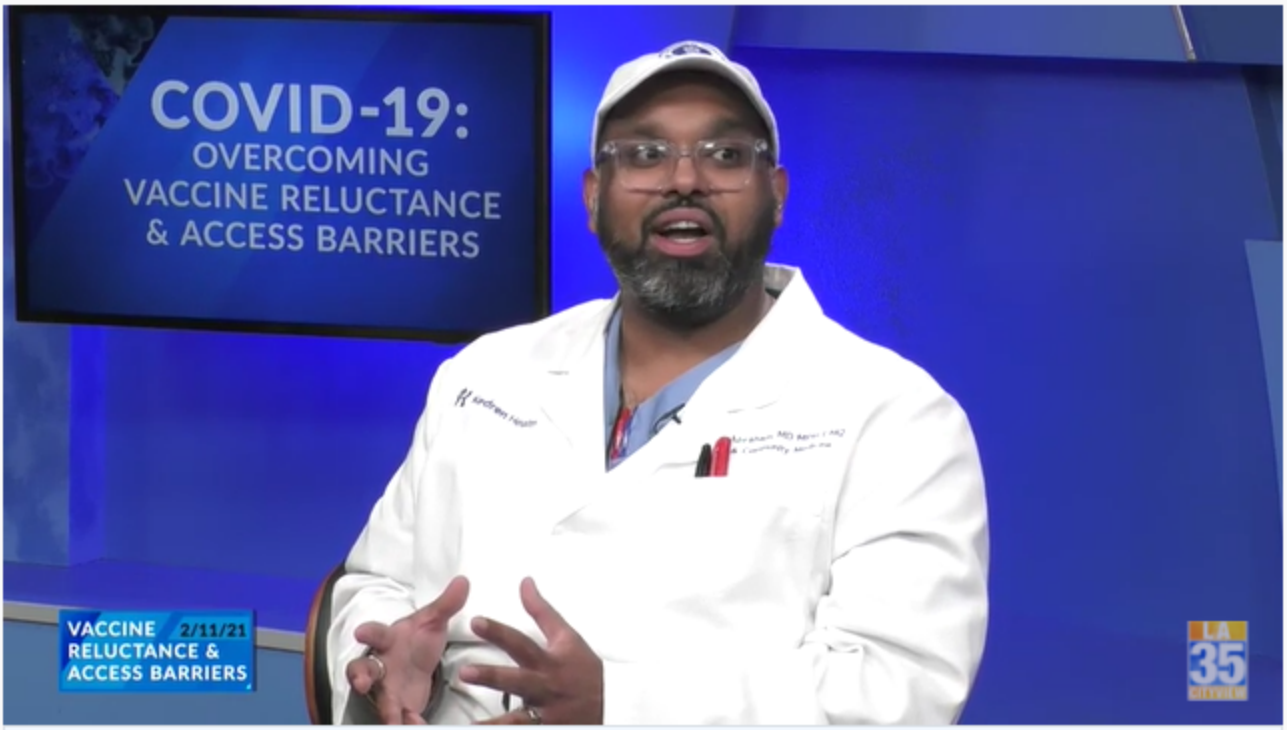
Dr. Jerry P. Abraham administers a Covid-19 vaccination to a senior citizen in a vaccination tent at the Kedren Community Health Center on January 25, 2021 in Los Angeles, California.(Patrick T. Fallon/AFP via Getty Images)

With COVID-19 vaccine still in short supply, state and local officials vowed Tuesday to make improvements to ensure doses are delivered equitably and that California's hardest-hit, harder-to-reach communities aren't left behind.

Recent data released by L.A. County showed that Black, Latino and Native American seniors were receiving COVID-19 vaccinations at a lower rate than white, Asian American and Pacific Islander seniors in the county.

"We have a lot of work to do to fix this," Public Health Director Barbara Ferrer said during Tuesday's Board of Supervisors meeting, "because however way you cut this data, it's clear that in some of our hardest-hit communities, there are populations that are not getting vaccinated at the same rate as other groups."

Overall, only 7% of Black residents age 65 and over have received at least one dose of the COVID-19 vaccine, according to county figures presented Monday. About 9% of Native American seniors and 14% of Latino seniors have received at least one dose — compared with 17% of white senior residents, 18% of Asian American and 29% of Native Hawaiian/Pacific Islander seniors.



COVID-19

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COVID-19: Overcoming Vaccine Reluctance & Access Barriers in Black & Brown Communities

30 views • Feb 11, 2021

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Join Councilmember Curren Price for a frank discussion on vaccine reluctance and access barriers in Black and Brown communities. He's joined by Dr. Jerry P. Abraham of Kedren Health and Dr. Kamala Gipson-McElroy of St. John's Well Child & Family Center.

L.A. Doctor Creates Model Vaccine Rollout to Black & Brown Residents

Dr. Jerry Abraham Creates Awesome Covid Vaccine Model To Service Minority Communities

COVID vaccines are not making their way to underserved neighborhoods and it seems no one has figured out how to make that happen ... no one except Dr. **Jerry Abraham**.

Dr. Abraham runs the Kedren Community Health Center in South L.A., whose population is heavily black and brown. The County overlooked the Health Center in the vaccine distribution, but Dr. Abraham pounded on doors until he got their attention ... and the vaccines came.

The next hurdle was figuring out how to get South L.A. residents to the Health Center ... a tall order, given that many had no Internet to make appointments and no transportation. Dr. Abraham got all hands on deck and he and his staff went out to the community and helped people make appointments and then made sure they had a way of getting to the Center.

He's also put his psychologist hat on ... explaining to residents why the vaccine was so essential.

The upshot ... he's created a model that can become a shining light of equity in the distribution of vaccines.

One other thing ... he's also made it a party, with music and dancing to make sure people don't get frustrated and scared and bail.

This model deserves national attention ... because it works.

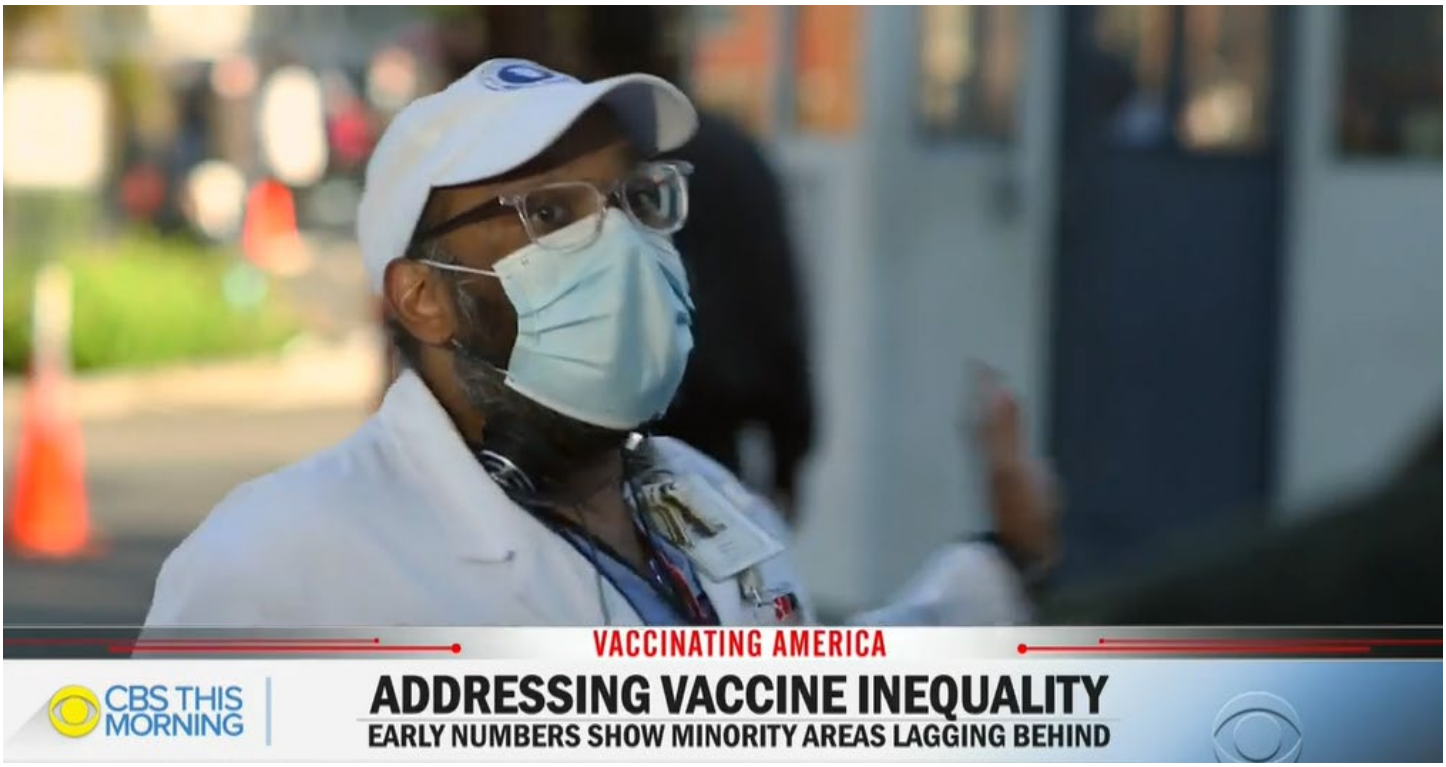
MSNBC

RACHEL MADDOW

Removing barriers is key to getting vaccine to underserved communities

Dr. Jerry Abraham of the Kedren Health clinic in South Los Angeles, talks about how his team has been successful administering the Covid vaccine to people in underserved communities by helping patients work around barriers like access to the internet or a car.

Feb. 5, 2021



South Los Angeles hospital removes barriers for minority communities seeking vaccine

Language barriers, lack of internet access and guidance within minority communities has kept some of Los Angeles' most vulnerable from receiving COVID-19 vaccines. David Begnaud reports on the relentless efforts of one South Los Angeles hospital to direct every available vial to their own underserved community.

Los Angeles doctor fights to ensure vaccine distribution in Black community

*Dr. **Jerry Abraham** and his staff went out in the community to set residents up with appointments and secured transportation to the center for their vaccinations.*

Dr. **Jerry Abraham** is going above and beyond to ensure Black folks are vaccinated.

The doctor of the Kedren Community Health Center in South L.A. demanded that the Black and brown community that he serves receive the vaccine, and it worked.

As reported by *TMZ*, the county did not provide the center with the vaccine, so the doctor took it upon himself to ensure they received the proper amount of doses.

It's been reported that Los Angeles County is one of many cities that has noticed that those most likely to contract COVID-19 has been left out of vaccine distribution. According to the *Los Angeles Times*, politicians and public health officials are talking about fixing what appears to be a racial inequity.

Dr. **Abraham** then decided to take things a step further. He and his staff went out in the community to set residents up with appointments and secured transportation to the center for their vaccinations.

He also reached out to residents of South L.A., who often don't have internet access or even a smartphone, to assist with making appointments through the provided online portal. He and a few volunteers distributed paper forms to the residents, promising to enter their paperwork into the online portals later.

Finally, he created a fun environment at the center, consisting of dancing and music while patients wait in line.

Dr. Abraham's actions are commendable, considering the difficulty Black people face regarding having access to the vaccine.

NEWS

They're chasing the dream of getting a Covid-19 vaccination

Vaccine chasers are using everything from word-of-mouth to social media to score a shot.

A couple make their way with others in the "by appointment only" line to get vaccine shots to protect against the coronavirus at the Balboa Sports Complex in Encino, Calif., on Jan. 27, 2021. Mel Melcon / Los Angeles Times via Getty Images

Feb. 11, 2021, 1:57 PM -08

By Matteo Moschella and Corky Siemaszko

For this vaccine chaser, the second time was the charm.

On her first attempt to get a Covid-19 shot last month, 28-year Leah Robson arrived at a Los Angeles city park at 4 a.m., waited all day with hundreds of other hopefuls, and wound up going home without the vaccination.

She tried again the next day at 2:30 a.m. at the Balboa Sports Complex in the Encino neighborhood and found six people already ahead of her in line. But this time, after another all-day wait she got her shot.

“It was worth the wait,” Robson told NBC News. “There were about a hundred shots left over at the end of the day that would have gone to waste if they weren’t used, so just about everybody I was in line with got a shot.”

Best of all, Robson said she’s got a confirmed Feb. 25 appointment to get a second dose of the Moderna vaccination.

“I’m very happy,” she said. “It’s been such a stress relief, just being able to walk around knowing that my chances of getting sick are already reduced. But I’m still being careful while everybody around me is being an idiot.”

There are thousands of people like Robson across the country who are chasing the dream of getting a Covid-19 vaccination even though their age, health and profession (she’s in the film industry, not a front-line health care worker) puts them at the end of the line.

Relying on word-of-mouth, social media and new websites that track potential dumps of leftover doses, vaccine chasers are banking on other people not showing up for their appointments or distribution hitches so they can have a shot at getting vaccinated.

“I’m glad they’re prioritizing older people but if there’s a chance I can get it, it’s totally worth staying in line for all day,” Robson said when NBC News interviewed her the first time last month.

Because the vaccine doses have a shelf life of just five hours once defrosted, they have to be used that same day or they will wind up in the garbage. New websites like vaccinehunter.org and Facebook groups like New Jersey Covid Vaccine Sites and Minneapolis Vaccine Hunters have popped up to assist people looking for leftover doses.

“There’s no downside to what we’re doing here,” vaccinehunter.org website founder Brad Johnson told "NBC Nightly News." “Any arm is better than the trash.”

The vaccine chasers who are mostly white and well-to do are turning up at community centers that serve mostly minority constituencies, as has happened everywhere from Florida to California. But doctors still say it’s better not to waste the doses -- just as long as the vaccine chasers don’t try to cut the line.

“There are times when we have no one here,” Dr. Jerry P. Abraham, who runs the Kedren Community Health Center in South Los Angeles, told The Los Angeles Times. “And there are times when your inventory has to be either put into someone's arm or discarded, and we refuse to waste a dose.”

Some state and county health departments and even hospitals, all determined not to waste the scarce vaccine doses, have created sign-up sheets where people willing to race over to a vaccination center to get a shot at a moment's notice can register.

That's how Martha Crawford, 56, a psychotherapist and cancer survivor in Santa Fe, New Mexico, got her Covid-19 vaccination in a state which is still largely limiting shots to front-line health care workers and people over age 75.

"I just got my NMDOH (New Mexico Department of Health) notification last night and got my first dose of Moderna at my local grocery store pharmacy," she said in an interview conducted via Twitter.

Crawford said she got a text message from the department of health at 5:37 p.m. Tuesday offering her a 6 p.m. appointment.

"It took me some time to negotiate the website and to understand that I was not being offered various sites, days or times, that this was a first-come, first-served opening about 20 minutes from my house," she said. "Several other people arrived at the pharmacy when I did. All appeared to have got the same message. And, as far as I could tell, all of them were vaccinated."

Crawford said she has an incurable "but currently dormant" cancer in her central nervous system.

"So, I was thrilled to have an opportunity to get in, however short the notice," she said.

In Washington state, Kevin O'Keefe, 65, told "NBC Nightly News" his son tipped him off that there were vaccine doses to be had after seeing a Jan. 29 tweet from the Swedish Medical Center in Seattle that a freezer had malfunctioned and their doses were in danger of being discarded.

O'Keefe said he raced over and got his first shot of Moderna at 2 a.m.

"What are the odds," a still-amazed O'Keefe said.

CBS Los Angeles

LA County Working To Address Racial Disparities In Distribution Of COVID-19 Vaccines

Dr. Jerry Abraham, who helps run the vaccination clinic at Kedren Community Health Clinic in South Los Angeles, said he sees the disparity, which is why his hospital was not waiting for the county to fix the problem.

COVID-19

Get the latest information from the CDC about COVID-19.

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Learn about vaccine progress from the CDC

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Vaccine Inequities: National Call to Action. What can we do to help bridge the vaccine inequity gap?

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Morning Brief: LA's Vaccine Inequity Mirrors The Rest Of The County

Updated February 8, 2021 1:00 AM Published February 8, 2021 12:30 AM

Good morning, L.A.

As local data is collected and processed, the emerging picture of vaccinations in L.A. County is mirroring the picture from across the country: Black and Latina/o Angelenos are being vaccinated at a much lower rate than other populations.

The most recent data shows that more than twice the number of white, Asian and Native Hawaiian or Pacific Islander residents have received the vaccine than Black and Latina/o residents.

While some have pointed to the Black community's mistrust of the medical community to explain the disparity, Dr. Jerry Abraham, director of vaccine programs at Kedren Health, disagrees.

"Misinterpreting lack of access for hesitancy was to me very offensive, because the Black and brown health care workers that came [to vaccine sites] came with their sleeves rolled up, and they were ready for a vaccination," he said.

Data from other states shows the same trend; according to a Kaiser Health News analysis, 1.2% of white Pennsylvanians had been vaccinated as of mid-January, compared with 0.3% of the state's Black residents. Inequities have also been found in Maryland, Nevada, Texas, Washington state, North Carolina, and dozens of other regions.

These trends come after the well-publicized fact that Black and Latina/o communities have been hit hardest by the pandemic.

Many residents, advocates and experts have expressed concern that state and local officials are prioritizing speed over equality when it comes to vaccine distribution. Those concerns were exacerbated when Gov. Gavin Newsom announced that California would move to age-based eligibility once residents over 65 are vaccinated.

Another concern is line-cutters; officials in L.A. recently reported that some people appear to be giving their second dose appointments to others, so they can receive a first dose.

Writing in *The Washington Post*, medical experts (and twin sisters) Uché and Oni Blackstock propose four solutions to vaccine inequity: putting Black Americans on the priority list, explicitly using race and ethnicity as a qualifying factor; identifying accessible vaccine sites in Black communities; public education campaigns; and the mandated collection of racial and ethnic data on vaccinations.

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District Judge Weighs in on Homelessness, Battle for Vaccine Equity, The Band 'SPARKS'

COMMUNITIES OF COLOR STRUGGLE FOR VACCINATION EQUITY

As governments around the world prepare to approve the first coronavirus vaccines, social media companies are cracking down on hoaxes and conspiracy theories. *ASHLEY LANDIS/AP*

We've talked a lot about the slow and confusing COVID-19 vaccine rollout around LA County and beyond Virtually everyone trying to get vaccinated -- or their vulnerable family members -- has dealt with ever-changing eligibility rules AND a glitch-y online signup system. Unfortunately, these systemic flaws are impacting those communities who've gotten sick and are dying at higher rates of COVID0-19 than others. That Black and Latino people as well as older adults of all backgrounds. As of Jan. 23, only 5% of those vaccinated so far were black.

Guest: **Dr**. **Jerry Abraham**, Director of Vaccine Programs at Kedren Health

Gary and Shannon

Local Doctor Has Figured Out How To Distribute Vaccines Equitably

By **Executive Producer Michelle**
Feb 2, 2021

It's no secret that Southern California has Covid vaccine distribution problems, and when we do distribute the vaccine, it's not being distributed equitably.

Dr. Jerry Abraham is an epidemiologist and the director of the vaccination site at **Kedren Community Health Center** in South L.A.

Like other vaccine sites, they're always overwhelmed, but what frustrates him the most are the people who camp out, who are mostly younger, more affluent white people who literally camp out overnight waiting to get leftover doses of the vaccine.

Why would they give the leftover vaccines to them versus giving them to the elderly, health care workers and low-income residents in the community that desperately need them? Just because they camped out and waited?

While local officials have finally acknowledged that there is inequity in vaccine distribution and say they're going to fix it, Dr. Abraham and his team haven't waited. They jumped into action and within weeks came up with their own workarounds to ensure that the people who NEED the vaccine the most, get it.

Dr. Abraham joined Gary & Shannon today to talk about it.

Why Do LA's Black And Latino Residents Have Lower Vaccination Rates?

Updated February 5, 2021 6:25 PM

Published February 5, 2021 4:40 PM

L.A. health officials have expressed concerns about low vaccination numbers among health care workers in South L.A. and other communities of color. Those concerns are valid — preliminary numbers show Blacks and Latinos are receiving fewer vaccinations as compared to white and Asian Angelenos. Some experts have attributed low vaccination numbers in more diverse neighborhoods to hesitancy and mistrust, especially among Black and brown communities (some of that mistrust is completely understandable, given the racist history of health care in the U.S.).

But Dr. Jerry Abraham, director of vaccine programs at Kedren Health, says the problem isn't *only* hesitancy. It's also a lack of availability and access:

> "What is most frustrating is, you may have heard me say *What vaccine?* We weren't even offered a vaccine ... So misinterpreting lack of access for hesitancy was to me very offensive, because the Black and brown health care workers that came [to vaccine sites], came with their sleeves rolled up, and they were ready for a vaccination."

Dr. Abraham says that straightforward messaging is the key to overcoming any doubts about the vaccine, and that partnerships with L.A. County offices, local elected officials, community-based organizations and faith leaders can help get useful information out.

The county has released some demographic data on who has gotten vaccines so far, although there's a delay in reporting.

As of Jan. 23, those who received one or more doses of the vaccine, were:

- 30.2% white (26% of county residents are white)
- 29.4% Latino (49% of county residents are Latino)
- 22.9% Asian (15% of county residents are Asian)
- 4.6% Black (8% of county residents are Black)
- 1.0% Native Hawaiian or Pacific Islander (.4% of county residents are Native/Pacific Islander)
- 0.4% American Indian or Alaska Native
- 11.5% multiple or other race/ethnicity

(Our data on race/ethnic breakdown of L.A. County came from the Census).

It's important to note that most of the people who received the vaccine by late January were frontline health workers, the county says. However, if you look at the above data, it's clear that Black and Latino residents are underrepresented in vaccine counts, while white and Asian residents are overrepresented. L.A. County officials say they are working to bring more vaccination sites to underserved communities and are making equity a priority.

Across the country, African Americans and Latinos are dying at higher rates of COVID-19 than their white neighbors. This is also true for L.A.'s Black community and other communities of color.

We covered death rates by race/ethnicity in this story in May.

Dr. Jerry Abraham, who runs the clinic at Kedren Community Health Center, said the clinic plans to continue to administer first doses of the COVID-19 vaccine, even as the County sites pull back.

South LA Clinic Will Continue to Give First Doses of COVID-19 Vaccine

By Kate Cagle South Los Angeles

PUBLISHED 8:46 PM ET Feb. 08, 2021

SOUTH LOS ANGELES — Quarantine isn't so bad with someone you love, but 68-year-old Martha Ree is excited nonetheless for the freedom that comes with the COVID-19 vaccine.

"I'm excited because we're worried about it. We're being fastidious about staying home and having things delivered and not interacting and keeping our distance."

What You Need To Know

- **Kedren Community Health Center will continue to give first doses of the COVID-19 vaccine**
- **Dr. Jerry Abraham said his clinic is stretched to the limit running the vaccination hub**
- **Seniors are able to walk up and register at Kedren without an appointment**

- **One dose of the Moderna vaccine may give 80% protection from the virus**

The retiree has been unable to get an appointment at any of the major Los Angeles County vaccination sites, but heard about Kedren Community Health Center, a clinic in South L.A. with walk-up registration for seniors.

Starting Tuesday, the major sites will prioritize second dose appointments, making getting a first dose even more difficult.

“Every morning and every evening I was looking at all the websites and then when there were phone numbers for hotlines and that type of thing I tried those. I sat on hold for an hour for one of them, didn’t get through,” Ree said.

Dr. Jerry Abraham runs the clinic at Kedren and said a lack of vaccine supply is forcing the county to make tough decisions. Moderna claims one dose of its vaccine provides 80% protection, with the second dose increasing it to 95%.

“They’re in so many ways competing interests,” Dr. Abraham said of the balance between prioritizing second doses over the need to inoculate as many people as possible. “The biggest limiting factor is we just don’t have enough vaccine.”

Los Angeles County received 184,625 doses of vaccine last week, according to Dr. Paul Simon, chief science officer for the county Department of Public Health. Health officials are hoping to get more supply in the coming weeks, as more Angelenos qualify for their second dose.

Kedren is a private clinic serving as a vaccination hub in South L.A., relying on its own staff, resources and volunteers to vaccinate up to 2,000 people a day. Dr. Abraham plans to continue to administer first doses, even as the County sites pull back.

“We need more help. We need more vaccines. We need more hands. We need more resources. We’re pretty much stretched to the limit now so I’m not sure how much more we can do without those things,” Abraham said.

For Ree and her husband, access to the first dose is a lifeline.

“It gives us our freedom back to be able to go out and participate in life and know we’re not going to die from doing that,” she said.

After a year cooped up in their condo, they know their relationship can survive a pandemic. Now with the vaccine, they are confident they will too.

People With Disabilities Feel Abandoned by State Leaders on Vaccine Rollout

With the new strain now taking hold in California, some worry time is running out for a vulnerable part of the population.

Speaking by putting toe to tablet, Tim Jin says he feels abandoned by state leaders who have put priorities on age and employment for the COVID vaccine.

"Why would a healthy 50-something get the vaccine before me?" he wrote. "A 45-year-old man with significant disabilities? Man, that's pretty heartless but it also makes no sense from a scientific perspective."

Judy Mark, the president of Disability Voices United, says California is falling behind what the U.S. Centers for Disease Control and Prevention says it should be doing for people with severe developmental disabilities.

"The CDC has very specific recommendations on that, listing very specific disabilities," Mark said.

With the new strain now taking hold in California, she worries time is running out for a very vulnerable part of the population.

"The problem is people with disabilities are more likely to die than a healthy 60 year old," she said.

Dr. Jerry Abraham, who was overseeing a vaccine site at Kedren Health in South Los Angeles last week, said he believes the state's current plan is working to get the most people vaccinated in the quickest way possible.

"It's a very complicated question and it's a very complicated answer," he said. "They are trusting health care providers and physicians to make these calls. It's not punitive. We're doing the best we can with a very limited supply of life-saving medicine."

But Jin is afraid.

"We shouldn't have to fight this hard to stay alive. Due to my fears of COVID, there are days I won't even step outside to get fresh air."

While his caregivers have been allowed to get the vaccine, he doesn't believe it's enough to protect people like him.

"I know Gov. Newsom thinks this will protect us. But you know what will help more? Actually give us the vaccine."

The California Department of Public Health did not respond to a request for comment.

Los Angeles Times

California to open COVID-19 vaccine to people with cancer, obesity, other conditions

A nurse administers the COVID-19 vaccine at Kedren Health in Los Angeles. (Jason Armond/Los Angeles Times)

California officials said Friday that people ages 16 to 64 who are disabled or at high risk for morbidity and mortality from COVID-19 will be eligible for vaccination beginning next month.

The move comes after weeks of debate over who will get to the front of the line for precious vaccine doses, which remain in short supply. Officials estimate the move will make 4 million to 6 million more people eligible, bringing the total of eligible Californians to 17 million to 19 million, or about half the state.

But supplies remain very limited. Based on current allocation projections, California won't come close to meeting demand for some time. It will ultimately be up to local providers to

decide who gets the vaccine immediately, with medical workers, first responders, people 65 and over, teachers and essential workers all vying for shots.

The underlying conditions explicitly stated under the latest guidance include cancer, chronic kidney disease of stage four or above, chronic pulmonary disease, Down syndrome, immunocompromised immune system from solid organ transplant, pregnancy, sickle cell disease, heart failure, coronary artery disease, cardiomyopathies (excluding hypertension), severe obesity, and Type 2 diabetes mellitus.

The state also broadly defined eligible individuals as those who are likely to develop a life-threatening illness or death from a COVID-19 infection or are limited in their ability to receive ongoing care or services vital to their survival.

These groups can begin getting the vaccine March 15.

State Health and Human Services Secretary Dr. Mark Ghaly said implementation and verification details were still being sorted out.

When asked about the state's announcement, Dr. Paul Simon, chief science officer for the Los Angeles County Department of Public Health, said he hopes many of the county's providers "will be vaccinating their own patients, will understand the medical conditions that their patients have" and that "the implementation would be relatively straightforward."

But he added during a briefing Friday, "it will also require, I think, very clear definitions of who is eligible under this new phase."

"It certainly means that there's even more urgency now to getting a greater supply of vaccine," he said.

That concern has been shared by others as vaccine eligibility continues to expand beyond allocation.

"Reprioritizing who gets doses does not get us more doses, and that's what we need," said Kat DeBurgh, executive director of the Health Officers Assn. of California.

The news follows a meeting last week set by a high-level task force with members from the departments of Aging, Disability Services and Health and Human Services that hashed out details of a proposal raised by a vaccine advisory committee. The working group responsible for drafting state vaccine guidance had said it would make its official recommendation to prioritize people with disabilities and underlying health conditions.

Gov. Gavin Newsom's previous announcement last month that the state would shift vaccine priority to an age-based eligibility structure sparked concerns from groups representing the disability community who were facing longer waits to get vaccinated, with hundreds sharing their frustrations on social media.

Friday's announcement was welcomed by advocates and activists.

"Most disabled people felt like, OK, I guess we're never going to be prioritized," said Lasharn Maelee Johnson, 32, of Long Beach, who has severe asthma and other chronic health conditions. "It's nice that we don't feel like we're being left to die."

"It's never going to be a perfect system," said Ntombi Peters, who uses multiple inhalers and daily medications to control her severe asthma and is on immunosuppressant drugs to treat multiple sclerosis. "But I appreciate that the advisory committee and task force members listened to our concerns and revised the priority list. This has been a huge stressor for me and so many others, but knowing there is light at the end of the tunnel helps tremendously."

The new priority list brought relief to some who hope the update will help those in marginalized communities who may have previously been left out.

"I hope this change will adhere to equity within the disabled community, namely in regards to the Black and brown community and higher risk-populations," said Reid Davenport, 30, a filmmaker in Oakland who has cerebral palsy. "In the meantime, I feel a sense of relief that I hope will prove warranted."

"There's no question that there's going to be a lot of challenges, but there's also no question that this new policy is dramatically better," said Andy Imparato of Disability Rights California, who also serves on the state's vaccine advisory committee. "This creates a safety valve for people under 65" who may still face significant risk.

Imparato said he hoped the new rule would ease the disparities that have plagued the vaccine rollout so far. Many of the same factors that have made the pandemic more deadly in Black, Latino and Native American communities also create or intensify disabilities, so extending the current tier to include those with significant comorbidities would mean more doses reaching hard-hit communities than in an age-based system, he said.

"We can look on a map and say which one has the most COVID cases — these are often the same communities that have higher rates of diabetes and other comorbid conditions," said Dr. Kirsten Bibbins-Domingo, an epidemiologist and co-founder of the UCSF Center for Vulnerable Populations. "But that type of language is hard to implement, and programs that are hard to implement create problems with efficiency and problems with equity."

In particular, she and others worried that the documentation requirement could gum up the works of California's already sluggish vaccination program.

"We need to be careful about not splitting hairs about who's disabled enough to get vaccinated," said Dr. Alyssa Burgart, a bioethicist at Stanford. "It's so easy to show what your age is. But there is immense variety in the type of disability that can place you at higher risk from COVID."

Alice Wong, a 46-year-old disabled activist in San Francisco who created the hashtag #HighRiskCA in response to the state's vaccine priority list, agreed.

"There are lots of people who don't have a primary care provider [to provide documentation]," she said. "We don't need more hurdles."

Some believe that while Friday's announcement was a sign of progress, earlier action needs to be taken to implement prioritization sooner.

"The timing for the directive to go into effect March 15 is still problematic, which we believe will be too late for many people with disabilities who could succumb to COVID in the meantime," said Judy Mark, president of Disability Voices United. "Dr. Anthony Fauci [recently] said that by April, getting vaccines will be 'open season.' We hope to work with the state to move up the timing in order to save more lives."

Claudia Center, legal director with Disability Rights Education and Defense Fund, echoed the sentiment.

"We are pleased to see the explicit inclusion of some people with high-risk disabilities, but the rollout will be too late for many, and the guidance excludes others. The state must immediately collaborate with its disability partners to carefully plan implementation so that people with high-risk disabilities can safely and effectively access the vaccine. We continue to urge the state to prioritize Californians who receive home and community-based services, and low-income people of color with disabilities," she said.

TODAY

NEWS

Unequal access to coronavirus vaccine spurs mounting outrage

SHARE THIS -

There is growing frustration and fury as some of the wealthy, famous, connected or simply crafty find ways to jump the line and get vaccinated while minority and vulnerable populations fall behind. NBC's Erin McLaughlin reports for TODAY's Vaccinating America series.

Feb. 1, 2021

ON AIR

SOUTH LA · JANUARY 30, 2021 2:58 AM

Volunteer Disaster Team Provides Support at Kedren Health Center

Neither rain nor cold could stop what's snowballed into a massive COVID-19 testing and vaccination site in South LA. Kedren Health Center, a foundation for mental health services since the Watts riots, is now taking the lead in helping fight the virus that's changed so many lives. John Cádiz Klemack reports for NBC4 News at 5 p.m. on Jan. 29, 2021.

New COVID-19 vaccination site at USC will open Tuesday

Uber partnership will allow South LA residents to get vaccinated

By Ameera Butt KNX 1070 NEWSRADIO

March 5, 2021 10:20 am

Mayor Eric Garcetti announced a new vaccination site at USC which will have the capacity to vaccinate up to 5,000 people a day.

The site will be at the corner of Exposition and Figueroa next to USC's University Park campus. The new site will open Tuesday March 9 and be open from 8 a.m. to 4 p.m. and will accommodate drive up, walk up and others who need additional access.

"Equity drives every facet of our strategy to end the pandemic, but our efforts will come up short unless we shorten the distance between life-saving vaccines and our hardest-hit Angelenos," said Mayor Garcetti in a press release. "Our City is determined to deliver doses to residents of South L.A. and every community — and our partnerships with both USC and Uber will enable us to get shots into the arms of thousands more Angelenos every day and move us closer to defeating COVID-19."

In its first week, the USC site will be limited to a few thousand doses, according to a press release. But starting next week a large portion of the appointments will be reserved for South LA seniors. Then up to 5,000 people per day will be able to be vaccinated.

"It's our privilege to help in this effort and actively partner with the City and Mayor Garcetti to fight this virus," said Dr. Carol Folt, President of USC. "This center will help bring vaccines into communities most impacted by COVID-19."

“The distribution of the COVID-19 vaccine must be rapid, equitable and accessible. For many vulnerable neighbors like the ones I represent, it can be a matter of life and death,” said Councilmember Curren Price. “The new vaccination site at USC will complement efforts happening on the ground in CD 9 right now. This includes our mobile vaccination sites, as well as trusted health centers that our community turns to like St. John's Well Child & Family Center and Kedren Health. Strategic partnerships such as this one increase access to care, protect our communities and ensure people of color are not sidelined.”

In addition, the city and the Mayor's Fund of LA will provide 15,000 free rides - and another 20,000 rides half-off - to get South LA residents to the USC site for their vaccinations if they don't have access to cars - through a partnership with Uber. Uber has committed to the amount of $500,000 worth of rides.

Los Angeles has six city-run mega-sites offering COVID-19 vaccinations -- Dodger Stadium, Hansen Dam drive through, San Fernando Park, Crenshaw, Lincoln Park and Cal State Los Angeles.

CBS Los Angeles

South LA Clinic Rushes To Administer 600 Expiring COVID-19 Vaccine Doses

SOUTH LOS ANGELES (CBSLA) — Three hours after closing time on Friday, workers at Kedren Community Care Clinic in South Los Angeles were still working — giving out extra doses of the COVID-19 vaccine to anyone who walked in.

“I refuse to let any drop go to waste,” Dr. Jerry Abraham, family physician and epidemiologist for Kedren Health, said.

The clinic has become a model of the success, and the mess, of vaccine distribution in Southern California.

Each day, hundreds of people with appointments get their shots, and hundreds more without reservations line up hoping to get any leftovers at the end of the day.

Most days, there are not any extras to give out, but on Friday it was a bonanza after several local nursing homes suddenly offered 600 extra doses just hours before closing time.

“Right now, I will not let this expiring vaccine go to waste, is that clear,” Abraham said. “I’m offering you a vaccine, an expiring dose of Moderna today, is that OK?”

And with that, Abraham’s team got to work prioritizing seniors and healthcare workers, then residents from South Los Angeles, cutting through the formalities and the red tape of the county system to get vaccines into arms.

“Grandmas and grandpas, non-English speakers, how are you supposed to use that complicated website,” Abraham said. “How are you supposed to, if you don’t have a cell phone or an email address, register? It’s difficult to get an appointment.”

But it’s not only the elderly getting in, there are a number of younger or otherwise not on the vaccine priority list who spend hours in line, even waiting overnight, for the chance at a shot. The hopeful masses come from all over the county and not everyone is OK with these so-called vaccine chasers.

“My commitment, as you know is nothing’s gonna go to waste here at Kedren, so if that means someone in this line gets one who’s not in those priority groups, so be it, I can sleep at night with that decision,” Abraham said. “I won’t be able to sleep if I know I dropped vaccine into the ground or disposed of it.”

One woman from West Los Angeles waiting at the clinic all day in the rain.

“These are for the leftovers, for vaccines that will be thrown out otherwise, so I don’t see how that is exploiting the system,” she said.

In fact, some waiting for the additional doses said the shame would be in letting the vaccines go to waste.

John La and his wife, who live in San Gabriel, spent three days outside the clinic trying to get vaccinated and praised the process — flawed as it may be.

“I wish we had more people like him you know pushing all these vaccinations,” he said. “Trust me, what he’s doing is a God send, he’s saving lives, you know?”

Abraham said he does not encourage people to campout waiting for extra doses, and is actually working on a plan to get the surplus doses to the underserved. But, as was evident Friday, there was a long way to go to beat the chaos of the current system.

Those Hoping to Get ‘Leftover’ Vaccine Doses Wait Nearly 15 Hours

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As vaccine doses make their way across the country, the final hurdle of getting the shot into people’s arms is proving more complicated than anticipated. When vaccination sites have fewer qualified patients than doses of the vaccine, some offer them on a first-come, first-served basis. In

Los Angeles Times

Column: How a South L.A. doctor is beating the system and distributing vaccines equitably

People wait in an unofficial standby line to receive a COVID-19 vaccine at Kedren Community Health Center in South L.A. (Gary Coronado / Los Angeles Times)

Even with a surgical mask covering his salt-and-pepper beard, it's obvious when Dr. Jerry P. Abraham is scowling. He does that a lot as director of the always overwhelmed COVID-19 vaccination site at Kedren Community Health Center in South Los Angeles.

But there's a special level of ire he reserves for the racial inequities he sees in vaccine distribution, which at Kedren Health is embodied by the dozens of young, mostly white people in yoga pants and beanies who lounge on beach chairs and blankets on the sidewalk every day. On Wednesday, there were dozens of them, many with MacBooks on laps, hoping to get leftover doses of the Moderna vaccine.

Next to them, a long line of anxious older people, most of them Latino or Black and from the surrounding neighborhoods, snaked down an adjacent sidewalk. Too many to count were leaning on rickety walkers and canes.

"This is the group of seniors — the walk-ups, plus the appointments. They kind of have to just wait somewhere while we figure out capacity. And *this,"* Abraham explained, pausing to glare at the vaccine chasers, "is the random line that people camped out in from like 8 p.m. the previous night."

It's a "Hunger Games"-like situation — caused by a shortage of vaccines and exacerbated by Los Angeles County's messy system for distributing doses — that galls Abraham, an epidemiologist who has spent much of his career advocating for equity in healthcare.

It's no surprise then that politicians and public health officials are now talking about fixing the raft of racial inequities that have cropped up as a result. Los Angeles isn't alone either. Several recent surveys have unearthed a pattern of disparities among vaccine recipients in multiple states, which is particularly disturbing given that those most likely to get COVID-19 are also least likely to get inoculated.

"I know there's large numbers of other populations that are getting the vaccine at higher rates than others," L.A. County Supervisor Hilda Solis said Tuesday, "and I would just ask: What are we going to do?"

Abraham and his team at Kedren Health aren't waiting for top-down fixes from politicians. In a matter of weeks, they have pioneered a number of workarounds to ensure that the people in South L.A. who need the vaccine most — healthcare workers and those over age 65 — can get it.

Politicians and public health officials — and, I suppose now Blue Shield of California — would be wise to follow Abraham's lead to build a more equitable vaccine distribution system. That it is already being built in South L.A. is all the more important, given how this community has been clobbered by the pandemic, with the essential workers who live there, often in crowded conditions that make social distancing impossible, dying at disproportionate rates.

So that clunky online portal for making appointments?

Forget about it. Kedren Health is determined to help residents from South L.A., who often don't have internet access, a computer or even a smartphone. Volunteers with paper forms are on hand to collect people's information when they arrive and enter it into the county's online database later. Many seniors have reported that technology is their biggest hurdle to getting vaccinated.

What about the need to have a vehicle, essential for getting vaccinated at drive-through sites such as the Forum and Dodger Stadium?

Forget about that, too. Kedren Health is one of only a handful of county-affiliated vaccination sites where people can arrive on foot instead of in a car.

Unfortunately, for those who do arrive by car, parking is chaotic — but that's in no small part because of the affluent people from outside of South L.A. who camp out on the sidewalk all day. Their vehicles, which on Wednesday included Porsches and BMWs and Audis, take up far too many street parking spots for far too many hours.

And the line?

It's long. But volunteers regularly check it to make sure that people who are seniors and frontline healthcare workers don't get stuck behind those who aren't eligible for the vaccine. There are also portable toilets on site.

What about not having a driver's license or not speaking English?

Interpreters for almost every language spoken in South L.A. are on site. And immigration status doesn't matter. Homeless people are also welcome.

"They deserve a vaccine just as much as everybody else," Abraham said. "If they come here, they will leave with the vaccine in the arm. It creates a lot of headaches and challenges for us to report that information to the county and to the state and the federal government, but we will find a way."

Abraham stuffed his brown hands into his white lab coat as he led me through a maze of blue and white tents hastily erected in the Kedren Health parking lot. Every few feet, he had to stop to answer questions. About a woman who was feeling itchy after the vaccine. About how many more doses they should distribute. About a chaplain who wanted to volunteer his services.

While he was talking, a group of men out on parole arrived from a transitional housing facility. They looked around warily, as dance music more fit for a nightclub blared in the background.

So far, more than 9,000 people, many of them Black and Latino healthcare workers, have received a first vaccine dose at Kedren Health.

Abraham doesn't entirely buy the data released this week by the county Department of Public Health, showing a sharply lower rate of vaccinations for doctors and nurses who live in South L.A. compared to other regions. And he certainly doesn't buy that the data are solely a reflection of vaccine hesitancy.

"It's about access," he said. "People didn't know where to go."

Eventually, Abraham says he wants to create a fleet of mobile units, so volunteers can take doses of the vaccine door to door or to homeless encampments. He and a group of other Black doctors and healthcare workers have started exploring grant funding to do it.

That way when there are doses left at the end of the day, Kedren Health can take them to elderly residents for whom standing outside in line is too dangerous. Or volunteers can set up a vaccination event at a church or community center to inoculate essential workers.

In some ways, Abraham's motivation comes back to the under-65 crowd of vaccine chasers whom he scowls at on the sidewalk every day. Missing the mark on vaccine equity means having to summon one of them from a beach chair.

Sure, it's better than throwing unused doses in the trash. Every vaccination is a step toward herd immunity. But with the yawning need among Black and Latino people in South L.A., well-off white people aren't who he wants to vaccinate.

"To come here and demand or to feel this sense of entitlement, or because you don't need to work or because you have those luxuries and you can sit here," Abraham said, "those people I'm not proud of vaccinating."

Los Angeles Times

Letters to the Editor: 'Vaccine chasers' aren't the story; South L.A. doctors fighting inequities are

People wait in the standby line to receive a COVID-19 vaccination at Kedren Community Health Center in Los Angeles on Jan. 22. (Los Angeles Times)

To the editor: I am an African American internal medicine physician who practices in the Crenshaw area. Two of your recently published articles on COVID-19 vaccination access include a piece on individuals receiving vaccinations outside their assigned tier and a column by Steve Lopez on the difficulty he had trying to get his first shot.

This difficulty is what many of my African American colleagues in healthcare and our patients are facing. We've endured the inequitable siting of testing locations, the inequitable distribution of Remdesivir to our community hospitals, and now the inequities

in accessing vaccines, all of which create racial disparities in COVID-19 morbidity and mortality.

If not for the vaccination site at Kedren Community Health Center in South Los Angeles, many healthcare workers of color would not have been vaccinated.

Our focus should not be on the anomalies of individuals who received the vaccine and then cried foul over unfairness. The focus should be on Kedren and Dr. Jerry P. Abraham, who runs the health center's vaccine operations, breaking economic and racial barriers to vaccine access.

COVID-19

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‘Vaccine chasers’ stake out Los Angeles hospitals, hoping for shot | AFP

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Officially, there are no "standby" lines for Covid-19 vaccines in Los Angeles. But over the past few days, large crowds of mostly young people have shown up in front of vaccine centers across the city, including Kedren Health in South LA. The word has spread that at the end of each day,

SPECTRUM NEWS 1

CORONAVIRUS

Doctor's Tenacity Brings Vaccinations to South LA

BY KATE CAGLE | LOS ANGELES
PUBLISHED 11:45 AM ET JAN. 11, 2021

LOS ANGELES — Every shot matters, and Dr. Jerry Abraham is running out of doses of the COVID-19 vaccine.

His clinic, Kedren Health in South Los Angeles, is a hub for health care workers at small, community clinics in L.A.'s poorest neighborhoods.

What You Need To Know

- **Dr. Jerry Abraham's Kedren Health clinic in South L.A. is a hub for health care workers at small community clinics**
- **Both the Moderna and Pfizer vaccines require two doses to give above 90% immunity**
- **Kedren is not saving any of their inventory for the second round, opting instead to vaccinate as many health care workers as possible**

“Our health care workers who are around COVID-19, they need vaccine today,” Abraham said between inoculations.

Both the Moderna and Pfizer vaccines require two doses to give above 90% immunity, but Kedren is not saving any of their inventory for the second round, opting instead to vaccinate as many health care workers as possible — even if that means Abraham himself has to wait longer for a second shot.

“I will wait if I have to, because we have to get everybody their first dose,” said Abraham, who closely follows guidelines set by L.A. County.

With their first 300 doses into the arms of local health care workers, it’s time to take a trip to get more. In a vaccine rollout that’s been criticized as slow and disorganized, Abraham’s daily phone calls to the county are paying off.

In fact, on a car ride over to pick up more vaccines, Abraham convinced L.A. County to double Kedren’s allotment — from 600 to 1,200 doses of Moderna.

“We don’t want Moderna just sitting in their freezers or their fridges for long periods of time," said Abraham. "That’s not going to do anyone any good.”

Once he’s back at the clinic, the boxes are immediately unpacked, and vaccinations resume.

SPECTRUM NEWS 1

CORONAVIRUS

South LA Clinic Needs Volunteers to Ramp up Vaccinations

BY KATE CAGLE | SOUTH LOS ANGELES
PUBLISHED 1:55 PM ET JAN. 20, 2021

LOS ANGELES — It's the shot that promises to save us all, and Dr. Jerry Abraham has been giving it out as quickly as he can.

"In this short amount of time, we've already gone through 400 doses," the doctor said as he collected empty Moderna vials off a table where nurses prepared syringes.

What You Need To Know

- **Kedren Health is currently vaccinating 5,000 healthcare workers per week, in partnership with LA County**
- **Dr. Jerry Abraham said the clinic needs more volunteers to process appointments**
- **President Joe Biden has pledged to vaccinate 100 million Americans in the next 100 daysThanks to L.A. County, Kedren is now receiving vaccines shipped directly to them**

Abraham manages the vaccination at a Kedren Health hub in South Los Angeles through a public-private partnership. L.A. County supplies the vaccines, and Kedren supplies the people and facilities.

Their biggest capacity limit is manpower — it takes about sixty people to check-in appointments, deliver the shots, and monitor for side effects. Even after moving staff out of the clinic to run the hub, they rely on volunteers to fill the gap.

“We just don’t have enough folks, and we’re begging and pleading for people to help,” Abraham said.

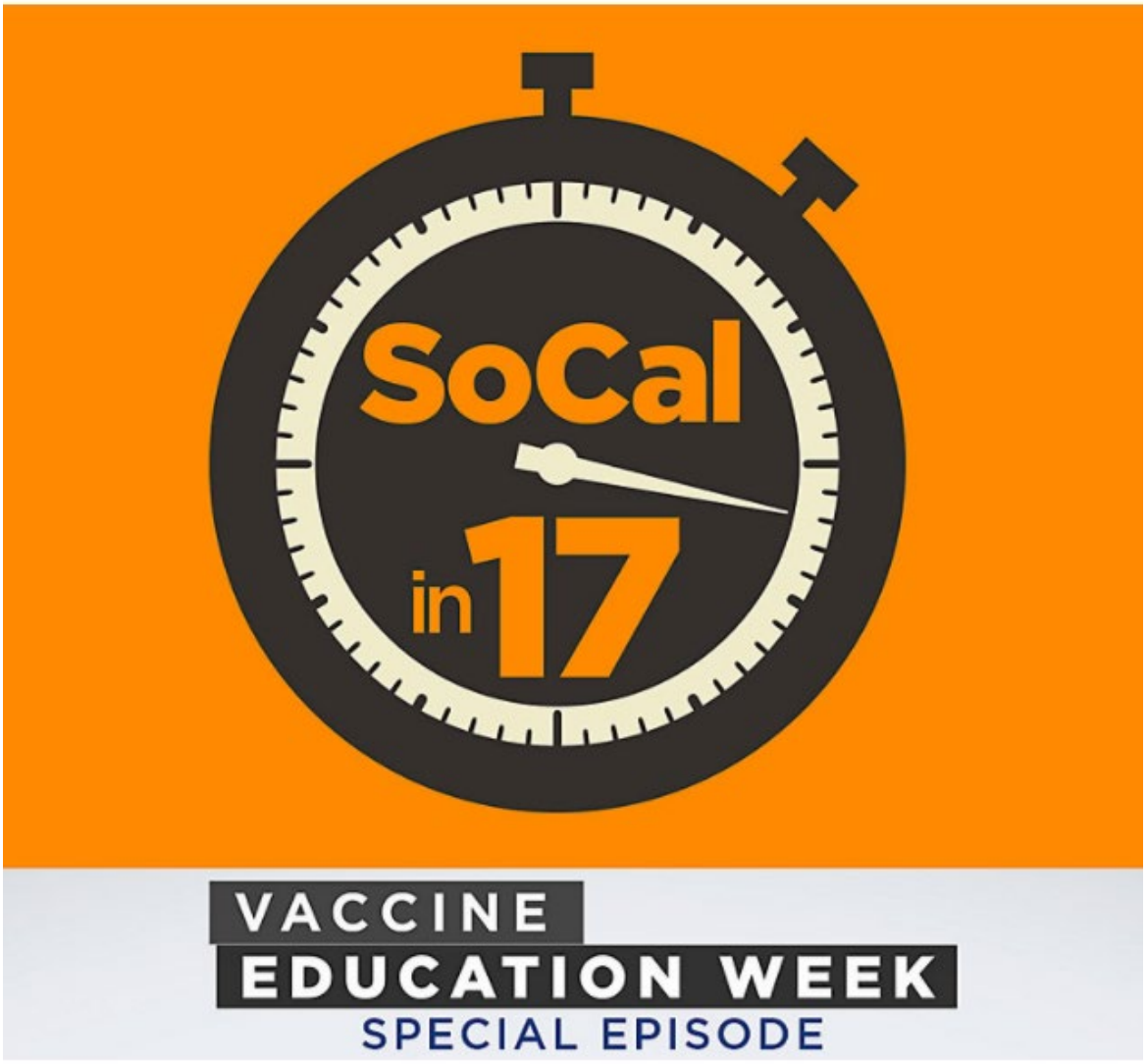
Under the new presidential administration, relief could be on the way. President Joe Biden has set an ambitious goal to vaccinate 100 million Americans in the next 100 days and has pledged $20 billion to do it. His plan includes mobilizing the National Guard to help staff clinics, calling on the Federal Emergency Management Agency (FEMA) to establish 100 Federal vaccination centers in February, and utilizing independent and chain pharmacies to administer doses.

Of course, none of that matters if America runs out of vaccine supply. Thanks to the county, Abraham’s clinic is now getting Moderna shipped directly to the clinic, saving him weekly trips to a secret county health facility to pick up supplies. Kedren Health is now vaccinating a healthcare worker every thirty seconds.

Abraham has worked every day for the past month to get the hub up and running, and when he finally takes a minute, he gets hit with the magnitude of the moment.

“My medical assistants and my staff are working tirelessly around the clock so they can do this, and they do it because they care,” he said.

No one is forcing the clinic to distribute the vaccine, but Abraham is ready to end the pandemic, and he’ll take whatever help he can get.



PODCAST

California's Vaccine Rollout and Road to Recovery: Are We There Yet?

BY SPECTRUM NEWS STAFF | EL SEGUNDO
PUBLISHED 8:00 AM ET FEB. 12, 2021

California is trying to vaccinate as many people as possible and as quickly as possible. And yet, new variants are emerging throughout the world at a dizzying rate. This week, *SoCal in 17* provides extensive coverage on the latest information and insight into vaccine hesitancy. Host Alex Cohen receives an update from Dr. Jerry Abraham, who is heading vaccine distribution at a South L.A. health center. Then Alex gets insight from Bishop Kenneth Ulmer of Faithful Central Bible Church in Inglewood on vaccine hesitancy within the Black community.

PODCAST

What Dr. Anthony Fauci Has to Say About California Lifting Stay-at-Home Orders

BY SPECTRUM NEWS STAFF | EL SEGUNDO
PUBLISHED 7:15 AM ET JAN. 29, 2021

Dr. Anthony Fauci has become such a fixture in this pandemic that some are calling the COVID-19 vaccine the "Fauci ouchie." Dr. Fauci opens up to host Alex Cohen about the "strange journey" of being the face of public health with Donald Trump as president and his first week under the new Biden administration. He also touches on California's pandemic journey.

A local doctor then shares what life is like on the front lines, doling out life-saving vaccines in South Los Angeles.

LA PODCAST

NOVEMBER STRAIN

It rained! COVID hospitalizations and tests are falling, but CA's vaccine rollout is now the worst in the country. What are the ethics of vaccine chasing? And is there actually a new strain? New FEMA guidelines open a path for Project Twomkey. Mitch Englander is about to be sentenced, and the developments Huizar greased get approved in PLUM. Finally, Culver City Vice Mayor and State Senate candidate DANIEL WAYNE LEE joins to talk about Culver City's unique role as a laboratory for equitable housing policy in the 2020 election.

COVID-19

Get the latest information from the CDC about COVID-19.

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Vaccine chasers lining up at South LA hospital

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Vaccine-seeking hopefuls from all over the Southland continued to line up by the hundreds for a 'shot at a shot' at Kedren Community Hospital in South Los Angeles, irking some local residents who argued that the vaccine should be reserved for them.

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Los Angeles Times

Young L.A. 'vaccine chasers' crowd unofficial standby lines in hopes of a shot

People wait in an unofficial standby line to receive a COVID-19 vaccination Friday at Kedren Community Health Center in South L.A. (Gary Coronado/Los Angeles Times)

There is, officially speaking, no such thing as a standby line for COVID-19 vaccinations in Los Angeles County.

But some clinics have soon-to-expire doses left over at the end of the day or during an early-afternoon lull, and word has quickly spread about this potential back door to vaccine access. Some who flock to the sites spend hours waiting in the hope of catching a lucky break.

Kedren Community Health Center in South Los Angeles and the Balboa Sports Complex in Encino have been at the center of the rumor mill in recent days, drawing large crowds that

begin assembling before dawn. Some people arrive from neighborhoods far from the vaccination sites.

Those crowds have included seniors who, despite being eligible to receive the shots, had failed to secure appointments. But many of the others camped out in line do not qualify for doses under the state's phased system of distribution.

Some expressed ethical qualms about potentially getting vaccinated before members of higher-priority groups. They did not want to take a dose from someone else, they said, but they had heard that vaccine would otherwise be thrown out.

"I think there are people who are so much more deserving than we are, and we just happened to find out," Brianna Bane, 23, who works in social media, said Thursday afternoon. She was summoned out of the standby line at Kedren Health and into the vaccination tent a few minutes later.

Los Angeles County Department of Public Health officials said in a statement Friday that while they do not have standby lines, some people are given doses that would otherwise be wasted.

The department said it "does not advise residents to show up at vaccination sites in the hopes of receiving a leftover vaccine at the end of day."

County health officials estimated the number of people being vaccinated through standby lines daily to be fewer than 20 or 30.

But Dr. Jerry P. Abraham, who runs vaccine operations at Kedren Health, said 40 of the more than 800 vaccine doses administered at the site Thursday went to non-healthcare workers who were younger than 65. The nonprofit health system serves as a vaccine point-of-distribution site for the county.

Sonny Tran, the site's clinical operations lead, said 20% to 30% of people with appointments have not shown up. The clinic is administering the Moderna vaccine, which expires six hours after a vial is punctured, according to guidelines from the Centers for Disease Control and Prevention. Abraham said Kedren Health experienced more no-shows than usual on Thursday because appointments had been scheduled through new CalVax software.

Countywide, the no-show rate has been less than 10%; this figure is taken into account when appointments are scheduled, health officials said.

The COVID-19 vaccine supply is extremely limited in the county, and only a small number of appointments are available for front-line healthcare workers and residents age 65 or older. Many frustrated seniors have been vying for the few available slots.

Abraham said healthcare workers and seniors remain the priority for vaccinations at his clinic.

“But there are times when we have no one here,” he said. “And there are times when your inventory has to be either put into someone’s arm or discarded, and we refuse to waste a dose.

“We’re not going to let documentation or technology stop us from vaccinating,” Abraham said, adding that those at the clinic are doing “everything in our power to make sure that our phases and tiers are respected and prioritized.”

The clinic is located in a part of South L.A. that is more than 97% Latino and Black, with a median income of $39,612. But many people who waited for long hours Thursday and Friday outside the clinic were white and came from beyond the surrounding neighborhood.

Early Friday morning, a woman in an Audi with a “Brentwood School” license-plate holder stopped to honk at people she knew as she circled for a parking space. Some people set up camping chairs, tapped away at laptops and read newspapers and iPads as they waited. A security guard occasionally walked down the block on Friday morning, whisking healthcare workers and those over 65 out of the general standby line to the front.

The majority of the “vaccine chasers,” as one woman jokingly called her group, said they lived on the Westside or in the Valley, though others hailed from downtown, Los Feliz and Echo Park, and a few from Topanga and Malibu. They had all heard about the opportunity through word of mouth in their social and professional networks.

“The moral question of getting it before somebody else was outweighed by the fact that there are doses being wasted,” Jasmine, a 28-year-old designer from Echo Park who asked that her last name not be used, said Friday morning.

As she spoke, the young man waiting just ahead of her dug a plastic fork into what appeared to be a to-go breakfast frittata. His meal had arrived a few minutes prior via delivery driver.

Multiple people remarked on how starkly the demographics of the line diverged from those of the neighborhood and expressed discomfort about that.

“I do feel a little weird. … I wish it was something more members of this community knew about,” Caitlin, a 57-year-old actress from the Valley, said Friday as she noted the “array of expensive cars in the parking lot.” Caitlin, who asked that her last name not be used, had been waiting with her college-age son since 4:45 a.m.

At the Balboa Sports Complex in Encino on Friday, a line of seniors and healthcare workers snaked around a red brick building where vaccinators administered shots to people with appointments. But just beyond that — alongside the park’s tennis courts and baseball fields — a separate line had formed: vaccine hopefuls.

Young people, families and even seniors were parked on lawn chairs and blankets, waiting to see if there would be extra shots available for them at the end of the day. Rumors abounded, including one often-repeated anecdote about 200 people who lucked into leftover shots one afternoon last week.

“It’s kind of like a game of telephone,” said William Crouse, 32, who was working on a jigsaw puzzle with his friend Teddy Jones, 38, while they waited.

Behind them, a paper sign taped to a post said the unofficial “non-appointment line” would give top priority to healthcare workers and those over 65 before moving on to others. Crouse and Jones said they first heard about the possible handout of leftover doses through an Instagram post.

The current pacing of L.A. County’s vaccine rollout means it could be well over six months before eligibility opens up to Crouse’s age group, he said, so he figured he would try his luck at Balboa.

“If the goal is to get as many people vaccinated as possible, why not?” he said. “I’m happy to play a role in that goal.”

Not everyone was so young, or so hopeful.

Josefa Celada, 71, joined the Balboa Sports Complex standby line at 9 a.m. Friday after trying and failing to secure an online appointment for seniors. The next opening she could find was in March, she said, but she needs the vaccine urgently for work. A nanny to three children, she was told by her boss not to return to her job until she’s been inoculated.

“I need it,” she said. “I don’t go outside; I do nothing. I’m so scared.”

Officials working the lines at the Balboa Sports Complex said seniors and healthcare workers would be pulled first from the standby group at the end of the day, but no one could make guarantees.

Selda Hollander, 86, joined Balboa's standby line after having no success reaching anyone through the telephone appointment system.

She wasn't prepared for the long wait, though, and didn't bring a chair. She was instead seated in the grass, bracing herself against the cold.

"I can't figure out if it's worth it," she said, shivering slightly. "I'm waiting for the vaccine, but I can get sick because of the weather."

Meanwhile, Natasha Moini and Siena Deck, both 23, came ready. Parked on folding chairs, with sweaters on and towels blanketing their legs, they had snacks and were watching an episode of "How to Get Away with Murder" on an Apple laptop.

Moini's mother was the one who heard about the Balboa standby line from a friend. She was able to secure a shot last week.

"You never really know, so we figured, why not come?" Moini said. "I mean, what else are we doing?"

Both Moini and Deck, who arrived at 10:30 a.m., said they would come back a few more times if they weren't able to get vaccinated Friday.

"I'll just feel better if I get it," Moini said.

COMPLEX

Young L.A. Residents Are Flocking to Vaccine Distribution Sites to Get Leftover Shots

Image via Getty

Young and affluent Los Angeles residents are flocking to clinics attempting to score COVID-19 vaccinations at risk of being discarded.

According to a report for *the Los Angeles Times*, these young, mostly white "vaccine chasers" form unofficial lines outside of local clinics and community centers to receive a dose of the dwindling Pfizer or Moderna supply.

The Los Angeles County Department of Public Health does not have any sort of official "standby" process for vaccine distribution and "does not advise residents to show up at vaccination sites in the hopes of receiving a leftover vaccine at the end of day." However, it did acknowledge that some people are being given doses that would otherwise be wasted.

Some of the people in these lines include seniors who qualified but weren't able to get an appointment, but most are neither healthcare workers or above the age of 65.
The *Times* reports that some clinics are seeing as many as 40 vaccinations in a day go to young, low-risk residents.
"The moral question of getting it before somebody else was outweighed by the fact that there are doses being wasted," a 28-year-old designer told the news outlet.

Both vaccines come in multi-dose vials. The Kedren Community Health Center, where "vaccine chasers" have been able to secure doses, administers the Moderna vaccine which expires after six hours.

"There are times when we have no one here," Dr. Jerry P. Abraham, who runs the center, told the *Times*. "And there are times when your inventory has to be either put into someone's arm or discarded, and we refuse to waste a dose."

The extra doses sometimes become available when people with appointments don't show up. As the *Times* reports, many of these "vaccine chasers" hail from wealthier parts of the city and descend on vaccine distributions in low-income communities.

People find out about these unofficial standy lines mostly through word of mouth and rumors. The new CDC director Dr. Rochelle Walensky recently revealed that due to low supply, the vaccine won't be widely available to the general public for several months.

COVID-19

Get the latest information from the CDC about COVID-19.

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Kedren Community Health Center Testing Site

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Mayor Eric Garcetti teamed up with Councilmember Curren Price and activist Anthony Anderson in an event that encouraged high-risk communities to get tested, for free!

New COVID-19 deaths in U.S. top 5,000 to set new single-day record

By Jean Lotus

People queue at the Kedren Community Health Center in Los Angeles, Calif., on Thursday to receive the coronavirus vaccine. Seniors 65 and older can now move to the head of the line without an appointment, officials said. Photo by Jim Ruymen/UPI | License Photo

South L.A. Physician Finds Workarounds to Distribute Vaccines Equitably

A physician assistant hands Dr. Jerry F. Abraham a box of the Moderna vaccine at the Kedren Community Health Center in Los Angeles on Thursday, February 4, 2021. Seniors 65 and older can now move to the head of the line to receive their vaccinations without an appointment. Abraham and his team at Kedren have pioneered workarounds to ensure that the people in South L.A. who need the vaccine the most , healthcare workers and those over 65 can get it. Photo by Jim Ruymen/UPI

South L.A. Physician Finds Workarounds to Distribute Vaccines Equitably

Senior citizens are inoculated with the Moderna COVID-19 vaccine at the Kedren Community Health Center in Los Angeles on Thursday, February 4, 2021. Seniors 65 and older can now move to the head of the line to receive their vaccinations without an appointment. Director Jerry Abraham and his team at Kedren have pioneered workarounds to ensure that the people in South L.A. who need the vaccine the most , healthcare workers and those over 65 can get it. Photo by Jim Ruymen/UPI

South L.A. Physician Finds Workarounds to Distribute Vaccines Equitably

Dr. Jerry F. Abraham directs the distribution of the COVID-19 Moderna vaccine at the Kedren Community Health Center in Los Angeles on Thursday, February 4, 2021. Seniors 65 and older can now move to the head of the line to receive their vaccinations without an appointment. Abraham and his team at Kedren have pioneered workarounds to ensure that the people in South L.A. who need the vaccine the most , healthcare workers and those over 65 can get it. Photo by Jim Ruymen/UPI

South L.A. Physician Finds Workarounds to Distribute Vaccines Equitably

A nurse inoculates a senior citizen with the Moderna COVID-19 vaccine at the Kedren Community Health Center in Los Angeles on Thursday, February 4, 2021. Seniors 65 and older can now move to the head of the line to receive their vaccinations without an appointment. Director Jerry Abraham and his team at Kedren have pioneered workarounds to ensure that the people in South L.A. who need the vaccine the most , healthcare workers and those over 65 can get it. Photo by Jim Ruymen/UPI

South L.A. Physician Finds Workarounds to Distribute Vaccines Equitably

Medical staff member picks up a syringe with Moderna COVID-19 vaccine doses at the Kedren Community Health Center in Los Angeles on Thursday, February 4, 2021. Seniors 65 and older can now move to the head of the line to receive their vaccinations without an appointment. Director Jerry Abraham and his team at Kedren have pioneered workarounds to ensure that the people in South L.A. who need the vaccine the most , healthcare workers and those over 65 can get it. Photo by Jim Ruymen/UPI

South L.A. Physician Finds Workarounds to Distribute Vaccines Equitably

An Americorps volunteer assists a senior citizen at the Kedren Community Health Center in Los Angeles on Thursday, February 4, 2021. Seniors 65 and older can now move to the head of the line to receive their vaccinations without an appointment. Director Jerry Abraham and his team at Kedren have pioneered workarounds to ensure that the people in South L.A. who need the vaccine the most , healthcare workers and those over 65 can get it. Photo by Jim Ruymen/UPI

South L.A. Physician Finds Workarounds to Distribute Vaccines Equitably

Residents wait in line to receive COVID-19 leftover doses of the Moderna vaccine at the Kedren Community Health Center in Los Angeles on Thursday, February 4, 2021. Seniors 65 and older can now move to the head of the line to receive their vaccinations without an appointment. Director Jerry Abraham and his team at Kedren have pioneered workarounds to ensure that the people in South L.A. who need the vaccine the most , healthcare workers and those over 65 can get it. Photo by Jim Ruymen/UPI

"The volunteer program Dr. Shover running has been an incredibly important collaboration with the Department of Public Health to get immediate data and other support to community clinics in the hardest hit areas. We are so thankful she is applying for funding to continue this important work."

M. Claire Jarashow, PhD, MPH
Director, Vaccine Preventable Disease Control Program
Los Angeles County Department of Public Health

KEDREN VACCINES MEDIA COVERAGE

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Sent: Saturday, March 6, 2021 8:50 PM
To: Anthony York
Cc: Sumi Folz; Doris Schwartz; Kedren COVID19; Kedren Vaccines
Subject: most updated KEDREN VACCINES media portfolio in preparation for Washington DC visit
Attachments: Resized_Resized_Resized_Screenshot_20210205-062810_Twitter.jpeg; Resized_IMG_27671.jpeg; FB_IMG_1613743553287.jpg; IMG_16931.jpg; IMG_39201(2).jpg; IMG_17401.jpg; IMG_17331.jpg; IMG_26051.jpg; IMG_26061.jpg; Screenshot_20210216-163153_Twitter.jpg; Screenshot_20210216-163151_Twitter.jpg

Sincerely,
Dr. Abraham
Director, KEDREN VACCINES

#ThisIsOurShot
Dr. Abraham
832.687.3242

KEDREN VACCINES MEDIA COVERAGE

US SENATE 03.06.21 | Examining Our COVID-19 Response: An Update from the Frontlines
https://www.help.senate.gov/hearings/examining-our-covid-19-response-an-update-from-the-frontlines

VICE NEWS 03.04.21 | KEDREN Serves People of Color in South Los Angeles, and is taking the reins to vaccinate those who may otherwise be left behind
https://video.vice.com/en_us/video/thursday-march-4-2021/6034393f206d072e113393f1?latest=1

CGTN 03.06.21 | COVID-19: Inside One of the Main Vaccination Sites in Los Angeles
https://youtu.be/dn086K1dmm4

CNN 03.02.21 | Nearly 70% of Americans want to get a Covid-19 vaccine as soon as the can or already have, poll shows
https://www.cnn.com/world/live-news/coronavirus-pandemic-vaccine-updates-03-02-21/h_1c71088e460a988bbe571a6ececee3cd

NPR 03.02.21 | Vaccine Distribution: An Equity Challenge
https://www.npr.org/2021/03/01/972561118/vaccine-distribution-an-equity-challenge

TELEMUNDO 03.05.21 | Buscan Voluntarios para Asistir a Centros de Vacunación de Áreas Más Vulnerables
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https://youtu.be/jKcRB8Ibp1E

BLACK NEWS CHANNEL 02.15.21 | South LA Clinic Steps Up Efforts to Bring Equity to COVID-19 Vaccine Distribution
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NPR 02.23.21 | Race Versus Time: Targeting Vaccine To The Most Vulnerable Is No Speedy Task
https://www.npr.org/sections/health-shots/2021/02/23/969384904/race-versus-time-targeting-vaccine-to-the-most-vulnerable-is-no-speedy-task

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https://www.newsweek.com/are-white-vaccine-chasers-reason-people-color-arent-getting-their-covid-19-shots-1572171

LA TIMES 02.24.21 | Of course, Californians misused vaccine codes. The system is designed for cheating
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KCET 02.19.21 | Vaccines Heading to L.A. Held Up by Winter Storms; Appointments Postponed
https://www.kcet.org/news-community/coronavirus/vaccines-heading-to-l-a-held-up-by-winter-storms-appointments-postponed

GEPHARDT DAILY 02.27.21 | FDA Approves Emergency Use of Johnson & Johnson Vaccine
https://gephardtdaily.com/top-stories/fda-approves-emergency-use-of-johnson-johnson-vaccine/

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https://fb.watch/3RIL_3ZGwi/

NHK WORLD TOKYO 02.22.21 | Equitable Vaccine Distribution in America
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https://www.kcrw.com/news/shows/greater-la/covid-vaccine-elderly-socal-edison/south-la-kedren-health-covid-vaccine-standby

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https://capitalandmain.com/vaccine-sites-missing-in-many-los-angeles-county-communities-0223

Big Pharma Shouldn't Control Covid-19 Vaccines
https://www.laprogressive.com/control-covid-19-vaccines/

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https://twitter.com/CAgovernor/status/1361824179511648259?s=20
https://www.facebook.com/photo?fbid=10103005977214387&set=a.869274385027
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https://www.cnn.com/2021/02/14/health/us-coronavirus-sunday/index.html

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https://www.latimes.com/california/story/2021-02-21/governor-admits-problems-covid-19-vaccine-rollout-latino-black-communities

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https://www.latimes.com/california/story/2021-02-14/state-data-on-vaccine-distribution-reveals-disaprities

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https://www.latimes.com/california/story/2021-02-13/california-covid-19-vaccine-shortages-delays

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https://ktla.com/news/local-news/inequities-in-vaccination-coverage-are-clear-l-a-county-health-officials-say/

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https://youtu.be/xwQvmU9EAg4
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TMZ LIVE 02.08.21 | Dr. Jerry Abraham Creates Awesome COVID Vaccine Distribution Model to Serve Minority Communities
https://www.tmz.com/2021/02/08/dr-jerry-abraham-los-angeles-kedren-clinic-vaccines-black-brown-people/
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MSNBC RACHEL MADDOW SHOW 02.05.21 | Removing Barriers is Key to Getting Vaccine to Underserved Communities
https://www.msnbc.com/rachel-maddow/watch/removing-barriers-is-key-to-getting-vaccine-to-underserved-communities-100619845748
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https://losangeles.cbslocal.com/video/5280480-la-county-working-to-address-racial-disparities-in-distribution-of-covid-19-vaccines/
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https://youtu.be/_fGIpJEMyvk

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https://www.latimes.com/california/story/2021-01-29/coronavirus-covid-vaccine-equity-hospital-south-los-angeles-kedren-health

LA TIMES | Letter to the Editor: 'Vaccine chasers' aren't the story; South L.A. doctors fighting inequities are
https://www.latimes.com/opinion/story/2021-01-26/vaccine-chasers-inequity

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https://youtu.be/2bggS3jLDio

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https://spectrumlocalnews.com/nc/coastal/coronavirus/2021/01/20/south-la-clinic-needs-volunteers-to-ramp-up-vaccinations
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SPECTRUM SOCAL IN 17 | California's Vaccine Rollout
https://spectrumnews1.com/ca/la-east/coronavirus/2021/02/11/california-s-vaccine-rollout-and-road-to-recovery--are-we-there-yet-

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https://spectrumnews1.com/ca/la-east/socal-in-17/2021/01/28/what-dr--anthony-fauci-has-to-say-about-california-lifting-stay-home-orders

LA PODCAST | CA's vaccine rollout is now the worst in the country. What are the ethics of vaccine chasing?
https://thelapod.com/episode/november-strain/

Fox 11 Los Angeles 02.10.21 | Vaccine Chasers Lining Up at South LA Hospital
https://youtu.be/h7UG3l5YjwE

LA TIMES | Young L.A. 'vaccine chasers' crowd unofficial standby lines in hopes of a shot
https://www.latimes.com/california/story/2021-01-23/standby-lines-backdoor-vaccine-access

INSIDE THE ISSUES w/ ALEX COHEN | Diversifying the Healthcare Workforce During the COVID-19 Pandemic
https://vimeo.com/503637567
the password: insidetheissues

NHK WORLD TOKYO & FUJI NEWS JAPAN | Young People in the US Seeking Surplus Vaccines
https://www.fnn.jp/articles/-/138285

COMPLEX | Young L.A. Residents Are Flocking to Vaccine Distribution Sites to Get Leftover Shots
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LA THIS WEEK | LA City Mayor Eric Garcetti Visits Kedren Community Health Center Site
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UNITED PRESS INTERNATIONAL UPI | South LA Physician Finds Workarounds to Distribute Vaccines Equitably
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anticipated 03.08.21

NEW YORKER | The Happiest Place on Earth -- A Vaccine Distribution Center in South LA
still waiting to print...

KCRW | 2nd Doses Are Hard To Find … But Not At Kedren
still waiting to air…

CGTN | Equitable Vaccine Distribution in America
still waiting to air…

LA TIMES | Zip Code Based Strategy Piloted at Kedren
still waiting to print...

SOUTH SIDE WEEKLY | How Digital Demons Stole Grandmas Shot -- Overcoming the Digital Divide to Getting Vaccinated
still waiting to print…

NBC | Celebrating Black Excellence -- Honoring Black History Month Special
still awaiting link...

AARP MAGAZINE | Getting Vaccinated -- Removing Barriers for Seniors
still waiting to print...

REUTERS | Get on Board the Bus -- Bus Loads of Teachers Get Vaccinated at KEDREN on the Bus
still waiting to print...

CHARLES DREW UNIVERSITY Magazine | How Dr. Abraham is Vaccinating South LA
still waiting to print...

THIS AMERICAN LIFE | A Day in the Life of A Vaccine Distribution Center in South Los Angeles
still pending...

BBC WORLD | Vaccines in America
still waiting to air…

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most updated KEDREN VACCINES digital media portfolio for Washington DC visit

Jerry P Abraham, MD MPH <abraham.jerry@gmail.com> Sun, Mar 7, 2021 at 12:46 AM
To: "Dr. Jerry Abraham" <jabraham@kedrenhealth.org>
Bcc: Jerry Abraham <abraham.jerry@gmail.com>

Sincerely,
Dr. Abraham
Director, KEDREN VACCINES

#ThisIsOurShot
Dr. Abraham
832.687.3242

KEDREN VACCINES MEDIA COVERAGE

US SENATE 03.06.21 | Examining Our COVID-19 Response: An Update from the Frontlines
https://www.help.senate.gov/hearings/examining-our-covid-19-response-an-update-from-the-frontlines

VICE NEWS 03.04.21 | KEDREN Serves People of Color in South Los Angeles, and is taking the reins to vaccinate those who may otherwise be left behind
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CGTN 03.06.21 | COVID-19: Inside One of the Main Vaccination Sites in Los Angeles
https://youtu.be/dn086K1dmm4

CNN 03.02.21 | Nearly 70% of Americans want to get a Covid-19 vaccine as soon as the can or already have, poll shows
https://www.cnn.com/world/live-news/coronavirus-pandemic-vaccine-updates-03-02-21/h_1c71088e460a988bbe571a6ececee3cd

NPR 03.02.21 | Vaccine Distribution: An Equity Challenge
https://www.npr.org/2021/03/01/972561118/vaccine-distribution-an-equity-challenge

TELEMUNDO 03.05.21 | Buscan Voluntarios para Asistir a Centros de Vacunación de Áreas Más Vulnerables
https://www.telemundo52.com/noticias/local/buscan-voluntarios-para-asistir-a-centros-de-vacunacion-de-areas-mas-vulnerables/2164018/
https://youtu.be/KcluQJ7ESAk

CBS NEWS 02.25.21 | A SHOT OF HOPE: Vaccine Questions Answered w/ Dr. Fauci & Dr. Abraham
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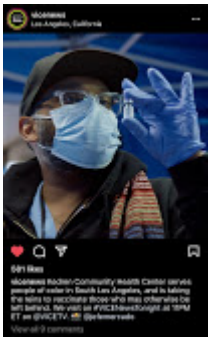

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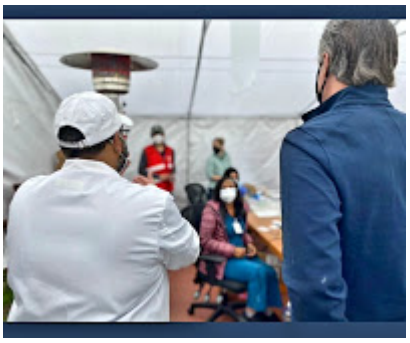

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JerryPAbraham MDMPHCMQ

@jabraham

#ThisIsOurShot grateful for the generosity of so many helping hands and resources to roll out these #COVID19 #vaccines! #BabyFauci @FauciFan #fanboy @NIAIDNews #everylastdrop #theshotwevebeenwaitingfor #MemeThis

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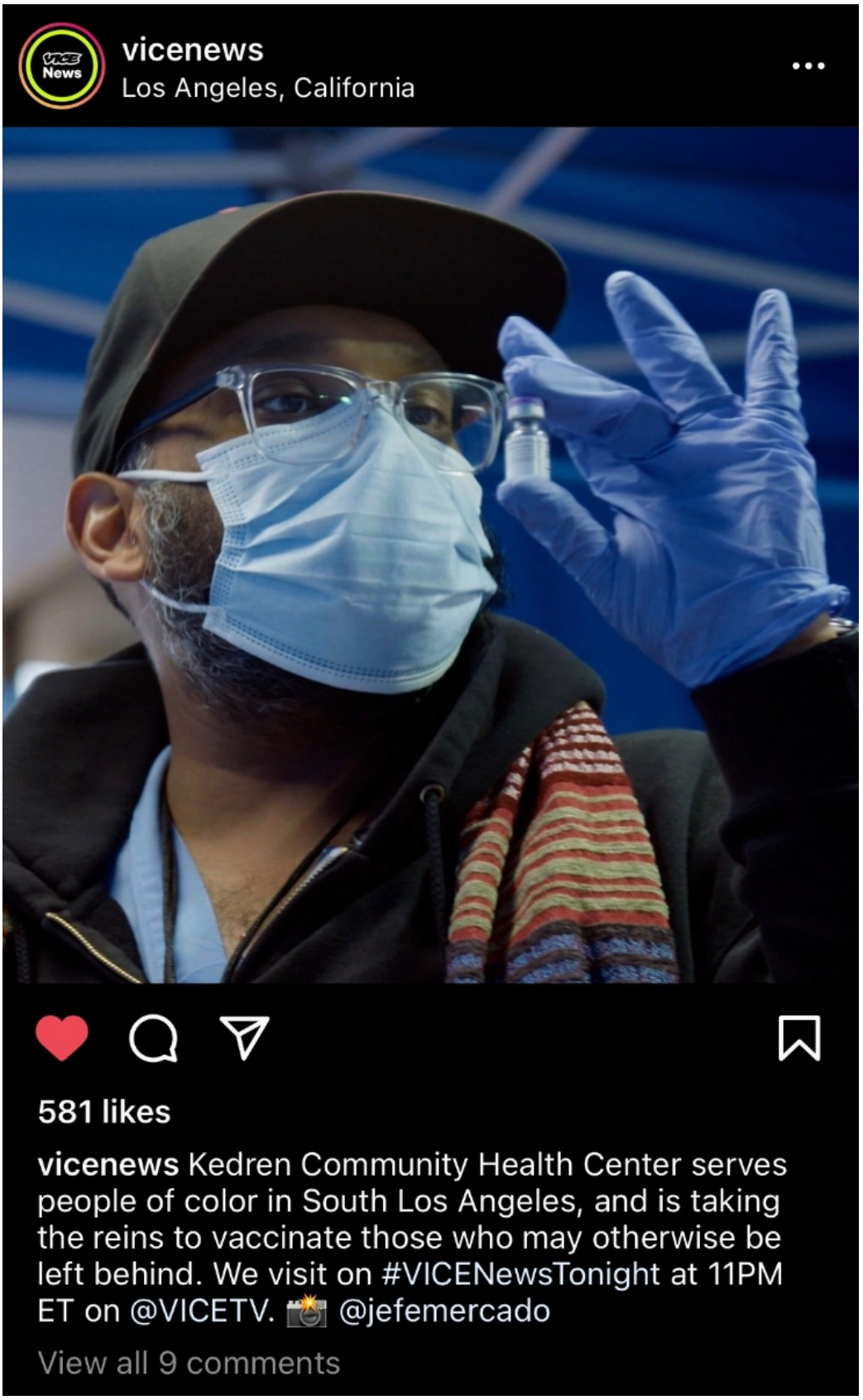

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Kedren Community Health Center Integrated Care System

Current Plan and Implementation

Since 1965 Kedren has been deeply connected with the South Los Angeles community and has come to be known as the safety net provider for mental health services in Service Planning Area 6. In 2014 responding to the gaps in service, Kedren Community Health Center implemented a delivery care system based on the following premise "the Organization aims to create and maintain health and wellness leadership within the service area and work collaboratively with partner agencies to deliver high quality care to consumers. Additionally, the Organization will build greater connectivity among the diverse health and wellness programs by developing new integrations, boundary crossing structures, and productive synergies". Always looking forward, Kedren articulated its plan for Healthcare Reform in the Strategic Plan developed in 2014 and took proactive steps to meet the goals of the Triple Aim.

Our Mission

Our Mission is to provide quality integrated health and behavioral health services to children, youth, adults, and families irrespective of immigration status, residency, language, culture, gender, ethnicity, religion, sexual orientation, or one's ability to pay.

Our Vision

Kedren's vision is to eliminate health disparities for children, youth, adults, and families in South Los Angeles by creating access to care irrespective of one's ability to pay. Kedren is committed to promoting well-being by enhancing the quality of life through best practices in healthcare delivery.

Service Delivery Model

This model brings together health, mental health, public health, and substance use providers in each neighborhood. This collaboration of providers comes together to coordinate patient care, remove access barriers, reduce duplicative information gathering processes, integrate multiple treatment goals into one service plan, provide care consultation, service linkage, improve patient service satisfaction, attain and sustain positive health outcomes, and improve care coordination communication and relationships among treatment providers whereby leading to optimum Integrated Care and achieving the goal of healthy neighborhoods and communities.

BOARD OF DIRECTORS

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President/Chief Executive Officer

BRIAN KAMEL, Esq.
Corporate Counsel

RAHN K. BAILEY, M.D.
Chief Medical Officer

Thus, this implementation of the model was strategic in addressing the progressing need of the community during the pandemic as we are prepared to offer all needed services from a "one stop" (see attached) platform utilizing community partners.

Sincerely,

John H, Griffith, Ph.D.
President/Chief Executive Officer

Kedren Community Health Center

ONE STOP SHOP

Community Partners

- Kedren Community Care Clinic
- Client Residences
- Parks
- Schools
- Freeways
- Major Roads

Community Partners

- Churches
- Primary Care Cluster
- Substance Abuse Cluster
- Law Enforcement
- LA County Social Services/DPSS
- Housing
- Other Collaborative Relationships

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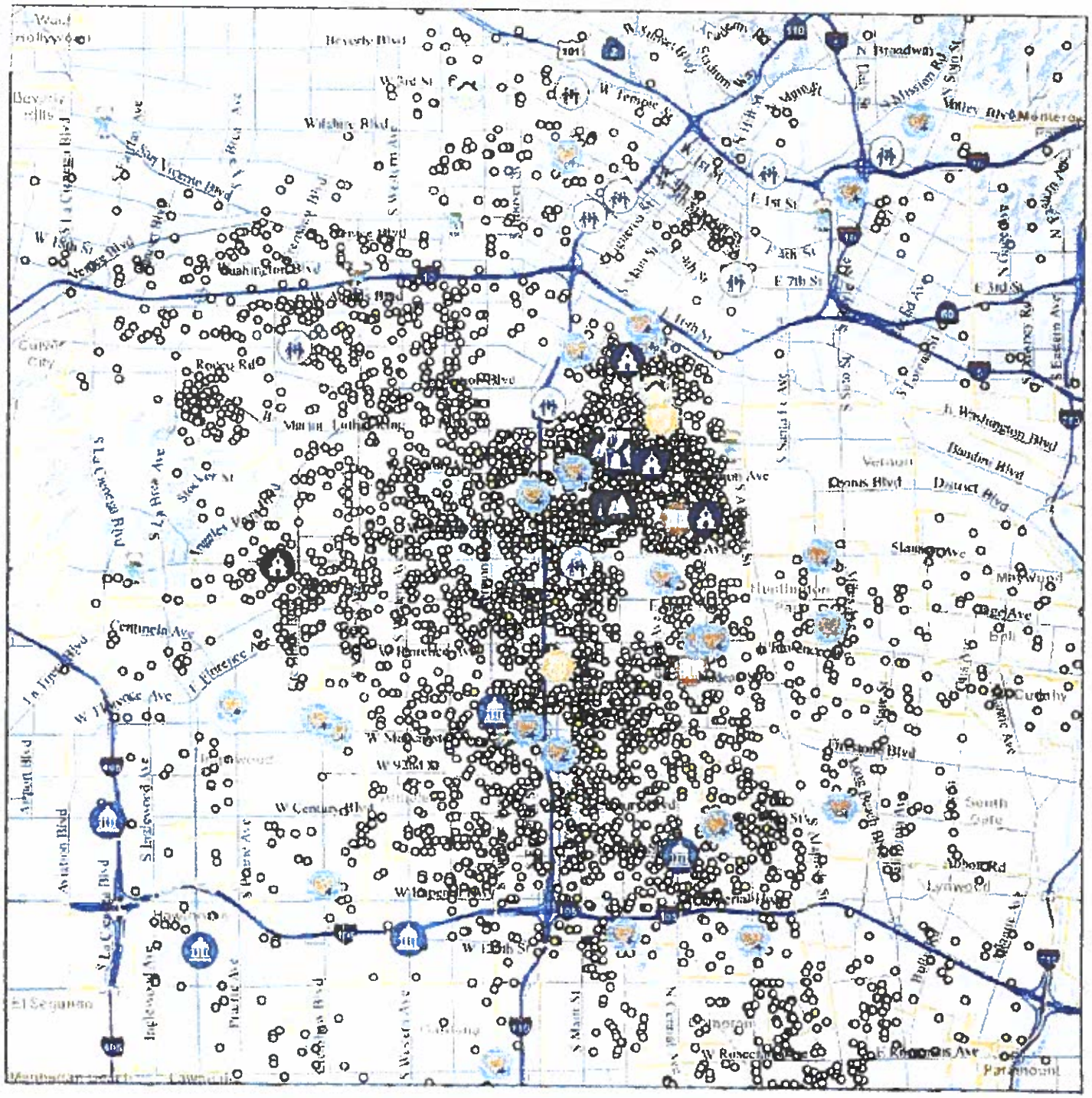


A History of
Kedren Community Health Center, Inc.

In Celebration of the ***50 Year Anniversary***
of the Community Mental Health Center Act

Community Mental Health Centers Act

The Mental Retardation Facilities and Community Mental Health Centers Construction Act, know as the Community Mental Health Center Act, in 1963. The law instituted a nationwide network of mental health centers based in local communities.

HISTORY

In the decades before the passage of the Community Mental Health Centers Act, support grew for community-based alternatives to the large custodial institutions that had been the primary option for the care of people with mental illness and mental disabilities. A series of press exposes of conditions in several large state institutions provoked public concern.

In 1955, an act of Congress commissioned a nationwide analysis of mental health needs. The resulting 10-volume report issued in 1960 became the basis for new legislation. New drugs for the treatment of a variety of mental illnesses also became available so that people with these illnesses could more easily manage life outside of custodial institutions. **Congress pass the Act in 1963 in response to a special message from President John F. Kennedy, the first such presidential message on mental health issues.**

PROVISIONS

The law initiated federal involvement in the construction of community mental health centers and authorized the National Institution of Mental Health to monitor the centers. Amendments to the law in 1965 authorized funding to staff the centers, and it expanded eligibility for grants to include treatment facilities for substance abuse and children's services. Funding was provided as "seed money." Local communities applied for grants to fund locally organized centers that met the law's specifications.

SERVICES

As the community centers opened, they provided both inpatient and outpatient services to the mentally ill, as well as emergency services, day treatment, consultation and education. The centers were accessible to the general population and provided services without regard to clients' ability to pay.

CHANGES

During the 1970s, President Richard Nixon and Gerald Ford both vetoed funding for the community mental health centers, but Congress voted to override their vetoes. The report of a commission during the administration of President Jimmy Carter led to the passage of the Mental Health Systems Act in 1980, intended to reinvigorate the centers, but it was repealed in 1981 under President Ronald Reagan as part of a budgeting revisions. Services provided by community mental health centers declined in the years that followed.

A Message from Patrick Kennedy:

Fifty years ago today marks President Kennedy's historic message to Congress on mental illness. It was in this message that JFK began laying the groundwork for what would be the first mental health bill to be introduced and passed into legislation. My uncle had the profound realization that as a county, we could no longer continue the inhumane institutionalization of those with mental illness. This message led to the signing of the Community Mental Health Act on October 24th, 1963.

I ask you all to join with me in celebration of this remarkable legislation and all it did to advance community mental health on October 23 – 24, 2013. It will be a time to reflect on all the progress we have made in the past fifty years and to identify the initiatives we need to continue to work on in order to have another fifty years of progress for those with mental illness.

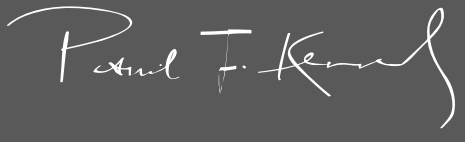
There will be many opportunities to participate in the celebration. On October 23, 2013, I will be hosting the Kennedy Forum on Community Mental Health Gala at the John F. Kennedy Presidential Library and Museum in Boston, MA. This private gala will be coordinated with mental health organizations from around the county that will be able to participate via webcast of the gala keynote speaker program live at each of their celebrations.

On October 24, 2013 the Kennedy Forum on Community Mental Health Conference will take place in Boston, MA. Advocates, academics, researchers, practitioners and politicians will be invited to come and reflect on current topics in the field of mental health through expert panel discussions and a keynote luncheon program.

I hope you'll all join me in honoring the work of President Kennedy in the field of community mental health and work with me to create ideas for the next 50 years of mental health policy. In the words of JFK:

"The mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities."

It is with this thought in mind that I urge us all to come together in order to progress the research, care, science and policy in the field of mental health. I look forward to celebrating with people all across the county on October 23-24, 2013.



Kedren Community Health Center, Inc.
Timeline: 1965 - Present

1965

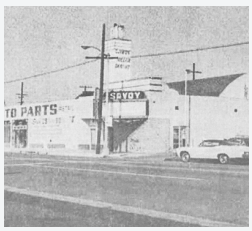
Founded October 22, 1965 by the late Dr. James L. Jones, MD, a child psychiatrist.

1966

1st Kedren Mental Health Center Site opens in 9th & San Pedro & 1st Head Start Site on 1219 Gramercy Place.

1968

Kedren moves to Kedren Community Mental Health Center at 7760 South Central Ave.



1970

Groundbreaking ceremony is held for the new Kedren Community Mental Health Center.

1985

Dr. Frank L. Williams becomes Kedren's first full time Medical Director.

1992

New programs begin to take shape and the amount of hospital beds increase. Kedren begins to expand services and locations with a residential center for homeless in Compton and 28 Head Start Facilities.

1996

LA Unified moves into Kedren's Headquarters at 4211 South Avalon Blvd. in order to deliver education for our Children's Inpatient Program.

1998

Both Mental Health and Head Start budgets double in size;
Mental Health capacity expands to 17 beds for children and 31 beds for adults

1971

Alban I. Niles becomes Executive Director.

1977

Grand Opening and expansion of Kedren Community Mental Health Center at 710 E. 111th Place, Los Angeles.

1980

Gloria Nabrit becomes Kedren's CEO, begins expanding services.

1985

Kedren Community Mental Health center moved into its current residence at 4211 South Avalon Blvd.

2002

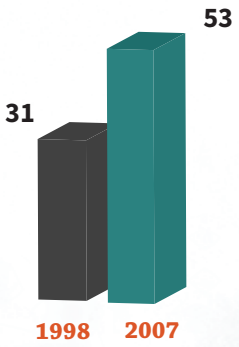
Dr. John H. Griffith becomes Kedren's CEO and adds Kedren's first inpatient pharmacy, reducing the cost of delivering inpatient care.

2005

Kedren begins developing strong partnerships with primary care physicians in the community.

2007

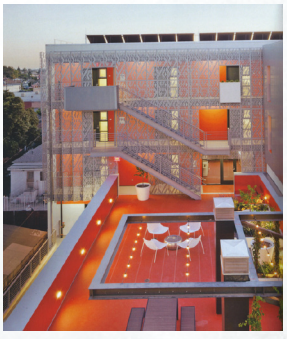
Kedren Headquarters adds an additional 22 adult inpatient beds.



ADULT BEDS

2012

In partnership with the YMCA, the 28th St. Apartments opens its doors to house Kedren's outpatient clients.



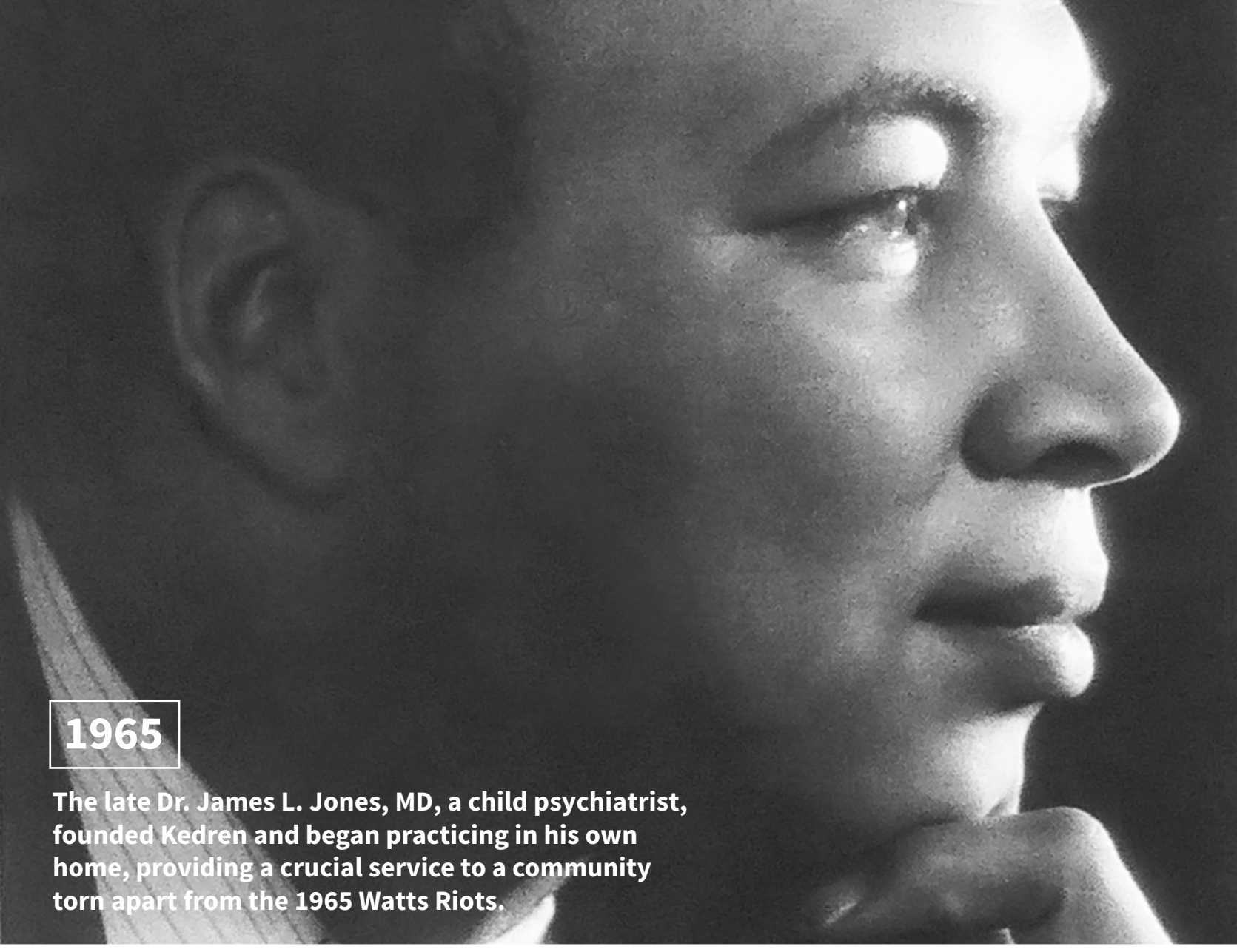
Historical Overview

Kedren Community Health Center, Inc. dba Kedren Community Mental Health Center and Kedren Head Start Preschool Program was founded October 22, 1965 by the late Dr. James L. Jones, MD, a child psychiatrist. It was founded after the Los Angeles Watts uprising in response to economic disenfranchisement, education deprivation, and minimal or no access to healthcare. After the Watts uprising in 1965, a group of 22 black male psychiatrists came together at the home of Dr. James L. Jones to discuss the problems that ignited the uprising. They determined that in order to understand the underlying reasons, they needed to reach out to the community and talk to its residents. Residents illustrated some issues that they believed caused the uprising from police brutality to absentee landlords and poverty. Some residents said that their schools were inadequate; others talked about gang violence, drugs and alcoholism, high teen pregnancy rates and absentee fathers. The doctors realized that there were pervasive community problems that needed to be addressed. After much discussion, the doctors decided that they would begin to make a difference with the youngest children, those who had been least affected by the negative influences of the community, and if successful, they would begin delivering mental health services.

This marked the beginning of Kedren Community Heath Center, Inc., in 1965. Dr. Jones and his colleagues proposed educational programs that would also serve families. They were laying the groundwork for the Head Start program to be implemented in Los Angeles. Head Start was concurrently being proposed and put into place by the former late President Lyndon Johnson in Washington DC as part of his “War on Poverty” legislation.

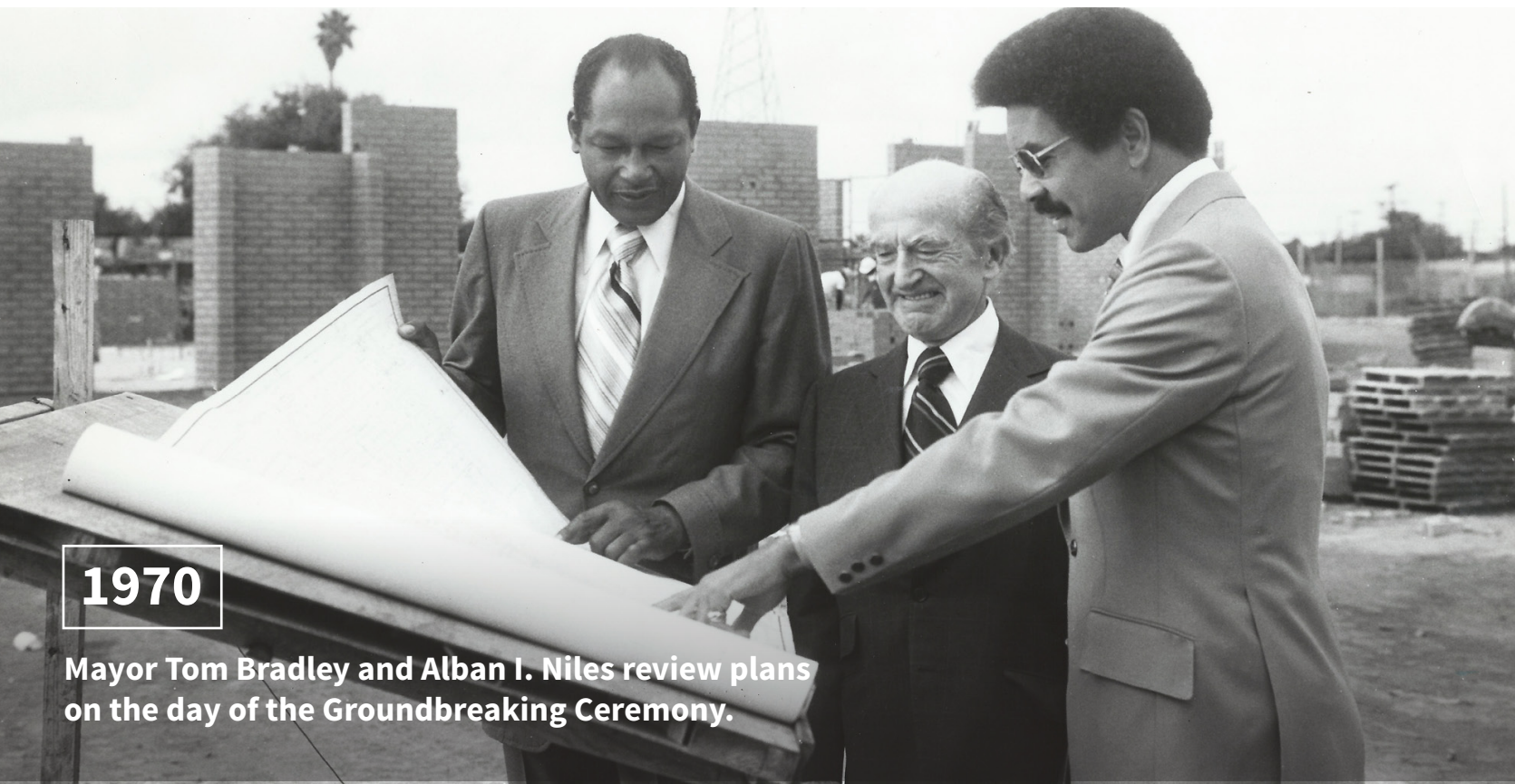
After receiving federal funds from the Department of Health and Human Services in 1965, Dr. Jones and his wife developed 10 Head Start sites within the South Central Community.

Dr. James L. Jones and his staff of 24 opened the outpatient clinic on Valentine’s Day in 1965. After the first week, 40 members of the community received services and within three months, up to 250 families were served. Dr. Jones believed that Kedren had to change the perception of mental health and “bridge the gap of resistance from a nut house to the concept of a mental health center.” Kedren is named after Dr. Jones’ second daughter Mrs. Kedren Jones-Zadikov. The organization today is a dream fulfilled for late Dr. Jones and Mrs. Shirley Jones, his wife and co-founder of Kedren. The original thrust was toward community-based psychiatric services for the residents of the inner city. This, in Dr. Jones’ opinion would minimize the difficulty and inconvenience in getting mental health and early childhood development services; alleviate some of the anxiety and subsequent illness caused by racial oppression and strife; and would generally improve the quality of life for the residents of South Central and Southeast Los Angeles.



1965

The late Dr. James L. Jones, MD, a child psychiatrist, founded Kedren and began practicing in his own home, providing a crucial service to a community torn apart from the 1965 Watts Riots.



1970

Mayor Tom Bradley and Alban I. Niles review plans on the day of the Groundbreaking Ceremony.

1977

Mayor Tom Bradley cuts the ribbon on the much-anticipated Kedren Community Mental Health Center located on 710 E. 111th Pl., Los Angeles

1977

Assemblywoman Maxine Waters enters the new Kedren Community Mental Health Center on Opening Day.

1977

Pictured from Left to Right:
Alban I. Niles, Kedren Jones-Zadikov, Shirley Jones,
Maxine Waters, James Woods. Opening Day Ceremony.

1977

Alban I. Niles and Supervisor, Kenny Hahn
who was instrumental in securing funds for Kedren.

At the time of the death of Dr. Jones, Kedren was operating in the building at 7760 South Central Avenue under the leadership of Executive Director Alban I. Niles. However, prior to Dr. Jones' death they were able to complete the preliminary plans for the construction of the beautifully designed contemporary building at 710 East 111th Place. Now commonly known as Kedren South, the building on 710 East 111th Place, was occupied in September of 1977 and continues to provide care to the community. This new center was therapeutically designed to allow the clientele and the surrounding community to enjoy both comfort and pride in their association with the center.

This move represented a giant step in the history of the agency since the first programs began in a single office. The new facility helped to centrally locate Kedren and allowed it to expand outpatient adult and children's services.

During its Opening Day Ceremony, Mayor Tom Bradley and Assemblywoman Maxine Waters arrived to commend the current success of Kedren and recognize the potential for its future. Kedren would soon face an even greater need for service expansion as the 1980s and 1990s proved to be some of the most challenging times in South Central and Central Los Angeles, as depression rates and drug abuse increased - Kedren was able to fulfill the growing needs for mental health services during this time.

1985

Current Kedren Community Mental Health Facility, located at 4211 South Avalon Blvd. and serves as a central point for administrative, outpatient, inpatient adult and children services as well as the future site for Primary Care.

1980-Present

Gloria Nabrit, became Kedren's CEO and began to shape and expand services during a challenging two decades from 1980-1998. During that time, Kedren reached many milestones.

In 1985, Kedren was awarded a contract by the Los Angeles County Department of Mental Health for mental health services formerly provided by Central City. This included inpatient services for children and adults and the facilities allowed Kedren to expand day treatment services as well as outpatient services in South Los Angeles. Kedren began operation at its current headquarters at 4211 S. Avalon, providing one of the largest outpatient programs in the state of California, serving children, adolescents and adults.

In the late 80s and 90s Kedren became aware of the extremely high recidivism rates. During that time, Kedren was able to increase inpatient funding and began to look at shifting the focus to community based treatment by utilizing an assertive community treatment model, collaborating inpatient and outpatients care through community partnerships, including housing and employment opportunities.

This was the beginning of implementation of the "one-stop" concept that was originally a result of a community needs assessment done by Dr. Jones and his colleagues in 1965. The identified needs were training, employment, childcare, and food services all located in one service center for timely access, without complicated transportation concerns. This concept was further advanced by Medical Director Dr. Frank L. Williams, who began his work alongside Dr. Jones. Dr. Williams was instrumental in the development and implementation of efficient and effective levels of care for the residents of the community. This model continues to grow and is the foundation for Kedren's current service delivery system.

In 2002 Dr. John H. Griffith was appointed CEO and an organization analysis conducted at that time determined that Kedren needed to revamp its structure in order to accommodate for the exceptional growth in the 80s and 90s. Under Dr. Griffith's leadership, Kedren's organizational changes progressively began to strengthen the collaboration between the medical and psychiatric professionals, while at the same time utilizing the expertise of many veteran Kedren employees for outreach and community development. This re-adjustment was crucial to continuing the service while keeping a clear view of the future needs of the organization and the community.

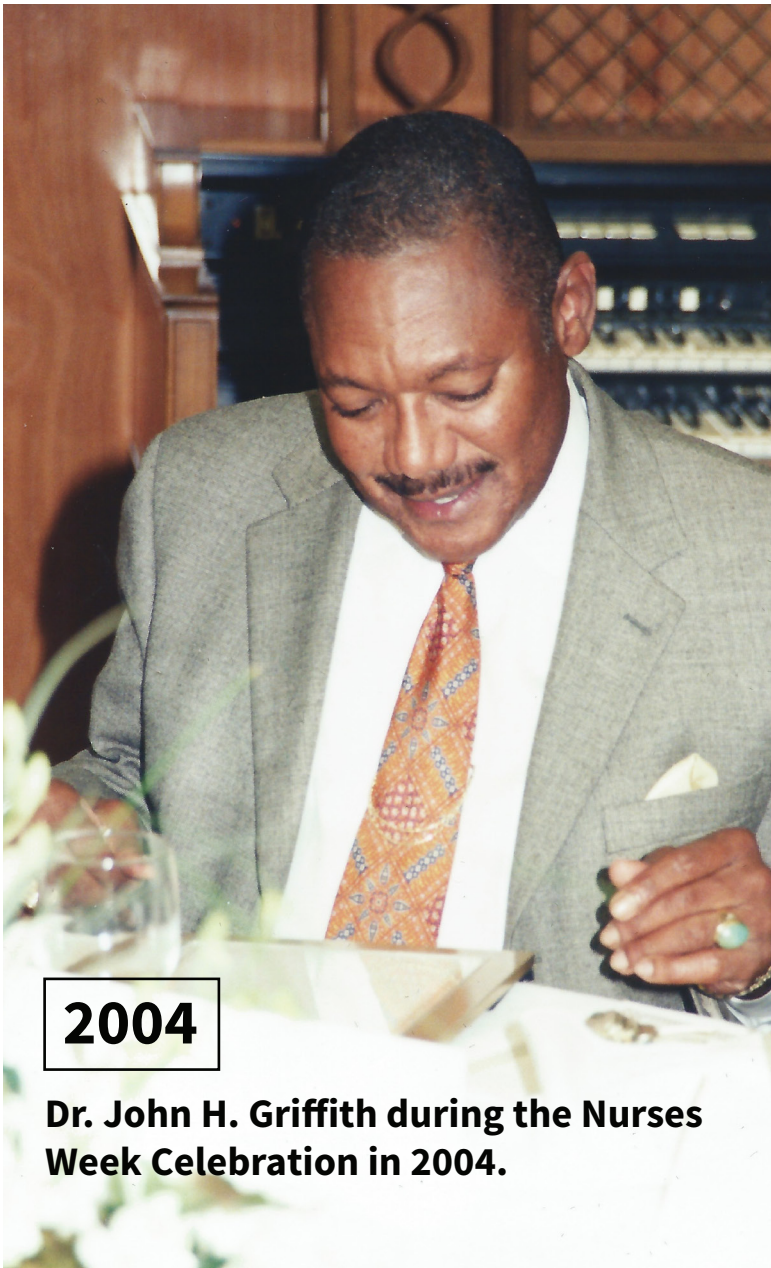
In more recent years, Kedren has almost doubled the amount of inpatient beds for adults, increased the budget for Mental Health and Head Start, as well as creating partnerships for housing clients as part of Kedren's Community Reintegration Program.

Kedren has successfully and systematically operationalized both their mental health services and their Head Start State Preschool Program and Family Service Center. Originally, each of these was federally funded and currently provides both an innovative and excellent array of services for special populations, thereby, demonstrating an exceptional organizational talent for effectiveness and versatility. Each program has also been accomplished under the fine leadership of an extraordinary governance Board and professional staff who commitment enables Kedren to fulfill its mission of providing culturally competent continuum of care services utilizing an efficient and effective collaborative and holistic approach to address the educational, health and mental health needs of residents of Service Area Six, and the surrounding communities.

Kedren has served the community for 48 years without interruption or discontinuation of care. Currently, Kedren serves almost 6,000 people annually.

1986

Gloria Nabrit, in Kedren's office at 4211 South Avalon Blvd.



2004

Dr. John H. Griffith during the Nurses Week Celebration in 2004.

The Future of Care:

The highest priority proposed for the next five years is to enhance overall organizational excellence. Such a priority is timely and important because of the need to anticipate and be proactive about forthcoming changes in healthcare laws and regulations from the Affordable Care Act shifting demographics in the surrounding community and a focus on innovative and integrated models of care for total health and wellness. Along with an organizational excellence priority, special emphasis should be given to promoting and recognizing excellence and leadership in clinical and program delivery, medical and education innovation, and patient satisfaction; as well as improving the quality and effectiveness of holistic wellness programs critical for ensuring a place among the top tier community health centers in the Los Angeles area. These emphases can and should be pursued with a parallel planning and leadership development.

Kedren will provide a full range of primary care services, directly or through referral, that together comprise a comprehensive primary health care system. The range of primary care services to be offered include: immunizations and diagnosis and treatment of acute and chronic illnesses, communicable disease screening and counseling, testing, prevention education, and treatment of chronic conditions, such as hypertension, asthma, and diabetes; outreach and community education services, and health education and prevention services on site and in the community.

While keeping an eye on the future, the legacy of Dr. Jones is never left behind. Our staff acts on these principles daily and believes in the ultimate measure of success to be the patients' satisfaction with our services.

2012

28th St. Apartments. Part of Kedren's innovative partnership with the YMCA to renovate apartments for low-income outpatient adults.

Service Overview

Kedren hospital provides psychiatric inpatient and outpatient services to children, transitional aged youths and adults. The types of services that are provided to our patients include medication therapy, extensive psychiatric evaluation, counseling in private and in group settings, and other best practices in an inpatient and outpatient setting. Our outpatient services also include outreach and transportation; as well as 24-hour availability for crisis response and management.

Kedren Community Care Clinic will provide community access to primary care physicians and pediatricians 5 days a week.

Kedren Head Start provides before and after school care for children who attend any one of the 28 Kedren Head Start Centers.

Kedren Rehabilitation and Wellness Center will provide medication and care management services and counseling for healthy living aimed at reducing obesity, diabetes and diabetes-related diseases, drug abuse and unsafe dietary and lifestyle decisions.

Community Care Clinic
Provide community access to primary care physicians and pediatricians 5 days a week.

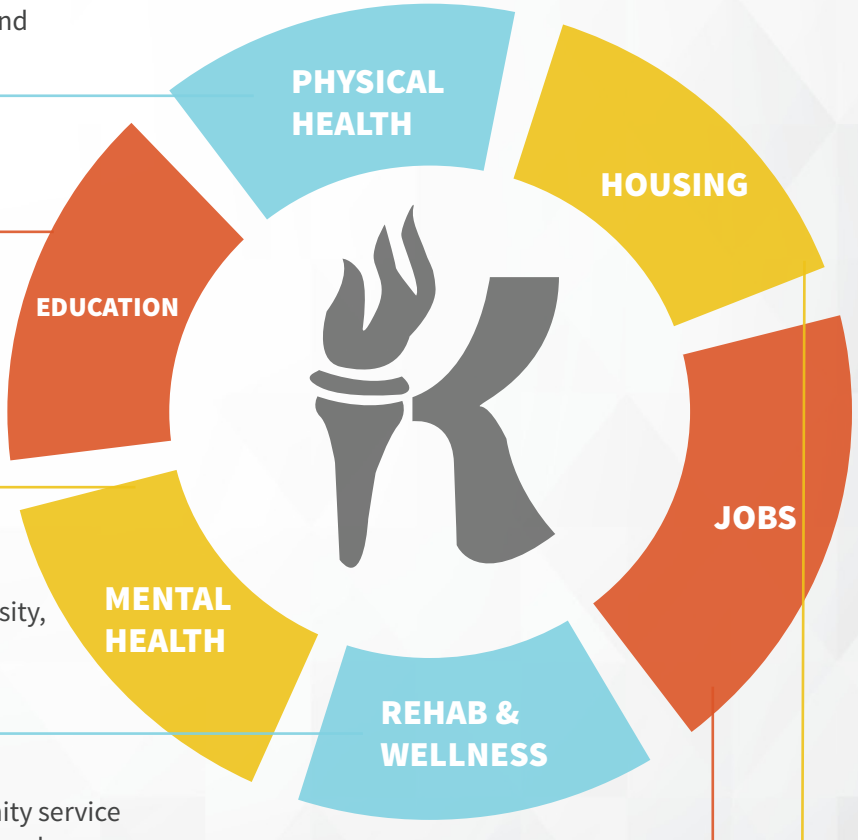
Head Start
28 Head Start Facilities, serving over 2,000 Children.

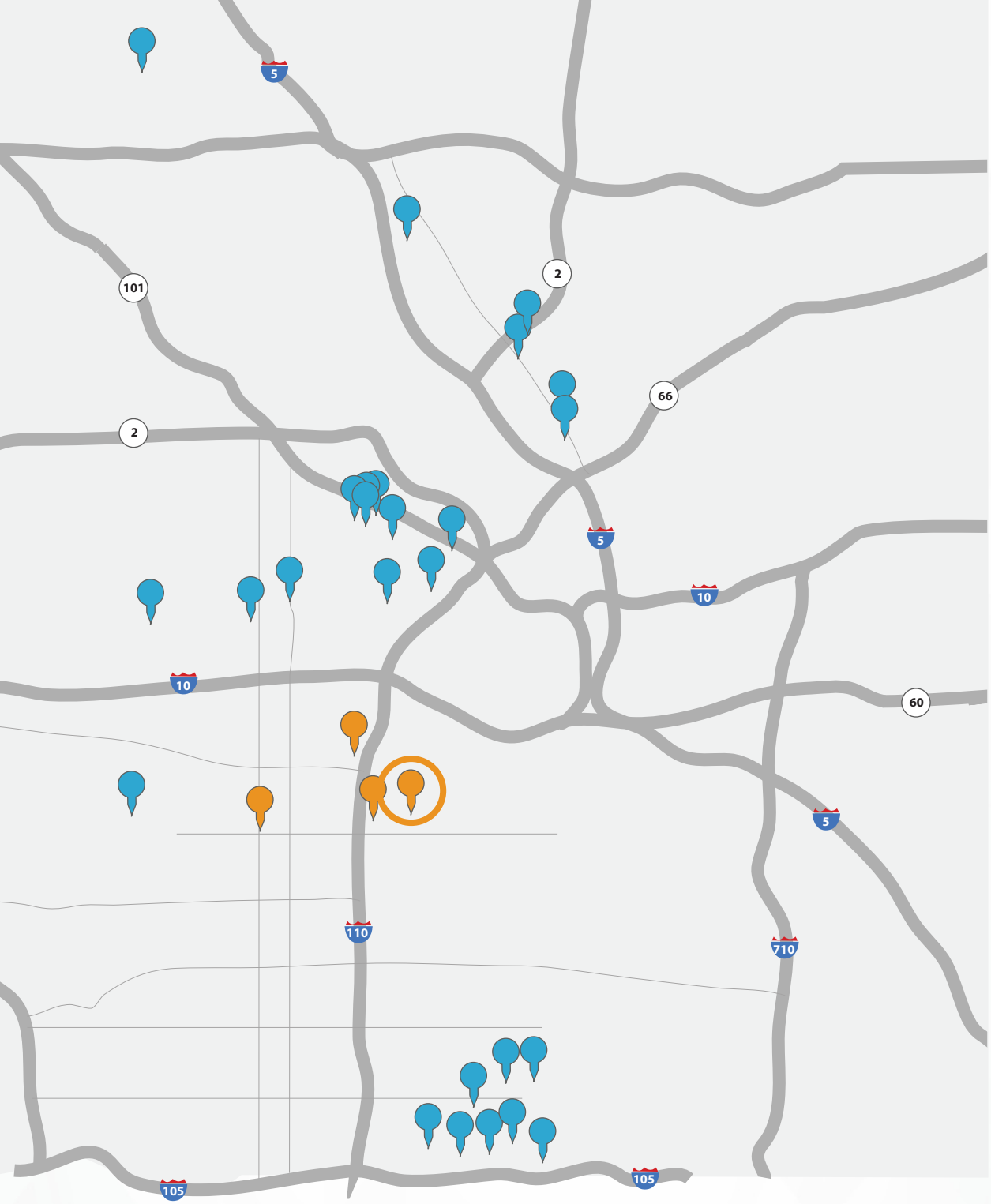
Mental Health
Inpatient and Outpatient Care, Children, Adults, Transitional Aged Youth, Community Outreach, Counseling, AB109 Community Reintegration Program, Kedren Integrated Services Model Program.

Rehabilitation Wellness Center
Provide medication and care management services and counseling for healthy living aimed at reducing obesity, diabetes and diabetes-related diseases, drug abuse and unsafe dietary and lifestyle decisions.

Jobs
Linkages to job sites, outreach to business and community service organizations, religious organizations, large and small employers.

Housing
Linkages to community housing providers of temporary and transitional assistance to permanent housing.





MENTAL HEALTH

Kedren Corporate
4211 South Avalon Boulevard
Los Angeles, CA 90011

Kedren Vernon
231 West Vernon Avenue
Los Angeles, CA 90037

Kedren Western
4322 South Western Avenue
Los Angeles, CA 90062

Kedren Figueroa
3800 South Figueroa Blvd.
Los Angeles, CA 90037

HEAD START

Head Start/State Preschool Administrative Program
710 East 111 Place
Los Angeles, CA 90059

Kedren Angelina
1336 W. Angelina Street
Los Angeles, CA. 90026

Kedren Baldwin Hills
3740 Don Felipe Drive
Los Angeles, CA. 90008

Kedren Beacon
731 Beacon Avenue
Los Angeles, CA 90017

Kedren Cypress I
1145 Cypress Avenue
Los Angeles, CA. 90065

Kedren Cypress II
2415 Avenue 30
Los Angeles, CA. 90065

Kedren Cypress III
3315 Verdugo Road
Los Angeles, CA. 90065

Kedren Imperial Courts
11513 Gorman Avenue
Los Angeles, CA. 90059

Kedren Imperial Courts II
11425 S. Gorman Ave
Los Angeles, CA 90059

Kedren Jordan Downs
9910 Grape St.
Los Angeles, CA 90002

Kedren Manhattan
1200 S. Manhattan Place
Los Angeles, CA. 90019

Kedren Magnolia
2828 W. Magnolia Blvd.
Burbank, CA. 91505

Kedren Mariposa
961 S. Mariposa
Los Angeles, CA. 90006

Kedren Maryland
1317 Maryland Street
Los Angeles, CA. 90017

Kedren Nickerson Gardens
11263 S. Compton Ave.
Los Angeles, CA 90059

Kedren Perlita
4118 Chevy Chase Drive
Los Angeles, CA 90039

Kedren Pico
4605 W. Pico Blvd.
Los Angeles, CA. 90019

Kedren Pleasant Hills
2737 Hyans Street
Los Angeles, CA 90026

Kedren St. Anne's
155 North Occidental Blvd
Los Angeles, C.A. 90026

Kedren Westlake I
3031 Beverly Blvd.,
Los Angeles, CA. 90057

Kedren Westlake II
1505 Beverly Blvd.,
Los Angeles, CA. 90057

Kedren Westlake III
2233 Beverly Blvd.,
Los Angeles, CA

Kedren Watts VI
1812 E. 110th Street,
Los Angeles, CA. 90059

Kedren Watts I
1341 East 104th Street,
Los Angeles, CA. 90002

Kedren Watts III
9622 Beach Street,
Los Angeles, CA

Kedren Watts IV
11230 S. Central Ave.,
Los Angeles, CA.

Kedren Watts V
710 E. 111th Place,
Los Angeles, CA. 90059

COVID-19 Testing. Click here to make an appointment. (323) 499-3619

KedrenHealth

Primary Menu

Donate to Kedren Health to help support our community and COVID Testing and Vaccination operations.

President's Message

It has been an honor and a challenge to support those we serve, helping them to attain their optimal growth and potential.

We are continuously evolving and growing to meet the community's increasingly more complex and diverse needs. We strive for excellence in all our endeavors and believe in every individual's resiliency and potential for recovery and growth.

Our central goal is to provide high-quality services and programs that are individually tailored, accessible, efficient, effective, and culturally competent. We have served the community since 1965, with a caring, competent staff, guided by an exceptional Board of Directors.

During my tenure with the agency, there have been many changes in the landscape of the community, and the myriad of needs to its residents. We provide a continuum of health services, primarily to residents in Service Area 6. As part of our evolutionary process, in 2013, Kedren launched its Primary Care Clinic, a designated Federally Qualified Health Center (FQHC), funded by the Federal Department of Health and Human Services (DHHS) Health Resources Services Administration (HRSA). The clinic provides comprehensive

medical services for adults, which include primary care and treatment, preventative care, immunizations, health education, treatment and management of acute and chronic health conditions like hypertension and diabetes management, prescribing of medications, ordering or interpreting lab testing, physical examinations, STD screenings, vision/hearing, family planning, nutrition, and referrals to specialty services.

We are at the forefront of change and organizational growth, embracing a model of wellness, and enhancing our service delivery system to provide more intensive and comprehensive services and care for those we serve. To that end, we are developing collaborative partnerships with primary care health providers, physicians, pediatricians, dietitians, and other practitioners, to offer educational, wellness and recovery services. Part of Kedren's mission is to provide medical, and behavioral health services to underserved and uninsured persons in South Los Angeles.

In July 2018, Kedren and Charles Drew University embarked upon an academic and community health collaboration with the students enrolled in their Graduate Medical Education program. These students are part of Charles Drew's Residency Program and consistent with Kedren's mission to serve under-served urban communities. Charles Drew residents in conjunction with Kedren's clinical staff focus its services on:

- Patient-centered team-based health care of under-resourced patients
- Trauma-informed assessment and care
- Community violence as a public-health problem
- Social and environmental determinants of health, illness, and health disparities
- Health needs and resources of immigrant communities
- Community engaged health equity research
- Democratization of health care for special needs populations
- Medical-Community Medical Care clinic partnerships
- Healthcare of families, youth, and adults

Charles R. Drew University has been awarded Accreditation with Commendation by the Accreditation Council for Continuing Medical Education (ACCME®) for demonstrating

excellence across each of the ACCME's Accreditation Criteria. The Charles R. Drew University Office of CME provides excellent continuing medical education that will enhance the ability of faculty physicians and community physicians to provide patient care. The overarching goal of the academic affiliation between Kedren Community Health and Charles R. Drew University is to improve patient care within underserved populations and reduce healthcare disparities.

Kedren's programs deliver services to underserved populations, in which they may not be served due to language, cultural or geographical barriers. Our services are guided by the tenant to "*do whatever it takes*" to help people recover from mental illness, enhance outcomes for children and families, and to identify potential problems early, to avert them from negatively impacting the lives of residents of the community.

This is why we are integrating programs that focus on early intervention and prevention, serving children from birth to older adults, with a strengths-based, family-focused model to enrich the lives of those we serve, planting the seeds of physical, social, emotional and cognitive growth, and overall wellness.

–Dr. John. H. Griffith

1.323.233.0425

information@kedren.org

4211 South Avalon Blvd.
Los Angeles, CA 90011

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Kedren Becomes a Major Staging Ground in COVID-19 Vaccine Inoculation

Dr. Jerry Abraham, the epidemiologist who leads Kedren Health's COVID-19 vaccination task force is perpetually busy. He's a roving, peripatetic man in motion. He makes sure that vaccination dosages are administered steadily throughout the various on-campus sites. He gives daily progress updates to staff and administrators. Intermittently, he reviews the daily count of available dosages of the Moderna vaccine. He periodically texts news media contacts. He constantly confers with his staff, inoculates patients himself, and strategizes with Kedren's senior medical team.

Sites such as Dodger Stadium and the Inglewood Forum, with many acres of real estate that serve as staging areas for vaccinations, dwarf the number of people that Kedren can daily serve. As the Kedren site has taken shape, by now having inoculated over 12,000 people since the facility was enrolled as a provider last December 24th, Kedren Health's primary mission of ministering to the local community's most vulnerable residents and workers has had an unquestionably vital community impact. On this day, the site began shutting down late afternoon with over 1,000 people vaccinated that day to preserve precious inventory.

Dr. Abraham bristled at the news media accounts that painted the group of "vaccine chasers" as a primary audience that the facility seeks to serve. "The story is not about rich white people. We vaccinate elderly African Americans and Latinos who live in our community. We vaccinate Koreans and Vietnamese. We want to get as much vaccine into as many arms as possible," he noted.

As he was speaking, a large number of elderly Korean Americans were a highly visible presence, lined up to receive their vaccine shot. Most had heard about the site from their church pastors who had arranged transportation to the site.

Kedren's clinical operations lead Sonny Tran described the infrastructure of the Kedren-built vaccination site. "We erected full-on critical care tents to protect our staff and clients. Our priority is serving seniors, particularly those with barriers to effective healthcare. We are also inoculating all tiers of medical workers and frontline people who serve our community."

All of the COVID-19 response leadership interviewed point to how effectively the institution pivoted to improving patient care in the face of the pandemic. The facility continues to test 400 people daily.

The strategy is based on flexibility. Dr. Kelly Jones, chief medical officer for primary care noted, "When the pandemic became a major threat last March, Kedren responded aggressively with a telehealth program as a way of remotely communicating with patients and colleagues. We had to change our service delivery logistics. Everything was taken outside and placed in tents. We've been flexible in ways that are safe such as using the whole campus for testing and vaccination."

"Our team's primary goals are to take all of our extra doses and put them in seniors' arms," notes Tran. "Kedren has the resources to work with this population." As Tran spoke, Dr. Abraham was on the phone with an AmeriCorps program representative seeking to send volunteers to Kedren for several months as additional program support.

The evolution of Kedren's participation as a frontline participant in the anti-COVID-19 fight was quite circuitous. As Dr. Abraham noted, "Like CDU, Kedren is an LA County and City health partner. By the week before Christmas, we were worried that the small psychiatric hospitals had been overlooked. Meanwhile, you had patients and frontline workers who were coming down with COVID. We had to stop patient admissions."

Dr. Abraham noted that the team became very persistent as they asked around how to participate in the relief effort. “Suddenly we were on the vaccine supply lists. Our first inoculations occurred on December 30th.” In the first days, his team vaccinated 300 people including the entire facility staff.

Emboldened and energized, Dr. Abraham and his staff started driving to County warehouses for vaccine supplies. The first delivery had 100 doses. With continued contact and demonstrating their reliability, the Kedren project snowballed. The County started shipping 600 doses at a time directly to the site. “Every day we faced a set of different challenges that we were committed to figuring out. We were encouraged and optimistic,” he said.

With no precedents or blueprint, the team adopted a “win or keep at it until we solve it” mentality. They became a pillar of support for the local Black and Brown community in South Los Angeles. Local physicians brought their whole staff to Kedren for a vaccination.

Dr. Abraham’s support team is almost exclusively CDU-related. Dr. Mohayed Mohayed is a Psychiatry resident in rotation. Of Dr. Mohayed, Dr. Abraham notes, “He has drawn almost 11,000 vaccine doses and has saved the lives of so many people.”

Kelly Delgardo, a University undergrad who grew up in the local community, noted that four of her relatives have died of COVID-19. Robert Gilbertson is a CDU Biomedical science undergrad. Natalia Peñaloza is a third-year medical student, and Jeff Warukira is a Post-Bacc student. “The participation of the CDU team is really important. We really couldn’t have done this work without them,” noted Tran.

Dr. Abraham summed up the progress made in the Kedren vaccine program in saying, “This work is analogous to the parting of the Red Sea. The team is like Moses leading his people across, one vaccination at a time. Or Noah’s Ark. We want people to get on board. Get in line, get a vaccine shot at Kedren.

“This is a tale of two Los Angeleses. First there is the incidence of Black and Brown seniors dying all across the city. A very grim picture. Then there is the prospect of ensuring that everyone gets a life-saving dose of the vaccine. The flood is coming, get in line, get on board.”

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Center / Health Center Profile

Do you self-identify as an NMHC? No

Title	Name	Phone	Fax	Email
UDS Contact	John H Griffith	(323) 233-0425 Ext. 149	(323) 233-5015	johngriffith0425@gmail.com
Project Director	Yolanda Whittington	(323) 233-0425 Ext. 1700	Not Available	y_whittington@kedren.org
CEO	John H Griffith	(323) 233-0425 Ext. 149	(323) 233-5015	johngriffith0425@gmail.com
Chairperson	Not Available	Not Available	Not Available	Not Available
Clinical Director	Not Available	Not Available	Not Available	Not Available

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Patients by ZIP Code

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
90001	26	122	12	0	160
90002	12	115	18	2	147
90003	42	265	54	6	367
90004	3	13	0	0	16
90005	2	8	1	0	11
90006	4	17	4	0	25
90007	30	293	17	1	341
90008	3	63	6	0	72
90011	247	766	86	12	1111
90013	2	49	3	0	54
90014	1	11	3	0	15
90015	2	10	0	0	12
90016	3	37	9	0	49
90017	2	10	0	0	12
90018	16	75	7	0	98
90019	2	20	4	0	26
90026	1	16	0	0	17
90037	44	251	36	4	335
90043	7	85	12	1	105
90044	24	234	40	2	300
90047	11	86	15	1	113
90057	3	16	2	0	21
90058	2	15	1	0	18
90059	10	74	8	1	93
90061	5	92	9	0	106
90062	11	83	14	1	109
90201	0	21	1	0	22
90220	1	27	1	2	31
90221	3	17	1	0	21
90222	3	21	2	0	26
90247	2	11	0	0	13
90250	4	19	0	1	24
90255	11	31	4	1	47
90262	6	11	2	0	19
90280	4	28	2	0	34
90301	1	13	2	0	16
90302	3	19	1	0	23
90303	2	10	0	0	12
90305	0	12	1	0	13
90805	5	11	0	1	17
Other ZIP Codes	44	260	51	5	360
Unknown Residence	1	0	0	0	1
Total	605	3337	429	41	4412

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Table 3A: Patients By Age And By Sex Assigned At Birth - Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	5	9
2.	Age 1	5	6
3.	Age 2	7	3
4.	Age 3	7	5
5.	Age 4	7	7
6.	Age 5	8	10
7.	Age 6	6	8
8.	Age 7	11	10
9.	Age 8	13	4
10.	Age 9	11	8
11.	Age 10	8	10
12.	Age 11	12	10
13.	Age 12	10	10
14.	Age 13	5	4
15.	Age 14	12	8
16.	Age 15	11	16
17.	Age 16	9	10
18.	Age 17	24	19
Subtotal Patients (Sum lines 1-18)		**171**	**157**
19.	Age 18	39	37
20.	Age 19	43	41
21.	Age 20	38	43
22.	Age 21	44	37
23.	Age 22	53	46
24.	Age 23	61	52
25.	Age 24	69	47
26.	Ages 25-29	229	249
27.	Ages 30-34	236	221
28.	Ages 35-39	234	221
29.	Ages 40-44	204	169
30.	Ages 45-49	197	190
31.	Ages 50-54	254	203
32.	Ages 55-59	238	199
33.	Ages 60-64	132	94
Subtotal Patients (Sum lines 19-33)		**2,071**	**1,849**

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Table 3A: Patients By Age And By Sex Assigned At Birth - Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
34.	Ages 65-69	56	51
35.	Ages 70-74	15	13
36.	Ages 75-79	9	12
37.	Ages 80-84	4	1
38.	Age 85 and over	0	3
Subtotal Patients (Sum lines 34-38)		**84**	**80**
39.	**Total Patients (Sum lines 1-38)**	**2,326**	**2,086**

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Table 3B - Demographic Characteristics - Universal

S.No	Patients by Race	Demographic Characteristics			
		Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d)
1.	Asian	0	28		28
2a.	Native Hawaiian	0	11		11
2b.	Other Pacific Islander	0	6		6
2.	**Total Hawaiian/Other Pacific Islander (Sum lines 2a+2b)**	**0**	**17**		**17**
3.	Black/African American	14	1,956		1,970
4.	American Indian/Alaska native	1	13		14
5.	White	4	177		181
6.	More than one race	32	42		74
7.	Unreported/Refused to report race	1,807	208	113	2,128
8.	**Total Patients (Sum lines 1+2+3 through 7)**	**1,858**	**2,441**	**113**	**4,412**

S.No	Patients by Language	Number (a)
12.	Patients Best Served in a Language other than English	780

S.No	Patients by Sexual Orientation	Number (a)
13.	Lesbian or Gay	61
14.	Straight (not lesbian or gay)	2,917
15.	Bisexual	46
16.	Something else	12
17.	Don’t know	703
18.	Chose not to disclose	673
19.	**Total Patients (Sum Lines 13 to 18)**	**4,412**

S.No	Patients by Gender Identity	Number (a)
20.	Male	1,910
21.	Female	1,788
22.	Transgender Male/ Female-to-Male	5
23.	Transgender Female/ Male-to-Female	11
24.	Other	37
25.	Chose not to disclose	661
26.	**Total Patients (Sum Lines 20 to 25)**	**4,412**

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Table 4 - Selected Patient Characteristics - Universal

S.No	Characteristic	Number of Patients (a)
Income as Percent of Poverty Guideline		
1.	100% and below	3,316
2.	101 - 150%	265
3.	151 - 200%	53
4.	Over 200%	15
5.	Unknown	763
6.	**Total (Sum lines 1-5)**	**4,412**

Principal Third Party Medical Insurance Source		0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	12	593
8a.	Regular Medicaid (Title XIX)	308	3,029
8b.	CHIP Medicaid	0	0
8.	**Total Medicaid (Sum lines 8a+8b)**	**308**	**3,029**
9a.	Dually eligible (Medicare and Medicaid)	1	289
9.	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)	6	423
10a.	Other Public Insurance Non-CHIP (Specify: -)	0	0
10b.	Other Public Insurance CHIP	0	0
10.	**Total Public Insurance (Sum lines 10a+10b)**	**0**	**0**
11.	Private Insurance	2	39
12.	**Total (Sum lines 7+8+9+10+11)**	**328**	**4,084**

Managed Care Utilization

S.No	Payer Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member months	20,073	401	0	0	20,474
13b.	Fee-for-service Member months	-	-	0	0	-
13c.	**Total Member Months (Sum lines 13a+13b)**	**20,073**	**401**	**0**	**0**	**20,474**

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Table 4 - Selected Patient Characteristics - Universal

S.No	Special Populations	Number of Patients (a)
14.	Migratory (330g grantees only)	
15.	Seasonal (330g grantees only)	
16.	**Total Agricultural Workers or Dependents (All Health Centers Report This Line)**	**4**
17.	Homeless Shelter (330h grantees only)	
18.	Transitional (330h grantees only)	
19.	Doubling Up (330h grantees only)	
20.	Street (330h grantees only)	
21.	Other (330h grantees only)	
22.	Unknown (330h grantees only)	
23.	**Total Homeless (All Health Centers Report This Line)**	**344**
24.	**Total School Based Health Center Patients (All Health Centers Report This Line)**	**0**
25.	**Total Veterans (All Health Centers Report This Line)**	**1**
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (All Health Centers Report This Line)**	**0**

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Table 5 - Staffing And Utilization - Universal

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Medical Care Services				
1.	Family Physicians	1.18	4,764	
2.	General Practitioners	-	-	
3.	Internists	0.20	1,357	
4.	Obstetrician/Gynecologists	-	-	
5.	Pediatricians	-	-	
7.	Other Specialty Physicians	-	-	
8.	**Total Physicians (Sum lines 1-7)**	**1.38**	**6,121**	
9a.	Nurse Practitioners	1.79	7,183	
9b.	Physician Assistants	-	-	
10.	Certified Nurse Midwives	-	-	
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**	**1.79**	**7,183**	
11.	Nurses	-	-	
12.	Other Medical Personnel	4.65		
13.	Laboratory Personnel	1.00		
14.	X-Ray Personnel	-		
15.	**Total Medical (Sum lines 8+10a through 14)**	**8.82**	**13,304**	**4,412**
Dental Services				
16.	Dentists	-	-	
17.	Dental Hygienists	-	-	
17a.	Dental Therapists	-	-	
18.	Other Dental Personnel	-		
19.	**Total Dental Services (Sum lines 16-18)**			**0**
Mental Health Services				
20a.	Psychiatrists	-	-	
20a1.	Licensed Clinical Psychologists	-	-	
20a2.	Licensed Clinical Social Workers	-	-	
20b.	Other Licensed Mental Health Providers	-	-	
20c.	Other Mental Health Staff	-	-	
20.	**Total Mental Health (Sum lines 20a-20c)**			**0**

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Table 5 - Staffing And Utilization - Universal

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Substance Abuse Services				
21.	Substance Abuse Services	-	-	0
Other Professional Services				
22.	Other Professional Services (Specify: Dietitian)	0.25	267	40
Vision Services				
22a.	Ophthalmologists	-	-	
22b.	Optometrists	-	-	
22c.	Other Vision Care Staff	-		
22d.	**Total Vision Services (Sum lines 22a-22c)**			**0**
Pharmacy Personnel				
23.	Pharmacy Personnel	-		
Enabling Services				
24.	Case Managers	-	-	
25.	Patient/Community Education Specialists	-	-	
26.	Outreach Workers	0.08		
27.	Transportation Staff	-		
27a.	Eligibility Assistance Workers	0.88		
27b.	Interpretation Staff	-		
27c.	Community Health Workers	-		
28.	Other Enabling Services (Specify: -)	-		
29.	**Total Enabling Services (Sum lines 24-28)**	**0.96**		**0**

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Table 5 - Staffing And Utilization - Universal

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Other Programs/Services				
29a.	Other Programs and services (Specify: -)	-		
29b.	Quality Improvement Staff	-		
Administration and Facility				
30a.	Management and Support Staff	1.72		
30b.	Fiscal and Billing Staff	1.00		
30c.	IT Staff	-		
31.	Facility Staff	-		
32.	Patient Support Staff	3.73		
33.	**Total Facility and Non-Clinical Support Staff (Lines 30a - 32)**	**6.45**		
Grand Total				
34.	**Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)**	**16.48**	**13,571**	

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Table 5A - Tenure for Health Center Staff

S.No	Health Center Staff	Full and Part Time		Locum, On-Call, etc	
		Persons (a)	Total Months (b)	Persons (c)	Total Months (d)
1.	Family Physicians	2	128	-	-
2.	General Practitioners	-	-	-	-
3.	Internists	1	478	-	-
4.	Obstetrician/Gynecologists	-	-	-	-
5.	Pediatricians	-	-	-	-
7.	Other Specialty Physicians	-	-	-	-
9a.	Nurse Practitioners	4	83	-	-
9b.	Physician Assistants	-	-	-	-
10.	Certified Nurse Midwives	-	-	-	-
11.	Nurses	-	-	-	-
16.	Dentists	-	-	-	-
17.	Dental Hygienists	-	-	-	-
17a.	Dental Therapists	-	-	-	-
20a.	Psychiatrists	-	-	-	-
20a1.	Licensed Clinical Psychologists	-	-	-	-
20a2.	Licensed Clinical Social Workers	-	-	-	-
20b.	Other Licensed Mental Health Providers	-	-	-	-
22a.	Ophthalmologist	-	-	-	-
22b.	Optometrist	-	-	-	-
30a1.	Chief Executive Officer	1	444	-	-
30a2.	Chief Medical Officer	-	-	-	-
30a3.	Chief Financial Officer	1	48	-	-
30a4.	Chief Information Officer	-	-	-	-

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21	52	19
3.	Tuberculosis	A15- through A19-	564	502
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0), M02.3-	146	102
4a.	Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51	9	6
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	312	111
Selected Diseases of the Respiratory System				
5.	Asthma	J45-	344	192
6.	Chronic obstructive pulmonary diseases	J40- through J44-, J47-	92	54
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, N63-, R92-	60	39
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820	70	48
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	2,504	1,207
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	112	43
11.	Hypertension	I10- through I16-	2,700	864
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)	103	75
13.	Dehydration	E86-	85	83
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-	2	2

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51. Z68.52)	9,185	3,013
Selected Childhood Conditions (limited to ages 0 through 17)				
15.	Otitis media and Eustachian tube disorders	H65- through H69-	13	9
16.	Selected perinatal medical conditions	A33-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	2	2
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only.Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3	1	1
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	F10-, G62.1	38	33
19.	Other substance related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	264	253
19a.	Tobacco use disorder	F17-	4,053	1,522
20a.	Depression and other mood disorders	F30- through F39-	1,689	1,589
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	248	213
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-	18	17
20d.	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F59- (exclude F55-), F60- through F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	857	794

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV test	CPT-4: 86689; 86701 through 86703; 87389 through 87391	1,796	1,391
21a.	Hepatitis B test	CPT-4: 86704, 86706, 87515 through 87517	178	137
21b.	Hepatitis C test	CPT-4: 86803, 86804, 87520 through 87522	178	137
22.	Mammogram	CPT-4: 77052, 77057, 77065, 77066, 77067 OR ICD-10: Z12.31	0	0
23.	Pap test	CPT-4: 88141 through 88155, 88164 through 88167, 88174, 88175 OR ICD-10: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	368	348
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	CPT - 4: 90633, 90634, 90645 through 90648, 90670, 90696 through 90702, 90704 through 90716, 90718 through 90723, 90743, 90744, 90748	698	579
24a.	Seasonal Flu vaccine	CPT-4: 90654 through 90662, 90672, 90673, 90685 through 90688	196	193

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
25.	Contraceptive management	ICD-10: Z30-	92	78
26.	Health supervision of infant or child (ages 0 through 11)	CPT-4: 99381 through 99383, 99391 through 99393	86	62
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	2	2
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408, 99409 HCPCS: G0396, G0397, H0050	-	-
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406, 99407 OR HCPCS: S9075 OR CPT-II: 4000F, 4001F	1,528	1,029
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	-	-

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
27.	I. Emergency Services	ADA: D9110	-	-
28.	II. Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180	-	-
29.	Prophylaxis - adult or child	ADA: D1110, D1120	-	-
30.	Sealants	ADA: D1351	-	-
31.	Fluoride treatment - adult or child	ADA: D1206, D1208	-	-
32.	III. Restorative Services	ADA: D21xx through D29xx	-	-
33.	IV. Oral Surgery (extractions and other surgical procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290 through D7294	-	-
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	-	-

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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Table 6B - Quality Of Care Measures

Prenatal Care Provided by Referral Only (Check if Yes): **Yes**

Section A - Age Categories for Prenatal Care Patients:

	Demographic Characteristics of Prenatal Care Patients	
S.No	**Age**	**Number of Patients (a)**
1.	Less than 15 years	0
2.	Ages 15-19	0
3.	Ages 20-24	1
4.	Ages 25-44	5
5.	Ages 45 and over	20
6.	**Total Patients (Sum lines 1-5)**	**26**

Section B - Early Entry into Prenatal Care

S.No	**Early Entry into Prenatal Care**	**Women Having First Visit with Health Center (a)**	**Women Having First Visit with Another Provider (b)**
7.	First Trimester	14	-
8.	Second Trimester	2	-
9.	Third Trimester	10	-

Section C - Childhood Immunization Status (CIS)

S.No	**Childhood Immunization Status (CIS)**	**Total Patients with 2nd Birthday (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients Immunized (c)**
10.	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	11	11	5

Section D - Cervical Cancer Screening

S.No	**Cervical Cancer Screening**	**Total Female Patients Aged 23 through 64 (a)**	**Number Charts Sampled or EHR Total (b)**	**Number of Patients Tested (c)**
11.	MEASURE: Percentage of women 23-64 years of age, who were screened for cervical cancer	1,608	1,608	626

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Table 6B - Quality Of Care Measures

Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

S.No	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12.	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile, and counseling on nutrition and physical activity documented	258	258	254

Section F - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

S.No	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13.	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	4,033	4,033	3,900

Section G - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

S.No	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User (c)
14a.	MEASURE: Percentage of patients 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months and if identified to be a tobacco user (2) received cessation counseling intervention	2,426	2,426	2,372

Section H - Use of Appropriate Medications for Asthma

S.No	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16.	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	63	63	53

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Table 6B - Quality Of Care Measures

Section I - Coronary Artery Disease (CAD): Lipid Therapy

S.No	Coronary Artery Disease (CAD): Lipid Therapy	Total Patients Aged 18 and Older with CAD Diagnosis (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed A Lipid Lowering Therapy (c)
17.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of CAD who were prescribed a lipid lowering therapy	33	33	18

Section J - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

S.No	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	24	24	19

Section K - Colorectal Cancer Screening

S.No	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19.	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	1,224	1,224	325

Section L - HIV Linkage to Care

S.No	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20.	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis	1	1	1

Section M - Preventive Care and Screening: Screening for Depression and Follow-Up Plan

S.No	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21.	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented	3,511	3,511	3,294

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Table 6B - Quality Of Care Measures

Section N - Dental Sealants for Children between 6-9 Years

S.No	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22.	MEASURE: Percentage of children 6 through 9 years of age, at moderate to high risk of caries who received a sealant on a first permanent molar	0	0	0

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Table 7 - Health Outcomes and Disparities

S.No	Prenatal Services	Total (i)
0	HIV Positive Pregnant Women	0
2	Deliveries Performed by Health Center's Provider	0

Section A: Deliveries and Birth Weight

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births : 1500 - 2499 grams (1c)	Live Births : > = 2500 grams (1d)
Hispanic/Latino					
1a.	Asian	0	0	0	0
1b1.	Native Hawaiian	0	0	0	0
1b2.	Other Pacific Islander	0	0	0	0
1c.	Black/African American	0	0	0	0
1d.	American Indian/Alaska Native	0	0	0	0
1e.	White	2	0	0	2
1f.	More Than One Race	0	0	0	0
1g.	Unreported/Refused to Report Race	0	0	0	0
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**2**	**0**	**0**	**2**
Non-Hispanic/Latino					
2a.	Asian	0	0	0	0
2b1.	Native Hawaiian	0	0	0	0
2b2.	Other Pacific Islander	0	0	0	0
2c.	Black/African American	1	0	0	1
2d.	American Indian/Alaska Native	0	0	0	0
2e.	White	0	0	0	0
2f.	More Than One Race	0	0	0	0
2g.	Unreported/Refused to Report Race	0	0	0	0
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**1**	**0**	**0**	**1**
Unreported/Refused to Report Ethnicity					
h.	Unreported /Refused to Report Race and Ethnicity	0	0	0	0
i.	**Total (Sum lines 1a-h)**	**3**	**0**	**0**	**3**

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Table 7 - Health Outcomes and Disparities

Section B: Controlling High Blood Pressure

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Hispanic/Latino				
1a.	Asian	5	5	3
1b1.	Native Hawaiian	-	-	-
1b2.	Other Pacific Islander	-	-	-
1c.	Black/African American	-	-	-
1d.	American Indian/Alaska Native	-	-	-
1e.	White	2	2	2
1f.	More Than One Race	3	3	1
1g.	Unreported/Refused to Report Race	218	218	153
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**228**	**228**	**159**
Non-Hispanic/Latino				
2a.	Asian	6	6	4
2b1.	Native Hawaiian	2	2	1
2b2.	Other Pacific Islander	1	1	1
2c.	Black/African American	455	455	257
2d.	American Indian/Alaska Native	1	1	1
2e.	White	22	22	16
2f.	More Than One Race	2	2	1
2g.	Unreported/Refused to Report Race	31	31	15
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**520**	**520**	**296**
Unreported/Refused to Report Ethnicity				
h.	Unreported /Refused to Report Race and Ethnicity	5	5	2
i.	**Total (Sum lines 1a-h)**	**753**	**753**	**457**

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Table 7 - Health Outcomes and Disparities

Section C: Diabetes: Hemoglobin A1c Poor Control

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts sampled or EHR Total (3b)	Patients with Hba1c < 8% (3d1)	Patients with HbA1c >9% Or No Test During Year (3f)
Hispanic/Latino					
1a.	Asian	1	1	1	0
1b1.	Native Hawaiian	1	1	1	0
1b2.	Other Pacific Islander	0	0	0	0
1c.	Black/African American	3	3	1	2
1d.	American Indian/Alaska Native	1	1	1	0
1e.	White	1	1	1	0
1f.	More Than One Race	10	10	3	6
1g.	Unreported/Refused to Report Race	349	349	174	160
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**366**	**366**	**182**	**168**
Non-Hispanic/Latino					
2a.	Asian	4	4	3	1
2b1.	Native Hawaiian	1	1	0	1
2b2.	Other Pacific Islander	1	1	1	0
2c.	Black/African American	427	427	220	196
2d.	American Indian/Alaska Native	1	1	1	0
2e.	White	28	28	11	16
2f.	More Than One Race	6	6	4	2
2g.	Unreported/Refused to Report Race	43	43	17	21
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**511**	**511**	**257**	**237**
Unreported/Refused to Report Ethnicity					
h.	Unreported /Refused to Report Race and Ethnicity	2	2	0	2
i.	**Total (Sum lines 1a-h)**	**879**	**879**	**439**	**407**

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Table 8A - Financial Costs

S.No		Accrued Cost (a) $	Allocation of Facility and Non-Clinical Support Services (b) $	Total Cost after Allocation of Facility and Non-Clinical Support Services (c) $
Financial Costs for Medical Care				
1.	Medical Staff	795,333	638,794	1,434,127
2.	Lab and X-ray	33,061	33,989	67,050
3.	Medical/Other Direct	366,553	409,640	776,193
4.	**Total Medical Care Services (Sum lines 1-3)**	**1,194,947**	**1,082,423**	**2,277,370**
Financial Costs for Other Clinical Services				
5.	Dental	-	-	
6.	Mental Health	-	-	
7.	Substance Abuse	-	-	
8a.	Pharmacy not including pharmaceuticals	-	-	
8b.	Pharmaceuticals	-		
9.	Other Professional (Specify: Nutritionist)	15,660	12,029	27,689
9a.	Vision	-	-	
10.	**Total Other Clinical Services (Sum lines 5-9a)**	**15,660**	**12,029**	**27,689**
Financial Costs of Enabling and Other Services				
11a.	Case Management	-		
11b.	Transportation	-		
11c.	Outreach	2,914		2,914
11d.	Patient and Community Education	-		
11e.	Eligibility Assistance	31,830		31,830
11f.	Interpretation Services	-		
11g.	Other Enabling Services (Specify: -)	-		
11h.	Community Health Workers	-		
11.	**Total Enabling Services Cost (Sum lines 11a-11h)**	**34,744**	**26,688**	**61,432**
12.	Other Related Services (Specify: -)	-	-	
12a.	Quality Improvement	-	-	
13.	**Total Enabling and Other Services (Sum Lines 11, 12, and 12a)**	**34,744**	**26,688**	**61,432**

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Table 8A - Financial Costs

S.No		Accrued Cost (a) $	Allocation of Facility and Non-Clinical Support Services (b) $	Total Cost after Allocation of Facility and Non-Clinical Support Services (c) $
Facility and Non-Clinical Support Services and Totals				
14.	Facility	164,558		
15.	Non-Clinical Support Services	956,582		
16.	**Total Facility and Non-Clinical Support Services (Sum lines 14 and 15)**	**1,121,140**		
17.	**Total Accrued Costs (Sum lines 4+10+13+16)**	**2,366,491**		**2,366,491**
18.	Value of Donated Facilities, Services and Supplies (Specify: -)			-
19.	**Total with Donations (Sum lines 17-18)**			**2,366,491**

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Table 9D: Patient Related Revenue (Scope of Project Only)

S.No	Payer Category	Full Charges this Period (a) $	Amount Collected this Period (b) $	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d) $	Sliding Discounts (e) $	Bad Debt Write Off (f) $
				Collection of Reconciliation/ Wrap around Current Year (c1) $	Collection of Reconciliation/ Wrap around Previous Years (c2) $	Collection of Other Payments: P4P, Risk Pools, Withholds, etc. (c3) $	Penalty/ Payback (c4) $			
1.	Medicaid Non-Managed Care	192,196	225,051	-	-	-	-	-52,463		
2a.	Medicaid Managed Care (capitated)	1,704,710	1,769,327	-	-	843	244	-64,617		
2b.	Medicaid Managed Care (fee-for-service)	-	-	-	-	-	-	-		
3.	**Total Medicaid (Sum lines 1+2a+2b)**	**1,896,906**	**1,994,378**			**843**	**244**	**-117,080**		
4.	Medicare Non-Managed Care	339,277	119,092	-	-	-	-	137,030		
5a.	Medicare Managed Care (capitated)	15,556	38,340	-	-	-	-	-22,784		
5b.	Medicare Managed Care (fee-for-service)	-	-	-	-	-	-	-		
6.	**Total Medicare (Sum lines 4+5a+5b)**	**354,833**	**157,432**					**114,246**		
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)	5,971	1,605	-	-	-	-	3,894		
8a.	Other Public including Non-Medicaid CHIP (Managed Care capitated)	-	-	-	-	-	-	0		
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)	-	-	-	-	-	-	-		
9.	**Total Other Public (Sum lines 7+8a+8b)**	**5,971**	**1,605**					**3,894**		
10.	Private Non-Managed Care	5,615	254			-	-	458		
11a.	Private Managed Care (capitated)	-	-			-	-	0		
11b.	Private Managed Care (fee-for-service)	-	-			-	-	-		
12.	**Total Private (Sum lines 10+11a+11b)**	**5,615**	**254**					**458**		
13.	Self-pay	1,499,219	11,032						1,488,187	0
14.	**Total (Sum lines 3+6+9+12+13)**	**3,762,544**	**2,164,701**	**0**	**0**	**843**	**244**	**1,518**	**1,488,187**	**0**

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Table 9E: Other Revenues

S.No	Source	Amount (a) $
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)		
1a.	Migrant Health Center	-
1b.	Community Health Center	889,470
1c.	Health Care for the Homeless	-
1e.	Public Housing Primary Care	-
1g.	**Total Health Center Cluster (Sum lines 1a-1e)**	**889,470**
1j.	Capital Improvement Program Grants	-
1k.	Capital Development Grants, including School Based Health Center Capital Grants	-
1.	**Total BPHC Grants (Sum lines 1g+1j+1k)**	**889,470**
Other Federal Grants		
2.	Ryan White Part C HIV Early Intervention	-
3.	Other Federal Grants (Specify:-)	-
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	106,250
5.	**Total Other Federal Grants (Sum lines 2-3a)**	**106,250**
Non-Federal Grants or Contracts		
6.	State Government Grants and Contracts (Specify:LA Care Tranquada Grant)	19,000
6a.	State/Local Indigent Care Programs (Specify:MHLA)	100,905
7.	Local Government Grants and Contracts (Specify:-)	-
8.	Foundation/Private Grants and Contracts (Specify:-)	-
9.	**Total Non-Federal Grants and Contracts (Sum lines 6+6a+7+8)**	**119,905**
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (Specify:-)	-
11.	**Total Revenue (Sum lines 1+5+9+10)**	**1,115,625**

OMB Control Number: 0195-0193

BHCMIS ID: 09E00280 - KEDREN COMMUNITY HEALTH CENTER, INC., Los Angeles, CA

Date Requested: 06/24/2020 10:46 PM EST
Date of Last Report Refreshed: 06/24/2020 10:46 PM EST

Program Name: Health Center 330

Submission Status: Accepted

UDS Report - 2017

Health Information Technology Capabilities and Quality Recognition

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?	[X] Yes, installed at all sites and used by all providers [_] Yes, but only installed at some sites or used by some providers [_] No
1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?	[X] Yes [_] No
Vendor	eClinicalWorks, LLC
Product Name	eClinicalWorks
Version Number	10e
Certified Health IT Product List Number	CC-2104-955447-1
1b. Did you switch to your current EHR from a previous system this year?	[_] Yes [X] No
1c. How many sites have the EHR system in use?	N/A
1d. How many providers use the EHR system?	N/A
1e. When do you plan to install the EHR system?	N/A
2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing)	[X] Yes [_] No [_] Not Sure
3. Does your center use computerized, clinical decision support such as alerts for drug allergies, checks for drug-drug interations, reminders for preventive screening tests, or other similar functions?	[X] Yes [_] No [_] Not Sure
4. Does your center exchange clinical information electronically with other key providers/health care settings such as hospitals, emergency rooms, or subspecialty clinicians?	[X] Yes [_] No [_] Not Sure
5. Does your center engage patients through health IT such as patient portals, kiosks, secure messaging (i.e., secure email) either through the EHR or through other technologies?	[X] Yes [_] No [_] Not Sure
6. Does your center use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when requested?	[X] Yes [_] No [_] Not Sure
7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?	[X] We use the EHR to extract automated reports [_] We use the EHR but only to access individual patient charts [_] We use the EHR in combination with another data analytic system [_] We do not use the EHR
8. Are your eligible providers participating in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program commonly known as "Meaningful Use"?	[_] Yes, all eligible providers at all sites are participating [X] Yes, some eligible providers at some sites are participating [_] No, our eligible providers are not yet participating [_] No, because our providers are not eligible [_] Not Sure
8a. If yes (a or b), at what stage of Meaningful Use are the majority (more than half) of your participating providers (i.e., what is the stage for which they most recently received incentive payments)?	[X] Received MU for Modified Stage 2 [_] Received MU for Stage 3 [_] Not Sure
8b. If no (c only), are your eligible providers planning to participate?	N/A

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UDS Report - 2017

Health Information Technology Capabilities and Quality Recognition

9. Does your center use health IT to coordinate or to provide enabling services such as outreach, language translation, transportation, case management, or other similar services?	[X] Yes [_] No
If yes, then specify the type(s) of service	Texting to provide announcements and reminders to patients. We also use it as an outreach mechanism for new registered patients.
10. Has your health center received or retained patient centered medical home recognition or certification for one or more sites during the measurement year?	[_] Yes [X] No
If yes, which third party organization(s) granted recognition or certification status? (Can identify more than one.)	[_] National Committee for Quality Assurance (NCQA) [_] The Joint Commission (TJC) [_] Accreditation Association for the Ambulatory Health Care (AAAHC) [_] State Based Initiative [_] Private Payer Initiative [_] Other Recognition Body (Specify: -)
11. Has your health center received accreditation?	[_] Yes [X] No
If yes, which third party organization granted accreditation?	[_] The Joint Commission (TJC) [_] Accreditation Association for the Ambulatory Health Care (AAAHC)

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Other Data Elements

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder	
How many physicians, certified nurse practitioners and physician assistants, on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?	2
How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?	10
2. Are you using telehealth? Telehealth is defined as the use of telecommunications and information technologies to share information, and provide clinical care, education, public health, and administrative services at a distance.	[_] Yes [X] No
If yes (a), how are you using telehealth?	[_] Provide primary care services [_] Provide specialty care services [_] Provide mental health services [_] Provide oral health services [_] Manage patients with chronic conditions [_] Other (Specify: -)
If no (b), please explain why you are not using telehealth:	Lack of resources and funding
3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment through the Marketplace, Medicaid or CHIP.	600

OMB Control Number: 0195-0193

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Submission Status: Accepted

UDS Report - 2017

Data Audit Report

Table 3A-Patients by Age and by Sex Assigned at Birth

Edit 03950: Numbers Questioned For Patients Aged 15 - 44. - Females age 15-44 is outside the typical range when compared to total patients age 15-44. Please correct or explain. Females aged 15-44 (1,208);Males aged 15-44 (1,294);Ratio of Females age 15-44 to total patients age 15-44: (48.28)%

Related Tables: Table 3A(UR)

Sonny Tran (Health Center) on 3/22/2018 11:40 AM EST: The health center has seen more male patients than female patients because we serve a large portion of homeless males from Male Community Reentry Program (MCRP) through our Memorandum of Understanding (MOU) with Amity Foundation. In 2017, we opened a satellite clinic at the Amity Foundation, located approximately 3 to 5 miles from our main campus, to provide primary care services to the male population from the MCRP program. Moreover, we do not have an OB/GYN department, nor an OB/GYN on staff, which may account for low female ratio. As we continue to market and establish family planning services, our hope is that the female to male ratio would change, and we could see an increase in females accessing health care at our facility.

Table 4-Selected Patient Characteristics

Edit 03852: Inter-year change in patients - The percentage of Uninsured patients to total patients has significantly decreased when compared to prior year. Current Year ((13.71)%, (605)); Prior Year ((16.59)%, (786). Please review the insurance reporting to ensure the information reported is patient's primary medical care insurance. Please correct or explain.

Related Tables: Table 4(UR)

Sonny Tran (Health Center) on 2/13/2018 2:07 AM EST: With Healthcare mandate more patients are required to have insurance thus reducing the number of uninsured.

Edit 05938: Inter-year change in Medicare patients - The proportion of Medicare patients to total patients has significantly decreased when compared to prior year. Current Year ((9.72)%, (429)); Prior Year ((12.79)% (606)). Please review the insurance reporting to ensure the information reported is patient's primary medical care insurance. Please correct or explain.

Related Tables: Table 4(UR)

Sonny Tran (Health Center) on 2/13/2018 2:07 AM EST: Upon review and manual queries, the data is correct.

Edit 04189: Inter-year Member Months in question - A significant change in managed care participation Fee-for-service Member months Medicaid Line 13b Column a () is reported compared with the prior year (1,560) . Please correct or explain.

Related Tables: Table 4(UR)

Sonny Tran (Health Center) on 2/14/2018 3:04 PM EST: We have no fee for service insurances

Edit 04200: Inter-year Member Months in question - A significant change in managed care participation Fee-for-service Member months Medicare Line 13b Column b () is reported compared with the prior year (29) . Please correct or explain.

Related Tables: Table 4(UR)

Sonny Tran (Health Center) on 2/14/2018 3:04 PM EST: We have no fee for service insurances

Table 5-Staffing and Utilization

Edit 04134: Substantial Inter-year variance in Providers - The number of Physician FTEs reported on Line 8 Column a differs from the prior year. Current Year - (1.38) . Prior Year - (0.68) . Confirm that this is consistent with staffing changes and that the FTE is calculated based on paid hours.

Related Tables: Table 5(UR)

Sonny Tran (Health Center) on 2/14/2018 4:21 AM EST: The Current Year number 1.38 is correct. The difference is due to Dr. Guevara worked 2-3 days per week last year, but in 2017 she worked 5 days a week.

Edit 06379: Other Professional Visit per Patient in Question - On Universal - Other Professional visits per Other Professional patient varies substantially from national average.CY (6.68); PY National Average (2.74). Please correct and explain.

Related Tables: Table 5(UR)

Christina Espersen (Reviewer) on 3/19/2018 10:50 PM EST: The data is correct. For other professional services we categorized our Dietitian here. Visits are more frequent because Dietitians are required to setup meal plans, goals, and other education. This is sometimes required by the provider in order to get that referral to the specialty. In regards to decrease in patients, we now have data and a plan to recall patients who missed their appointments or who needs to have one of their quality measures met. We also plan on partnering up with additional IPAs.

Table 6A-Selected Diagnoses and Services Rendered

Edit 04356: Mental Health Patients questioned - More mental health patients are reported on Table 6A Line 20a Column b (1,589) than total mental health patients and a portion of the medical patients reported on Table 5 (882.4). Please correct or explain.

Related Tables: Table 6A(UR), Table 5(UR)

Sonny Tran (Health Center) on 2/14/2018 5:09 AM EST: Our PCP diagnosis our patients as mental health and is referred out.

Edit 02149: Contraceptive Management Patients Questioned - The number reported on Line 25 Column b (78) on Table 6A appears low when compared to women aged 15-44 (1,208) reported on Table 3A. If you use an alternate code for contraception management visits, especially Title X visits, use them to identify and add the patients and visits to line 25.

Related Tables: Table 6A(UR), Table 3A(UR)

Sonny Tran (Health Center) on 2/14/2018 10:49 AM EST: This is correct. We plan on having campaigns in 2018 to let patients know we offer this service.

Table 6B-Quality of Care Indicators

Edit 03873: Entry By Trimester In Question - You report a disproportionate number of women entering prenatal care in the third trimester (10) on Table 6B Line 9 compared to the total number of prenatal patients reported on Line 6 (26) ; (38.46)%. Please correct or explain.

Related Tables: Table 6B

Sonny Tran (Health Center) on 2/14/2018 4:27 AM EST: Patient(s) appointment to the clinic already in prenatal care.

Edit 05788: Line 18 Universe in Question - Based on the universe reported for total patients with Ischemic Vascular Disease (IVD) on line 18 column A we estimate a prevalence rate of (0.59)%. This appears low compared to the prior year national average. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 5(UR), Table 4(UR)

Christina Espersen (Reviewer) on 3/24/2018 10:52 PM EST: Please see table comment - this section should be marked questionable

Edit 05866: Line 20 Compliance Rate Questioned - A compliance rate of 100% is reported for the Newly Identified HIV Cases and Follow-up measure, Line 20. Please review the reporting of Column c in relation to the sample or universe reported in Column b for accuracy and correct or explain.

Related Tables: Table 6B

Sonny Tran (Health Center) on 3/22/2018 11:57 AM EST: Upon further review we only had 1 patient who was newly diagnosis with HIV.

Table 7-Health Outcomes and Disparities

Edit 01325: Number Delivering Questioned - Line i Column 1a (3) on Table 7, Total Total seems low when compared to Total Patients (Sum lines 1-5) Line 6 Column a (26) on Table 6B. Please correct or explain.

Related Tables: Table 7, Table 6B

John Griffith (Health Center) on 3/23/2018 6:07 PM EST: Kedren has implemented an OB flow sheet, and training for clinical staff in order to properly track this information. Kedren has an MOU in place with an OBGYN, and refers patients who are pregnant for follow-up care, including labor and delivery. We are developing and strengthening our current policies/procedures in order to assist Kedren in tracking this information as the services are provided through referral arrangement.

Edit 06322: Hypertension Patients by Race or Ethnicity in Question - The total number of patients of More than one race with hypertension reported on Table 7 (5) is low compared to total patients of More than one race reported on Table 3B (74) . Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Sonny Tran (Health Center) on 2/14/2018 4:36 AM EST: This is correct.

Edit 06326: Hypertension Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to Report Race and Ethnicity patients with hypertension reported on Table 7 (5) is low compared to total Unreported/Refused to Report Race and Ethnicity patients reported on Table 3B (113) . Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Sonny Tran (Health Center) on 2/14/2018 10:31 AM EST: This is correct as table 7 only reports on hypertension patients and table 3 has the universe.

Edit 06337: Diabetes Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to Report Race and Ethnicity patients with diabetes reported on Table 7 (2) is low compared to total Unreported/Refused to Report Race and Ethnicity patients reported on Table 3B (113) . Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Sonny Tran (Health Center) on 2/14/2018 4:38 AM EST: This is correct as table 3B is the universe and 7 only counts diabetes unknown patients.

Edit 05795: Diabetes Universe in Question - Based on the universe for Total Patients with diabetes reported on Line i Column 3a we estimate a prevalence rate of (21.68)%.This appears high compared to national averages. Please review and correct or explain.

Related Tables: Table 7, Table 4(UR), Table 3A(UR), Table 5(UR)

Christina Espersen (Reviewer) on 3/19/2018 10:57 PM EST: We understated last year. Below is the Kaiser Foundation Hospital – Los Angeles community health assessment: Diabetes affects an estimated 23.6 million people in the United States and is the seventh leading cause of death. A diabetes diagnosis can indicate an unhealthy lifestyle, a risk factor for further health issues, and is also linked to obesity. Diabetes prevalence is higher in KFH-LA (18.5%) versus Los Angeles County

(10.5%), highest in SPA 7 (23.3%), SPA 6 (23.1%), SPA 4 (17.1%), SPA 3 (16.9%) and SPA 2 (12.3%). The diabetes hospitalization rate for adults in the KFH-LA service area is higher (174.3) when compared to the Los Angeles County rate of 145.6 per 100,000 persons. The uncontrolled diabetes hospitalization rate per 100,000 adults is also higher (17.7) when compared to Los Angeles County (9.5). Diabetes is more common among males (8.5%) than females (7.1%). In addition, more males (1.1%) have been discharged from hospitals for diabetes-related incidents than females (0.8%). Also, more African-Americans (1.6%) and Hispanic/Latinos (1.0) experienced hospital discharges resulting from diabetes. Those between the ages of 45 and 64 (1.5%) and 65 and over (1.0%) experienced the most diabetes-related hospital incidents when compared to other age groups. Stakeholders noted that the elderly, adult Chinatown residents, recent immigrants, the homeless, Latinos, and Latino residents of Skid Row are particularly impacted by diabetes. Drivers associated with diabetes include being overweight, high blood pressure, high cholesterol, high blood sugar (or glucose), physical inactivity, smoking, unhealthy eating, age, race, gender, and having a family history of diabetes. The lack of access to a usual source of care, medical insurance, and the availability of primary care providers within a community are also contributing factors.

Table 8A-Financial Costs

Edit 04117: Cost Per Visit Questioned - Total Medical Care Cost Per Visit is substantially different than the prior year. Current Year (166.14); Prior Year (133.58).

Related Tables: Table 8A, Table 5(UR)

Sonny Tran (Health Center) on 2/14/2018 4:04 AM EST: Cost increased by 34% but clinic visits increased only by 10%

Edit 05767: Charge to Cost Ratio Questioned - Total charge to cost ratio of (1.63) is reported which suggests that charges are more than costs. Please review the information reported across the tables and correct or explain.

Related Tables: Table 8A, Table 9D

Sonny Tran (Health Center) on 2/14/2018 10:55 AM EST: These charges were brought over from prior year.

Edit 04129: Cost Per Visit Questioned - Other Professional Cost Per visits is substantially different than the prior year. Current Year (103.7); Prior Year (71.98).

Related Tables: Table 8A, Table 5(UR)

Sonny Tran (Health Center) on 2/14/2018 4:05 AM EST: Cost is pretty similar to last year, but the nutritionist visits decreased by 30%

Edit 04136: Costs and FTE Questioned - Other Professional Services are reported on Table 8A, Line 9 (15,660) (Nutritionist) and Table 5, Line 22 (0.25) (Dietitian) . Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Sonny Tran (Health Center) on 2/14/2018 4:11 AM EST: Nutritionist and Dietitian are the same person.

Edit 03727: Inter-Year Variance Questioned - Current Year Facility costs vary substantially from last years cost. (Current Year: Facility Accrued Cost Line 14 Column a (164,558) ; Prior Year: Facility Accrued Cost Line 14 Column a (53,989)). Please correct or explain.

Related Tables: Table 8A

Sonny Tran (Health Center) on 2/14/2018 4:11 AM EST: Lease expense increased significantly because we add 2 more buildings in 2017.

Edit 03945: Inter-Year variance questioned - Current Year Non-Clinical Support costs, Line 15 Column a (956,582) varies substantially from cost on the same line last year (705,875) . Please correct or explain.

Related Tables: Table 8A

Sonny Tran (Health Center) on 2/14/2018 4:12 AM EST: Current Year non-clinical cost increased especially consultants costs.

Table 9D-Patient Related Revenue (Scope of Project Only)

Edit 04155: Inter-year Capitation PMPM questioned - The average Medicaid capitation PMPM reported on Line 2a (88.11) is significantly different from the prior year (12.65). Please correct or explain.

Related Tables: Table 9D, Table 4(UR)

Sonny Tran (Health Center) on 3/22/2018 11:53 AM EST: Total medicaid capitation payment = $256,584 / Medicaid member month 20,073 = PMPM = $12.78

Edit 05099: PMPM collections in question - Medicaid Capitation PMPM (88.11) is outside the typical range. Check to see that the revenue and member months are entered correctly or explain.

Related Tables: Table 9D, Table 4(UR)

Sonny Tran (Health Center) on 3/22/2018 11:54 AM EST: We use the number of cap patients seen vs total enrolled patients. Total medicaid capitation payment = $256,584 / Medicaid member month 20,073 = PMPM = $12.78

Edit 04062: Inter-year Medicare patients and charges Questioned - A (-29.21)% change in MEDICARE patients is reported, but (25.04)% in charges is reported. Review the report for consistency. Please correct or explain.

Related Tables: Table 9D, Table 4(UR)

Sonny Tran (Health Center) on 2/14/2018 10:51 AM EST: Our charges were posted in 2017.

Edit 02028: Large change in accounts receivable for Total Private is reported - Total Private, Line 12: When we subtract collections (Column b) and adjustments (Column d) from your total Private charges (Column a) there is a large difference (87.32)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.

Related Tables: Table 9D

Sonny Tran (Health Center) on 2/14/2018 4:18 AM EST: Medcor (billing outsource company) did not clear the claims yet. So, it looks like the payments or denials have not yet received by us

Edit 03988: No Accounts Recievable in question - Table 9D Line 13, Self Pay Charges - Collections - Sliding Discount - Bad Debt equals zero. It is unusual to have no accounts receivable/balance. Please correct or explain.

Related Tables: Table 9D

Sonny Tran (Health Center) on 3/15/2018 2:56 PM EST: Recommended by our reviewer

Edit 04216: Average Collections - A large change from the prior year in collections per medical+dental+mental health visit is reported. Current Year (162.71); Prior year (131.5). Please review the information and correct or explain.

Related Tables: Table 9D, Table 5(UR)

Sonny Tran (Health Center) on 2/14/2018 4:17 AM EST: CY ratio = 2,247,568.71/13,304 = 168.94. We monitor revenue cyle more closely in 2017. Thus, we could submit bill in timely manner and minimize uncollectible AR.

Table 9E-Other Revenues

Edit 03466: Inter-Year variation in grant funds - Current year Community Health Center(Section 330(e)) funds vary substantially from the prior year. This may occur if BPHC has substantially changed the grant amount or may be due to the timing of draw downs. Please correct or explain. Current Year - Community Health Center Amount Line 1b Column a (889,470) . Prior Year - Community Health Center Amount Line 1b Column a (614,367) .

Related Tables: Table 9E

Sonny Tran (Health Center) on 2/14/2018 4:17 AM EST: Prior year, we did not fully use 330 grant because several positions were not in the budget. In 2017, the approved budget justification period 2/1/17-1/31/18 includes more staff's positions and physician consultants.

Edit 03736: Inter-Year variance questioned - Total income reported on Tables 9D and 9E for this year varies substantially from the prior year. Please correct or explain. Current Year (3,280,326); Prior Year (2,256,306).

Related Tables: Table 9E, Table 9D

Sonny Tran (Health Center) on 2/14/2018 4:16 AM EST: CY ratio = 2,247,568.71/13,304 = 168.94. We monitor revenue cyle more closely in 2017. Thus, we could submit bill in timely manner and minimize uncollectible AR. Prior year, we did not fully use 330 grant because several positions were not in the budget. In 2017, the approved budget justification period 2/1/17-1/31/18 includes more staff's positions and physician consultants.

Edit 04094: Profit and Loss - When comparing cash income to accrued expenses a large surplus or deficit is reported. Please correct or explain. Surplus or Deficit = $ (913,835); Percent Surplus or Deficit (38.62)%. Note: If the value is a surplus it will be distinguished as a number inside a parentheses (Value). If the value is a deficit it will be distinguished as a number with a negative sign inside a parentheses (-Value).

Related Tables: Table 9E, Table 8A, Table 9D

Sonny Tran (Health Center) on 2/14/2018 4:15 AM EST: Accrued expense = $2,366,491; cash income = $3,280,325. We collected more cash income this year than last year.

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UDS Report - 2017

Comments

Report Comments
Not Available

Table 4 Comments
Here was a data entry error on the homeless line. We corrected it. Staff used the health center's address if the patient was homeless and other homeless addresses such as homeless street to mark patients as homeless. We are going to correct this by training staff to check the homeless box for easy tracking going forward.

Table 9E Comments
Previous comment deleted by user.

Table EHR Comments
We are in process of getting NCQA accreditation. Target date is March 2018.

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UDS Report - 2018

Contact Information

Do you self-identify as an NMHC?: No

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Clinical Director	Not Available	Not Available	Not Available	Not Available
Chair Person	Not Available	Not Available	Not Available	Not Available
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Patients by ZIP Code

ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
90001	19	73	6	0	**98**
90002	12	97	11	0	**120**
90003	31	182	32	2	**247**
90006	4	12	2	0	**18**

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
90007	19	302	7	1	**329**
90008	3	51	4	0	**58**
90011	205	607	85	13	**910**
90013	0	30	7	0	**37**
90014	2	9	2	0	**13**
90015	2	13	0	0	**15**
90016	4	32	9	1	**46**
90017	2	10	0	1	**13**
90018	8	57	10	1	**76**
90019	2	17	5	0	**24**
90026	1	10	0	1	**12**
90037	17	179	24	1	**221**
90043	7	68	11	1	**87**
90044	13	127	24	3	**167**
90047	5	66	12	0	**83**
90057	5	129	4	1	**139**
90058	1	14	0	0	**15**
90059	7	45	3	0	**55**
90061	5	70	12	0	**87**
60062	10	48	9	1	**68**
90201	5	20	1	0	**26**
90220	2	22	6	0	**30**
90221	2	16	2	0	**20**
90222	1	14	0	0	**15**
90250	4	23	2	0	**29**
90255	7	25	5	1	**38**
90262	2	9	0	0	**11**
90280	3	15	2	0	**20**

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
90301	2	14	5	0	**21**

Other ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes	57	284	38	2	**381**
Unknown Residence	4	1	0	0	**5**
Total (Zip Codes + Other Zip Codes)	**473**	**2691**	**340**	**30**	**3534**

Comments

BHCMIS ID: 09E00280 - KEDREN COMMUNITY HEALTH CENTER, INC., Los Angeles, CA

Program Name: Health Center 330

Submission Status: Accepted

Date Requested: 06/24/2020 7:47 PM EST

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Table 3A - Patients By Age And By Sex Assigned At Birth

Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	4	6
2.	Age 1	8	10
3.	Age 2	4	8
4.	Age 3	5	4
5.	Age 4	9	3
6.	Age 5	9	3
7.	Age 6	4	7
8.	Age 7	6	5

S.No	Age Groups	Male Patients (a)	Female Patients (b)
9.	Age 8	7	5
10.	Age 9	9	5
11.	Age 10	8	9
12.	Age 11	11	7
13.	Age 12	5	13
14.	Age 13	10	7
15.	Age 14	4	7
16.	Age 15	6	7
17.	Age 16	5	10
18.	Age 17	6	9
	Subtotal Patients (Sum lines 1-18)	**120**	**125**
19.	Age 18	23	20
20.	Age 19	24	25
21.	Age 20	31	33
22.	Age 21	23	21
23.	Age 22	35	31
24.	Age 23	29	26
25.	Age 24	48	33
26.	Ages 25-29	210	189
27.	Ages 30-34	213	157
28.	Ages 35-39	219	148
29.	Ages 40-44	189	127
30.	Ages 45-49	180	142
31.	Ages 50-54	204	156
32.	Ages 55-59	225	120
33.	Ages 60-64	133	95
	Subtotal Patients(Sum lines 19-33)	**1786**	**1323**
34.	Ages 65-69	80	43

S.No	Age Groups	Male Patients (a)	Female Patients (b)
35.	Ages 70-74	16	16
36.	Ages 75-79	6	11
37.	Ages 80-84	2	4
38.	Ages 85 and over	0	2
	Subtotal Patients(Sum lines 34-38)	**104**	**76**
39.	**Total Patients(Sum Lines 1-38)**	**2010**	**1524**

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Table 3B - Demographic Characteristics

Universal

S.No	Patients by Race	Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1.	Asian	2	23		**25**
2a.	Native Hawaiian	0	7		**7**
2b.	Other Pacific Islander	0	4		**4**
2.	**Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)**	**0**	**11**		**11**
3.	Black/African American	14	1481		**1495**
4.	American Indian/Alaska Native	0	9		**9**
5.	White	7	150		**157**
6.	More than one race	12	34		**46**
7.	Unreported/Refused to report race	1371	388	32	**1791**
8.	**Total Patients (Sum Lines 1 + 2 + 3 to 7)**	**1406**	**2096**	**32**	**3534**

S.No	Patients by Linguistic Barriers to Care	Number (a)
12.	Patients Best Served in a Language Other Than English	595

S.No	Patients by Sexual Orientation	Number (a)
13.	Lesbian or Gay	40
14.	Straight (not lesbian or gay)	2502
15.	Bisexual	31
16.	Something else	3
17.	Don't know	478
18.	Chose not to disclose	480
19.	**Total Patients (Sum Lines 13 to 18)**	**3534**

S.No	Patients by Gender Identity	Number (a)
20.	Male	1711
21.	Female	1297
22.	Transgender Male/ Female-to-Male	5
23.	Transgender Female/ Male-to-Female	0
24.	Other	148
25.	Chose not to disclose	373
26.	**Total Patients (Sum Lines 20 to 25)**	**3534**

Table 4 - Selected Patient Characteristics

Universal

Income As Percent Of Poverty Guideline

S.No	Characteristic	Number of Patients (a)
1.	100% and below	2645
2.	101 - 150%	121
3.	151 - 200%	14
4.	Over 200%	13
5.	Unknown	741
6.	**Total (Sum lines 1-5)**	**3534**

S.No	Principal Third Party Medical Insurance	0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	18	455
8a.	Medicaid (Title XIX)	226	2465
8b.	CHIP Medicaid		
8.	**Total Medicaid (Sum lines 8a+8b)**	**226**	**2465**
9a.	Dually eligible (Medicare and Medicaid)	0	247
9.	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)	0	340
10a.	**Other Public Insurance (Non-CHIP) (specify)**		
10b.	Other Public Insurance CHIP		
10.	**Total Public Insurance (Sum lines 10a+10b)**	**0**	**0**
11.	Private Insurance	1	29
12.	**Total (Sum lines 7+8+9+10+11)**	**245**	**3289**

Managed Care Utilization

S.No	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)

S.No	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member Months	23592	564			24156
13b.	Fee-for-service Member Months					0
13c.	**Total Member Months (Sum lines 13a+13b)**	**23592**	**564**	**0**	**0**	**24156**

S.No	Special Populations	Number of Patients (a)
16.	**Total Agricultural Workers or Dependents (All health centers report this line)**	**2**
23.	**Total Homeless (All health centers report this line)**	**304**
24.	**Total School Based Health Center Patients (All health centers report this line)**	**0**
25.	**Total Veterans (All health centers report this line)**	**1**
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (All health centers report this line)**	**290**

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Table 5 - Staffing And Utilization

Universal

Medical Care Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1.	Family Physicians	1	4844	
2.	General Practitioners			
3.	Internists	0.2	1309	
4.	Obstetrician/Gynecologists			
5.	Pediatricians			
7.	Other Specialty Physicians			
8.	**Total Physicians (Sum lines 1-7)**	**1.2**	**6153**	
9a.	Nurse Practitioners	1.22	4247	
9b.	Physician Assistants	0.07	212	
10.	Certified Nurse Midwives	0		
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**	**1.29**	**4459**	
11.	Nurses	0		
12.	Other Medical Personnel	4.91		
13.	Laboratory Personnel	1		
14.	X-Ray Personnel			
15.	**Total Medical (Sum lines 8+10a through 14)**	**8.4**	**10612**	**3487**

Dental Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
16.	Dentist			
17.	Dental Hygienists			
17a.	Dental Therapists			
18.	Other Dental Personnel			
19.	**Total Dental Services (Sum lines 16-18)**	**0**	**0**	

Mental Health Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
20a.	Psychiatrists			
20a1.	Licensed Clinical Psychologists			
20a2.	Licensed Clinical Social Workers			
20b.	Other Licensed Mental Health Providers			
20c.	Other Mental Health Staff			
20.	**Total Mental Health (Sum lines 20a-20c)**	**0**	**0**	

Substance Use Disorder Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
21.	**Substance Use Disorder Services**			

Other Professional Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
22.	**Other Professional Services Specify** Dietitian	0.11	171	47

Vision Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
22a.	Ophthalmologists			
22b.	Optometrists			
22c.	Other Vision Care Staff			
22d.	**Total Vision Services (Sum lines 22a-22c)**	**0**	**0**	

Pharmacy Personnel

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
23.	Pharmacy Personnel			

Enabling Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
24.	Case Managers			
25.	Patient/Community Education Specialists			
26.	Outreach Workers	1		
27.	Transportation Staff			
27a.	Eligibility Assistance Workers	0.45		
27b.	Interpretation Staff			
27c.	Community Health Workers			
28.	**Other Enabling Services Specify**			
29.	**Total Enabling Services (Sum lines 24-28)**	**1.45**	**0**	

Other Programs/Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
29a.	**Other Programs/Services Specify:**			
29b.	Quality Improvement Staff			

Administration And Facility

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
30a.	Management and Support Staff	1.4		
30b.	Fiscal and Billing Staff	1		
30c.	IT Staff			
31.	Facility Staff			
32.	Patient Support Staff	1.92		
33.	**Total Facility and Non-Clinical Support Staff (Lines 30a - 32)**	**4.32**		

Grand Total

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
34.	**Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)**	**14.28**	**10783**	

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Table 5A - Tenure for Health Center Staff

Universal

S.No	Health Center Staff	Full and Part Time Persons (a)	Full and Part Time Total Months (b)	Locum, On-Call, etc Persons (c)	Locum, On-Call, etc Total Months (d)

S.No	Health Center Staff	Full and Part Time Persons (a)	Full and Part Time Total Months (b)	Locum, On-Call, etc Persons (c)	Locum, On-Call, etc Total Months (d)
1.	Family Physicians	3	157		
2.	General Practitioners				
3.	Internists	1	490		
4.	Obstetrician/Gynecologists				
5.	Pediatricians				
7.	Other Specialty Physicians				
9a.	Nurse Practitioners	4	101	2	5
9b.	Physician Assistants			2	2
10.	Certified Nurse Midwives				
11.	Nurses				
16.	Dentists				
17.	Dental Hygienists				
17a.	Dental Therapists				
20a.	Psychiatrists				
20a1.	Licensed Clinical Psychologists				
20a2.	Licensed Clinical Social Workers				
20b.	Other Licensed Mental Health Providers				
22a.	Ophthalmologist				
22b.	Optometrist				
30a1.	Chief Executive Officer	1	456		
30a2.	Chief Medical Officer	1	5		
30a3.	Chief Financial Officer	1	60		
30a4.	Chief Information Officer				

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Table 6A - Selected Diagnoses And Services Rendered

Universal

Selected Infectious And Parasitic Diseases

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
1-2.	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21	126	32
3.	Tuberculosis	A15- through A19-, O98.01	4	4
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0)	78	55
4a.	Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	3	1
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	503	155

Selected Diseases Of The Respiratory System

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
5.	Asthma	J45-	459	245
6.	Chronic lower respiratory diseases	J40- through J44-, J47-	99	50

Selected Other Medical Conditions

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	41	30
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	77	54
9.	Diabetes mellitus	E08- through E13-, O24-(exclude O24.41-)	1884	678
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	158	72
11.	Hypertension	I10- through I16-	2883	908
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	103	83
13.	Dehydration	E86-	3	3
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-	1	1
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51. Z68.52)	7666	2532

Selected Childhood Conditions (Limited To Ages 0 Through 17)

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
15.	Otitis media and Eustachian tube disorders	H65- through H69-	10	10
16.	Selected perinatal medical conditions	A33-, P19-, P22-through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	2	1
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3	5	5

Selected Mental Health And Substance Use Disorder Conditions

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
18.	Alcohol related disorders	F10-, G62.1	53	42
19.	Other substance related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	113	100
19a.	Tobacco use disorder	F17-, O99.33	3175	1210
20a.	Depression and other mood disorders	F30- through F39-	931	853
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	143	118
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-	19	17
20d.	Other mental disorders excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0-and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34, R45.1, R45.2, 45.5, R45.6, R45.7, R45.81, R45.82, R48.0	612	539

Selected Diagnostic Tests/Screening/Preventive Services

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
21.	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806	560	560
21a.	Hepatitis B test	**CPT-4:** 86704 through 86707, 87340, 87341, 87350	302	200
21b.	Hepatitis C test	**CPT-4:** 86803, 86804, 87520 through 87522		
22.	Mammogram	**CPT-4:** 77052, 77057, 77065, 77066, 77067 OR **ICD-10:** Z12.31	259	200
23.	Pap test	**CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	258	234
24.	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal; diphtheria; tetanus; pertussis (DTaP) (DTP) (DT); mumps; measles; rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4:** 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	887	682
24a.	Seasonal flu vaccine	**CPT-4:** 90630, 90653 through 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90688, 90749, 90756	432	418
25.	Contraceptive management	**ICD-10:** Z30-	280	223
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99381 through 99383, 99391 through 99393	68	61
26a.	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4:** 83655	4	3
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, H0050	1	1
26c.	Smoke and tobacco use cessation counseling	**CPT-4:** 99406, 99407 OR **HCPCS:** S9075 OR **CPT-II:** 4000F, 4001F, 4004F	2030	1170
26d.	Comprehensive and intermediate eye exams	**CPT-4:** 92002, 92004, 92012, 92014		

Selected Dental Services

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
27.	Emergency Services	**ADA:** D9110		
28.	Oral Exams	**ADA:** D0120, D0140, DO145, D0150, D0160, D0170, D0171, D0180		
29.	Prophylaxis - adult or child	**ADA:** D1110, D1120		
30.	Sealants	**ADA:** D1351		
31.	Fluoride treatment - adult or child	**ADA:** D1206, D1208 **CPT-4:**99188		
32.	Restorative services	**ADA:** D21xx through D29xx		
33.	Oral surgery (extractions and other surgical procedures)	**ADA:**D7xxx		
34.	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Sources of Codes:
ICD-10-CM (2018). National Center for Health Statistics (NCHS).
CPT (2018). American Medical Association (AMA).
Code on Dental Procedures and Nomenclature CDT Code (2018) - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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Table 6B - Quality Of Care Measures

Universal

[X]: Prenatal Care Provided by Referral Only (Check if Yes)

Section A - Age Categories For Prenatal Care Patients:

Demographic Characteristics Of Prenatal Care Patients

S.No	Age	Number of Patients (a)

S.No	Age	Number of Patients (a)
1.	Less than 15 years	0
2.	Ages 15-19	1
3.	Ages 20-24	1
4.	Ages 25-44	4
5.	Ages 45 and over	1
6.	**Total Patients (Sum lines 1-5)**	**7**

Section B - Early Entry Into Prenatal Care

S.No	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7.	First Trimester	4	3
8.	Second Trimester	0	0
9.	Third Trimester	0	0

Section C - Childhood Immunization Status

S.No	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10.	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	12	12	9

Section D - Cervical Cancer Screening

S.No	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11.	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	1158	1158	502

Section E - Weight Assessment And Counseling For Nutrition And Physical Activity Of Children And Adolescents

S.No	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12.	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile and counseling on nutrition and physical activity documented	194	194	181

Section F - Preventive Care And Screening: Body Mass Index (BMI) Screening And Follow-Up Plan

S.No	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13.	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	3279	3279	3187

Section G - Preventive Care And Screening: Tobacco Use: Screening And Cessation Intervention

S.No	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User (c)
14a.	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, and (2) if identified to be a tobacco user received cessation counseling intervention	1971	1971	1926

Section H - Use Of Appropriate Medications For Asthma

S.No	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16.	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	83	83	53

Section I - Coronary Artery Disease (CAD): Lipid Therapy

S.No	Coronary Artery Disease (CAD): Lipid Therapy	Total Patients Aged 18 and Older with CAD Diagnosis (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed a Lipid Lowering Therapy (c)
17.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy	35	35	20

Section J - Ischemic Vascular Disease (IVD): Use Of Aspirin Or Another Antiplatelet

S.No	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	33	33	28

Section K - Colorectal Cancer Screening

S.No	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19.	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	1050	1050	212

Section L - HIV Linkage To Care

S.No	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20.	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis	9	9	5

Section M - Preventive Care And Screening: Screening For Depression And Follow-Up Plan

S.No	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21.	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive,(2) had a follow-up plan documented	2996	2996	2611

Section N - Dental Sealants For Children Between 6-9 Years

S.No	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22.	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar			

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Table 7 - Health Outcomes and Disparities

Deliveries and Birth Weight

S.No	Prenatal Services	Patients (a)
0	HIV-Positive Pregnant Women	0
2	Deliveries Performed by Health Center's Providers	0

Hispanic/Latino

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
1a.	Asian				
1b1.	Native Hawaiian				
1b2.	Other Pacific Islander				
1c.	Black/African American	0	0	0	0
1d.	American Indian/Alaska Native				
1e.	White	1	0	0	1
1f.	More Than One Race				
1g.	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino	**1**	**0**	**0**	**1**

Non-Hispanic/Latino

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
2a.	Asian				
2b1.	Native Hawaiian				
2b2.	Other Pacific Islander				
2c.	Black/African American	1	0	0	1
2d.	American Indian/Alaska Native				
2e.	White				
2f.	More Than One Race				
2g.	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino	**1**	**0**	**0**	**1**

Unreported/Refused To Report Race And Ethnicity

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
h.	Unreported/Refused to Report Race and Ethnicity	1	0	0	1
i.	**Total**	**3**	**0**	**0**	**3**

Controlling High Blood Pressure

Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
1a.	Asian	0	0	0
1b1.	Native Hawaiian	0	0	0
1b2.	Other Pacific Islander	0	0	0
1c.	Black/African American	4	4	2
1d.	American Indian/Alaska Native	0	0	0
1e.	White	2	2	0
1f.	More Than One Race	0	0	0
1g.	Unreported/Refused to Report Race	249	249	138
	Subtotal Hispanic/Latino	**255**	**255**	**140**

Non-Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
2a.	Asian	6	6	4
2b1.	Native Hawaiian	2	2	0
2b2.	Other Pacific Islander	1	1	0
2c.	Black/African American	472	472	195
2d.	American Indian/Alaska Native	2	2	2
2e.	White	27	27	15
2f.	More Than One Race	7	7	5
2g.	Unreported/Refused to Report Race	51	51	22
	Subtotal Non-Hispanic/Latino	**568**	**568**	**243**

Unreported/Refused To Report Race And Ethnicity

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
h.	Unreported/Refused to Report Race and Ethnicity	7	7	4
i.	**Total**	**830**	**830**	**387**

Diabetes: Hemoglobin A1c Poor Control

Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
1a.	Asian	1	1	1
1b1.	Native Hawaiian	0	0	0
1b2.	Other Pacific Islander	0	0	0
1c.	Black/African American	1	1	1
1d.	American Indian/Alaska Native	0	0	0
1e.	White	1	1	1
1f.	More Than One Race	0	0	0
1g.	Unreported/Refused to Report Race	206	206	105
	Subtotal Hispanic/Latino	**209**	**209**	**108**

Non-Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
2a.	Asian	1	1	0
2b1.	Native Hawaiian	0	0	0
2b2.	Other Pacific Islander	1	1	1
2c.	Black/African American	205	205	121
2d.	American Indian/Alaska Native	0	0	0
2e.	White	14	14	8
2f.	More Than One Race	3	3	1
2g.	Unreported/Refused to Report Race	29	29	15
	Subtotal Non-Hispanic/Latino	**253**	**253**	**146**

Unreported/Refused To Report Race And Ethnicity

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
h.	Unreported/Refused to Report Race and Ethnicity	5	5	2
i.	**Total**	**467**	**467**	**256**

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Table 8A - Financial Costs

Universal

* Column c is equal to the sum of column a and column b.

Financial Costs For Medical Care

S.No	Cost Center	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
1.	Medical Staff	828467	718437	**1546904**
2.	Lab and X-ray	28140	31725	**59865**
3.	Medical/Other Direct	239067	322248	**561315**
4.	**Total Medical Care Services (Sum lines 1-3)**	**1095674**	**1072410**	**2168084**

Financial Costs For Other Clinical Services

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
5.	Dental	0	0	**0**
6.	Mental Health	0	0	**0**
7.	Substance Use Disorder	0	0	**0**
8a.	Pharmacy not including pharmaceuticals	0	0	**0**
8b.	Pharmaceuticals	89894		**89894**
9.	**Other Professional Specify:** Dietitian	14195	11852	**26047**
9a.	Vision	0	0	**0**
10.	**Total Other Clinical Services (Sum lines 5-9a)**	**104089**	**11852**	**115941**

Financial Costs Of Enabling And Other Services

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
11a.	Case Management			0
11b.	Transportation			0
11c.	Outreach	43459		43459
11d.	Patient and Community Education			0
11e.	Eligibility Assistance	36133		36133
11f.	Interpretation Services			0
11g.	**Other Enabling Services Specify:**			0
11h.	Community Health Workers			0
11.	**Total Enabling Services Cost (Sum lines 11a-11h)**	**79592**		**79592**
12.	**Other Related Services Specify:**			0
12a.	Quality Improvement		66456	**66456**
13.	**Total Enabling and Other Services (Sum Lines 11, 12, and 12a)**	**79592**	**66456**	**146048**

Facility And Non-Clinical Support Services And Totals

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
14.	Facility	157560		
15.	Non-Clinical Support Services	993158		
16.	**Total Facility And Non-Clinical Support Services (Sum Lines 14 And 15)**	**1150718**		
17.	**Total Accrued Costs (Sum lines 4+10+13+16)**	**2430073**		**2430073**
18.	**Value of Donated Facilities, Services and Supplies Specify:**			
19.	**Total with Donations (Sum lines 17 and 18)**			**2430073**

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Table 9D - Patient Related Revenue (Scope of Project Only)

Universal

S.No	Payer Category	Full Charges This Period (a) $	Amount Collected This Period (b) $	Collection of Reconciliati / Wrap Around Current Year (c1) $	Collection of Reconciliati / Wrap Around Previous Year (c2) $	Collection of Other Payments: P4P, Risk Pools, etc. (c3) $	Penalty / Payback (c4) $	Allowances (d) $	Sliding Fee Discounts (e) $	Bad Debt Write Off (f) $
1.	Medicaid Non-Managed Care	115821	127500					-17889		
2a.	Medicaid Managed Care (capitated)	1432592	1442757		1692	12714		-20273		
2b.	Medicaid Managed Care (fee-for-service)									
3.	**Total Medicaid (Sum lines 1+2a+2b)**	**1548413**	**1570257**	**0**	**1692**	**12714**	**0**	**-38162**		
4.	Medicare Non-Managed Care	381820	112679					261837		
5a.	Medicare Managed Care (capitated)	84698	55534					23328		
5b.	Medicare Managed Care (fee-for-service)									
6.	**Total Medicare (Sum lines 4+5a+5b)**	**466518**	**168213**	**0**	**0**	**0**	**0**	**285165**		
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)	29870	5329					14689		
8a.	Other Public including Non-Medicaid CHIP (Managed Care capitated)									

S.No	Payer Category	Full Charges This Period (a) $	Amount Collected This Period (b) $	Collection of Reconciliati / Wrap Around Current Year (c1) $	Collection of Reconciliati / Wrap Around Previous Year (c2) $	Collection of Other Payments: P4P, Risk Pools, etc. (c3) $	Penalty / Payback (c4) $	Allowances (d) $	Sliding Fee Discounts (e) $	Bad Debt Write Off (f) $
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	**Total Other Public (Sum lines 7+8a+8b)**	**29870**	**5329**	**0**	**0**	**0**	**0**	**14689**		
10.	Private Non-Managed Care	191433	97482					83802		
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)									
12.	**Total Private (Sum lines 10+11a+11b)**	**191433**	**97482**			**0**	**0**	**83802**		
13.	Self-pay	109918	68772						31455	0
14.	**Total (Sum lines 3+6+9+12+13)**	**2346152**	**1910053**		**1692**	**12714**		**345494**	**31455**	**0**

Table 9E - Other Revenues

Universal

BPHC Grants (Enter Amount Drawn Down - Consistent With PMS-272)

S.No	Source	Amount (a) $

S.No	Source	Amount (a) $
1a.	Migrant Health Center	0
1b.	Community Health Center	1028413
1c.	Health Care for the Homeless	0
1e.	Public Housing Primary Care	0
1g.	**Total Health Center (Sum lines 1a through 1e)**	**1028413**
1j.	Capital Improvement Program Grants	0
1k.	Capital Development Grants, including School Based Health Center Capital Grants	0
1.	**Total BPHC Grants (Sum lines 1g+1j+1k)**	**1028413**

Other Federal Grants

S.No	Source	Amount (a) $
2.	Ryan White Part C HIV Early Intervention	0
3.	**Other Federal Grants Specify:**	0
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	8500
5.	**Total Other Federal Grants (Sum lines 2-3a)**	**8500**

Non-Federal Grants Or Contracts

S.No	Source	Amount (a) $

S.No	Source	Amount (a) $
6.	**State Government Grants and Contracts Specify:**	0
6a.	**State/Local Indigent Care Programs Specify:**	0
7.	**Local Government Grants and Contracts Specify:**	0
8.	**Foundation/Private Grants and Contracts Specify:** Provider performance incentives from IPAs	47425
9.	**Total Non-Federal Grants and Contracts (Sum lines 6+6a+7+8)**	**47425**
10.	**Other Revenue (non-patient related revenue not reported elsewhere) Specify:**	0
11.	**Total Revenue (Sum lines 1+5+9+10)**	**1084338**

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Health Center Health Information Technology (HIT) Capabilities

HIT

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?:

[X]: Yes, installed at all sites and used by all providers

[_]: Yes, but only installed at some sites or used by some providers

[_]: No

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?:

[X]: Yes

[_]: No

Vendor: eClinicalWorks, LLC

Other (Please specify):

Product Name: eClinicalWorks

Version Number: 10e

ONC-certified Health IT Product List Number: 0014EQX1QQV343M

Vendor:

Other (Please specify):

Product Name:

Version Number:

1b. Did you switch to your current EHR from a previous system this year?:

[_]: Yes

[X]: No

1c. How many sites have the EHR system in use?:

1d. How many providers use the EHR system?:

1e. When do you plan to install the EHR system?:

[_]: a. 3 months

[_]: b. 6 months

[_]: c. 1 Year or more

[_]: d. Not planned

2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing):

[X]: Yes

[_]: No

[_]: Not Sure

3. Does your center use computerized, clinical decision support, such as alerts for drug allergies, checks for drug-drug interactions, reminders for preventive screening tests, or other similar functions?:

[X]: Yes

[_]: No

[_]: Not Sure

4. Does your center exchange clinical information electronically with other key providers/health care settings, such as hospitals, emergency rooms, or subspecialty clinicians?:

[X]: Yes

[_]: No

[_]: Not Sure

5. Does your center engage patients through health IT, such as patient portals, kiosks, or secure messaging (i.e., secure email) either through the EHR or through other technologies?:

[X]: Yes

[_]: No

[_]: Not Sure

6. Does your center use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when requested?:

[X]: Yes

[_]: No

[_]: Not Sure

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?:

[X]: We use the EHR to extract automated reports

[_]: We use the EHR but only to access individual patient charts

[_]: We use the EHR in combination with another data analytic system

[_]: We do not use the EHR

8. Are your eligible providers participating in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program commonly known as Meaningful Use?:

[_]: Yes, all eligible providers at all sites are participating

[X]: Yes, some eligible providers at some sites are participating

[_]: No, our eligible providers are not yet participating

[_]: No, because our providers are not eligible

[_]: Not Sure

8a. If yes (a or b), at what stage of Meaningful Use (MU) are the majority (more than half) of your participating providers attested (i.e., what is the stage for which they most recently received incentive payments)?:

[X]: Received MU for Modified Stage 2

[_]: Received MU for Stage 3

[_]: Not Sure

8b. If no (c only), are your eligible providers planning to participate?:

[_]: Yes, over the next 3 months

[_]: Yes, over the next 6 months

[_]: Yes, over the next 12 months or longer

[_]: No, they are not planning to participate

9. Does your center use health IT to coordinate or to provide enabling services, such as outreach, language translation, transportation, case management, or other similar services?:

[X]: Yes

[_]: No

If yes, specify the type(s) of service: eCW CCMR, Care Plan, HEDIS, Texting, Messaging.

Other Data Elements

Other Data Elements

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

1a. How many physicians, certified nurse practitioners and physician assistants, on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?: 0

1b. How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?: 0

2. Did your organization use telehealth in order to provide remote clinical care services? (The term 'telehealth' includes 'telemedicine' services, but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.):

[_]: Yes

[X]: No

2a1. Who did you use telehealth to communicate with? (Select all that apply):

[_]: Patients at remote locations from your organization (e.g., home telehealth, satellite locations)

[_]: Specialists outside your organization (e.g., specialists at referral centers)

2a2. What telehealth technologies did you use? (Select all that apply):

[_]: Real-time telehealth (e.g., video conference)

[_]: Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)

[_]: Remote patient monitoring

[_]: Mobile Health (mHealth)

2a3. What primary telehealth services were used at your organization? (Select all that apply):

[_]: Primary care

[_]: Oral health

[_]: Behavioral health: Mental health

[_]: Behavioral health: Substance use disorder

[_]: Dermatology

[_]: Chronic conditions

[_]: Disaster management

[_]: Consumer and professional health education

[_]: Other (Please specify)

Other (Please specify):

2b. If you did not have telehealth services, please comment why (Select all that apply):

[_]: Have not considered/unfamiliar with telehealth service options

[_]: Lack of reimbursement for telehealth services

[X]: Inadequate broadband/telecommunication service (Select all that apply)

[_]: Lack of funding for telehealth equipment

[X]: Lack of training for telehealth services

[_]: Not needed

[_]: Other (Please specify)

Other (Please specify):

Inadequate broadband/telecommunication service (Select all that apply):

[_]: Cost of service

[X]: Lack of infrastructure

[_]: Other (Please specify)

Other (Please specify):

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists: 350

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Data Audit Report

Table 3A-Patients by Age and by Sex Assigned at Birth

Edit 03950: Numbers Questioned For Patients Aged 15 - 44. - Females age 15-44 is outside the typical range when compared to total patients age 15-44. Please correct or explain. Females aged 15-44 (836);Males aged 15-44 (1061);Ratio of Females age 15-44 to total patients age 15-44: (0.44)

Related Tables: Table 3A(UR)

Sonny Tran (Health Center) on 02/11/2019 9:06 PM EST: We have more male patients due to our Amity site. We serve a lot of ex-inmates from the county.

Table 5A-Tenure for Health Center Staff

Edit 05878: More Contracted Providers than Core Staff - It appears that you have more contracted Physician Assistants than you have for core staff. Please correct or explain.

Related Tables: Table 5A

Sonny Tran (Health Center) on 02/12/2019 3:34 AM EST: We used locum mid-levels as our core staff were either out on family leave or left the company. We are hiring staff physicans.

Table 5-Staffing and Utilization

Edit 04135: Substantial Inter-year variance in Providers - The number of Mid-Level FTEs reported on Line 10a Column a differs from the prior year. Current Year - (1.29). Prior Year - (1.79). Confirm that this is consistent with staffing changes and that the FTE is calculated based on paid hours.

Related Tables: Table 5(UR)

Sonny Tran (Health Center) on 02/13/2019 3:04 AM EST: In 2018 both of our full time mid levels left and we had to turn to part-time locums.

Edit 00809: Table 3A / 5 Patient Conflict - The total of Medical Patients reported on Line 15 Column c through Vision Service Patients reported on Line 22 Column c on Table 5 Universal (3534) equals the total patients reported on Table 3A (3534). This is only possible if there is only one category of service. Please correct or explain.

Related Tables: Table 5(UR), Table 3A(UR)

Sonny Tran (Health Center) on 02/13/2019 11:17 AM EST: We currently do not provide vision services.

Edit 03697: Table 3A / 5 Patient Conflict - The total of Medical Patients reported on Line 15 Column c, Dental Patients reported on Line 19 Column c and Other Professional Patients reported on Line 22 Column c on Table 5 Universal (3534) equals the total patients reported on Table 3A (3534). This is only possible if there is only one category of service. Please correct or explain.

Related Tables: Table 5(UR), Table 3A(UR)

Sonny Tran (Health Center) on 02/13/2019 11:18 AM EST: We currently do not provide dental services.

Edit 04093: Dental Visits per User - The number of dental visits per dental patient appears low when compared nationally. Please correct or explain. CY (0); Previous Year National Average (2.56).

Related Tables: Table 5(UR)

Sonny Tran (Health Center) on 02/13/2019 11:18 AM EST: We currently do not provide dental services.

Table 6A-Selected Diagnoses and Services Rendered

Edit 04356: Mental Health Patients questioned - More mental health patients are reported on Table 6A Line 20a Column (b) (853) than total mental health patients and a portion of the medical patients reported on Table 5 (697.4). Please correct or explain.

Related Tables: Table 6A(UR), Table 5(UR)

Sonny Tran (Health Center) on 02/13/2019 3:29 PM EST: We do not have an LCSW and a lot of our patients are diagnosed with mental health which they are referred to another mental health facility.

Table 6B-Quality of Care Indicators

Edit 03735: Inter-Year variance questioned - Current year prenatal patients Line 6 Column (a) (7) is substantially different from the prior year (26). Please correct or explain.

Related Tables: Table 6B

Christina Espersen (Reviewer) on 03/12/2019 9:39 AM EST: This news story is not generalizable to your organization nor is it an appropriate time frame. Please correct or provide additional detail why your prenatal population decreased by 73% from last year. Kedren serves a large male population based on our relationship with CorrrectCare through our satellite site Amity. This relationship, and services offered at this site continues to expand. Male inmates' transition through Amity, and receive primary health care services at our satellite site.

Edit 05788: Line 18 Universe in Question - Based on the universe reported for total patients with Ischemic Vascular Disease (IVD) on line 18 column A we estimate a prevalence rate of (1.02)%. This appears low compared to the prior year national average. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Christina Espersen (Reviewer) on 03/12/2019 9:42 AM EST: Your prevalence of IVD is only .68%, whereas national rates are closer to 3.5%. Please explain why your population has such a low prevalence. We reran the IVD report and the numbers are now 28/33 with an 84.85% compliance.

Edit 06161: Line 20 Universe in Question - You are reporting (0.26)% of total possible medical patients in the universe for Patients Seen Within 90 Days of First Diagnosis of HIV (Line 20 Column A). This appears high compared to medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Christina Espersen (Reviewer) on 03/12/2019 9:39 AM EST: This edit is essentially point out that a quarter of your HIV patient are recently identified. Please explain why this would be consistent with your practice and your patient population this year, or correct. Our patient population is at higher risk because our Amity/HR360 patient population receiving services once they are released from prison, as well as our large mental health population which we serve on campus. Based on our experience, these populations tend to seek care late. We know how important it is to capture HIV early, and have been focusing on screenings, ensuring we are capturing and referring patients, as needed. We also have an HIV specialist provider who is getting more exposure to patients.

Table 7-Health Outcomes and Disparities

Edit 06332: Diabetes Patients by Race or Ethnicity in Question - The total number of White patients with Diabetes reported on Table 7 (15) is low compared to total White patients reported on Table 3B (157). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Sonny Tran (Health Center) on 03/28/2019 4:39 PM EST: In the year 2018, We submitted to test 112 patients with Hemoglobin A1c labs who were white and got results back for 78 of those patients. 44 patients did not show to take their lab. We are working on training to continuously recall the 47 patients to remind them to get their labs done. In addition: Adults with mental illness who otherwise have no chronic conditions: As we are on the same campus of Kedren Mental Health, through our integrated care model we see patients who are seen by mental health providers but do not have a primary care provider. Because of the improved access due to location, these are patients who would otherwise often not see a medical provider. Adults in the re-entry program through the Correctional Department: We have a relationship with multiple transition sites which house men and women who are still in custody but not physically in prison. Through this relationship, we are able to conduct medical exams and help with the transition to the community. We conduct weekly office visits at one of the locations where they are housed, and also provide transportation to those who come to our home office. Again, this is a population who may have a lower rate of chronic disease but have less access to medical care, or would otherwise not choose to see a medical provider.

Edit 06333: Diabetes Patients by Race or Ethnicity in Question - The total number of More than One Race patients with diabetes reported on Table 7 (3) is low compared to total More Than One Race patients reported on Table 3B (46). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Sonny Tran (Health Center) on 03/28/2019 4:40 PM EST: In the year 2018, we submitted to test 29 patients with Hemoglobin A1c labs who were more than one race and got results back for 22 of those patients. 9 patients did not show to take their lab. We are working on training to continuously recall the 9 patients to remind them to get their labs done. In addition: Adults with mental illness who otherwise have no chronic conditions: As we are on the same campus of Kedren Mental Health, through our integrated care model we see patients who are seen by mental health providers but do not have a primary care provider. Because of the improved access due to location, these are patients who would otherwise often not see a medical provider. Adults in the re-entry program through the Correctional Department: We have a relationship with multiple transition sites which house men and women who are still in custody but not physically in prison. Through this relationship, we are able to conduct medical exams and help with the transition to the community. We conduct weekly office visits at one of the locations where they are housed, and also provide transportation to those who come to our home office. Again, this is a population who may have a lower rate of chronic disease but have less access to medical care, or would otherwise not choose to see a medical provider.

Table 8A-Financial Costs

Edit 04117: Cost Per Visit Questioned - Total Medical Care Cost Per Visit is substantially different than the prior year. Current Year (198.66); Prior Year (166.14).

Related Tables: Table 8A, Table 5(UR)

Sonny Tran (Health Center) on 02/12/2019 3:31 AM EST: This is correct. While our expenses increased, the number of our encounters were lower for 2018.

Edit 04129: Cost Per Visit Questioned - Other Professional Cost Per visits is substantially different than the prior year. Current Year (152.32); Prior Year (103.70).

Related Tables: Table 8A, Table 5(UR)

Sonny Tran (Health Center) on 02/12/2019 3:30 AM EST: This is correct. The number of our encounters were down in 2018 while our expenses increased.

Edit 04136: Costs and FTE Questioned - Other Professional Services are reported on Table 8A, Line 9 (14195)(Dietitian) and Table 5, Line 22 (0.11)(Dietitian) . Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Sonny Tran (Health Center) on 02/12/2019 3:29 AM EST: This is correct. We have a part-time dietitian who works an average of 5 hours per week and the average payment per month is $1,200

Edit 03772: Overhead Costs Questioned on Line 11 - You report direct costs for Table 8A Line 11 Column a (79592) but no overhead allocation has been made. Please check to see that the numbers are entered correctly.

Related Tables: Table 8A

Christina Espersen (Reviewer) on 03/28/2019 10:07 AM EST: Grantee corrected report

Edit 06303: Overhead Costs Questioned - You report (66456) on Table 8A Line 12a Column b, but no Direct costs in Column a. Please correct or explain.

Related Tables: Table 8A

Christina Espersen (Reviewer) on 03/28/2019 10:07 AM EST: Grantee corrected report

Table 9D-Patient Related Revenue (Scope of Project Only)

Edit 03994: Accounts Receivable not equal to zero - Line 2a, Capitated Medicaid Charges - Collections - Allowances does not equal zero (10108). Allowances for capitated plans are the difference between charges and payments unless payments are not received in the month of service. Please correct or explain.

Related Tables: Table 9D

Sonny Tran (Health Center) on 03/28/2019 4:43 PM EST: This is correct. We never receive the entire payments within the month. We normally expect payments without three months from the date of service.

Edit 04155: Inter-year Capitation PMPM questioned - The average Medicaid capitation PMPM reported on Line 2a (60.54) is significantly different from the prior year (88.11). Please correct or explain.

Related Tables: Table 9D, Table 4(UR)

Sonny Tran (Health Center) on 03/28/2019 4:44 PM EST: Total medicaid captiated payment $304,105/ Medicaid member month $23,592 = 12.89 PMPM

Edit 05099: PMPM collections in question - Medicaid Capitation PMPM (60.54) is outside the typical range. Check to see that the revenue and member months are entered correctly or explain.

Related Tables: Table 9D, Table 4(UR)

Sonny Tran (Health Center) on 03/28/2019 4:44 PM EST: Last year, we used the number of cap patients seen vs the total enrolled patients member months. Therefore, PMPM is 12.89 when taking medicaid cap payment and dividing by medicaid member months of enrolled patients.

Edit 03995: Accounts Receivable not equal to zero - Line 5a, Medicare Managed Care (capitated) - Collections - Allowances does not equal zero (5836). Allowances for capitated plans are the difference between charges and payments unless payments are not received in the month of service. Please correct or explain.

Related Tables: Table 9D

Sonny Tran (Health Center) on 03/28/2019 4:44 PM EST: This is correct. We never receive full payments within the same month. We normally expect payment within three months of service.

Edit 04007: Possible Material Reclassification Problem - The self pay collection rate (0.63) exceeds the combined collection rate for Medicare and Private Insurance (0.40). Suggests collections are being properly reclassified to secondary and subsequent payers but charges are not. Please correct or explain.

Related Tables: Table 9D

Sonny Tran (Health Center) on 03/28/2019 4:44 PM EST: This is correct. When MHLA patients order labs there are no CPT charges but we receive $30-$40 from the patients to do the labs. The system is also recording the patient co-pays as self-pay.

Edit 04062: Inter-year Medicare patients and charges Questioned - A (-20.75)% change in MEDICARE patients is reported, but (31.48)% in charges is reported. Review the report for consistency. Please correct or explain.

Related Tables: Table 9D, Table 4(UR)

Sonny Tran (Health Center) on 03/28/2019 4:43 PM EST: Although Medicare patients drop compared to the prior year, we have an increase in return visits from our current Medicare patients.

Edit 01965: Large change in accounts receivable for Total Other Public is reported - Total Other Public, Line 9: When we subtract collections (Column b) and adjustments (Column d) from your total Other Public charges (Column a) there is a large difference (32.98)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.

Related Tables: Table 9D

Sonny Tran (Health Center) on 03/28/2019 4:44 PM EST: We have not collected the payments. These are outstanding claims.

Edit 04216: Average Collections - A large change from the prior year in collections per medical+dental+mental health+vision+other professional visit is reported. Current Year (177.14); Prior year (159.51). Please review the information and correct or explain.

Related Tables: Table 9D, Table 5(UR)

Sonny Tran (Health Center) on 03/28/2019 4:43 PM EST: The amount collected this period included the prior years services.

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UDS Report - 2018

Comments

BHCMIS ID: 09E00280 - KEDREN COMMUNITY HEALTH CENTER, INC., Los Angeles, CA

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UDS Report - 2019

Contact Information

Do you self-identify as an NMHC?: No

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UDS Report - 2019

Patients by ZIP Code

ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
90017	2	11	0	4	**17**
90001	13	44	2	7	**66**
90002	7	50	6	1	**64**
90003	25	114	34	5	**178**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
90004	3	8	0	0	**11**
90006	8	12	0	1	**21**
90007	11	140	0	9	**160**
90008	5	37	2	1	**45**
90011	321	610	51	6	**988**
90013	4	17	1	0	**22**
90016	6	34	6	1	**47**
90018	7	22	10	2	**41**
90019	3	10	3	1	**17**
90026	3	13	0	0	**16**
90037	17	117	27	3	**164**
90043	3	44	5	0	**52**
90044	12	90	18	1	**121**
90047	3	50	6	3	**62**
90057	7	183	2	3	**195**
90058	0	10	2	0	**12**
90059	8	26	1	2	**37**
90061	7	45	9	2	**63**
90062	8	38	5	1	**52**
90201	7	12	0	0	**19**
90220	1	11	1	0	**13**
90221	2	9	4	0	**15**
90247	5	5	0	1	**11**
90250	6	9	1	0	**16**
90255	7	14	2	0	**23**
90280	2	9	1	0	**12**
90301	1	11	2	0	**14**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
90302	3	9	0	0	**12**

Other ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes	152	242	39	5	**438**
Unknown Residence	45	30	0	0	**75**
Total	**714**	**2086**	**240**	**59**	**3099**

Comments

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UDS Report - 2019

Table 3A - Patients by Age and by Sex Assigned at Birth

Universal

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1	5	5
2	Age 1	4	5
3	Age 2	4	7
4	Age 3	6	5
5	Age 4	4	3
6	Age 5	5	2
7	Age 6	8	4
8	Age 7	2	5

Line	Age Groups	Male Patients (a)	Female Patients (b)
9	Age 8	4	4
10	Age 9	7	3
11	Age 10	7	6
12	Age 11	9	7
13	Age 12	11	3
14	Age 13	10	11
15	Age 14	5	6
16	Age 15	6	3
17	Age 16	6	1
18	Age 17	5	6
19	Age 18	6	9
20	Age 19	19	10
21	Age 20	13	12
22	Age 21	25	17
23	Age 22	21	20
24	Age 23	33	27
25	Age 24	40	25
26	Ages 25-29	203	112
27	Ages 30-34	254	108
28	Ages 35-39	211	118
29	Ages 40-44	217	108
30	Ages 45-49	170	96
31	Ages 50-54	193	138
32	Ages 55-59	197	127
33	Ages 60-64	145	73
34	Ages 65-69	74	36
35	Ages 70-74	14	9
36	Ages 75-79	1	12

Line	Age Groups	Male Patients (a)	Female Patients (b)
37	Ages 80-84	2	4
38	Age 85 and over	1	5
39	**Total Patients (Sum of Lines 1-38)**	**1947**	**1152**

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UDS Report - 2019

Table 3B - Demographic Characteristics

Universal

Line	Patients by Race	Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1	Asian	0	38		**38**
2a	Native Hawaiian	0	4		**4**
2b	Other Pacific Islander	0	3		**3**
2	**Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)**	**0**	**7**		**7**
3	Black/African American	19	1117		**1136**
4	American Indian/Alaska Native	2	6		**8**
5	White	1112	170		**1282**
6	More than one race	3	15		**18**
7	Unreported/Refused to report race	230	343	37	**610**
8	**Total Patients (Sum of Lines 1 + 2 + 3 to 7)**	**1366**	**1696**	**37**	**3099**

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	562

Line	Patients by Sexual Orientation	Number (a)

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	28
14	Straight (not lesbian or gay)	2112
15	Bisexual	17
16	Something else	3
17	Don't know	111
18	Chose not to disclose	828
19	**Total Patients (Sum of Lines 13 to 18)**	**3099**

Line	Patients by Gender Identity	Number (a)
20	Male	1442
21	Female	836
22	Transgender Male/Female-to-Male	2
23	Transgender Female/Male-to-Female	4
24	Other	45
25	Chose not to disclose	770
26	**Total Patients (Sum of Lines 20 to 25)**	**3099**

Table 4 - Selected Patient Characteristics

Universal

Income as Percent of Poverty Guideline

Line	Income as Percent of Poverty Guideline	Number of Patients (a)

Line	Income as Percent of Poverty Guideline	Number of Patients (a)
1	100% and below	2785
2	101 - 150%	61
3	151 - 200%	8
4	Over 200%	5
5	Unknown	240
6	**TOTAL** (Sum of Lines 1-5)	**3099**

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**	23	691
8a	Medicaid (Title XIX)	169	1917
8b	CHIP Medicaid	0	0
8	**Total Medicaid** (Line 8a + 8b)	**169**	**1917**
9a	Dually Eligible (Medicare and Medicaid)	0	159
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	0	240
10a	**Other Public Insurance (Non-CHIP) (specify)**	0	0
10b	Other Public Insurance CHIP	0	0
10	**Total Public Insurance** (Line 10a + 10b)	**0**	**0**
11	**Private Insurance**	2	57
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)	**194**	**2905**

Managed Care Utilization

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months	24075	563	0	0	24638
13b	Fee-for-service Member Months					
13c	**Total Member Months** (Sum of Lines 13a + 13b)	24075	563	0	0	24638

Line	Special Populations	Number of Patients (a)
16	**Total Agricultural Workers or Dependents** (All health centers report this line)	3
23	**Total Homeless** (All health centers report this line)	441
24	**Total School-Based Health Center Patients** (All health centers report this line)	1
25	**Total Veterans** (All health centers report this line)	2
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	350

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Table 5 - Staffing and Utilization

Universal

Medical Care Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	1.06	3258	0	
2	General Practitioners	0	0	0	
3	Internists	0.2	1235	0	
4	Obstetrician/Gynecologists	0	0	0	
5	Pediatricians	0	0	0	
7	Other Specialty Physicians	0	0	0	
8	**Total Physicians** (Lines 1-7)	**1.26**	**4493**	**0**	
9a	Nurse Practitioners	1.72	5475		
9b	Physician Assistants	0.17	708		
10	Certified Nurse Midwives	0	0		
10a	**Total NPs, PAs, and CNMs** (Lines 9a-10)	**1.89**	**6183**	**0**	
11	Nurses	0	0		
12	Other Medical Personnel	3.28			
13	Laboratory Personnel	0.99			
14	X-ray Personnel	0			
15	**Total Medical** (Lines 8 + 10a through 14)	**7.42**	**10676**	**0**	**3099**

Dental Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
16	Dentists	0	0	0	
17	Dental Hygienists	0	0	0	
17a	Dental Therapists	0	0	0	
18	Other Dental Personnel	0			
19	**Total Dental Services** (Lines 16-18)	**0**	**0**	**0**	**0**

Mental Health Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a	Psychiatrists	0	0	0	
20a1	Licensed Clinical Psychologists	0	0	0	
20a2	Licensed Clinical Social Workers	0.29	239	0	
20b	Other Licensed Mental Health Providers	0	0	0	
20c	Other Mental Health Staff	0	0	0	
20	**Total Mental Health** (Lines 20a-c)	**0.29**	**239**	**0**	**189**

Substance Use Disorder Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21	**Substance Use Disorder Services**	**0.29**	**0**	**0**	**0**

Other Professional Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22	**Other Professional Services Specify** Dietitian	0.09	179		63

Vision Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists	0	0	0	
22b	Optometrists	0	0	0	
22c	Other Vision Care Staff	0			
22d	**Total Vision Services** (Lines 22a-c)	**0**	**0**	**0**	**0**

Pharmacy Personnel

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
23	**Pharmacy Personnel**	0			

Enabling Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
24	Case Managers	1.77	1177	0	
25	Patient/Community Education Specialists	0	0	0	
26	Outreach Workers	1.82			
27	Transportation Staff	0			
27a	Eligibility Assistance Workers	1.24			
27b	Interpretation Staff	0			
27c	Community Health Workers	0			
28	**Other Enabling Services Specify**	0			
29	**Total Enabling Services** (Lines 24-28)	**4.83**	**1177**	**0**	**798**

Other Programs/Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
29a	**Other Programs/ Services Specify** 0	0			
29b	**Quality Improvement Staff**	0			

Administration and Facility

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
30a	Management and Support Staff	2.57			
30b	Fiscal and Billing Staff	1.55			
30c	IT Staff	0.17			
31	Facility Staff	0			
32	Patient Support Staff	1.41			
33	**Total Facility and Non-Clinical Support Staff (Lines 30a-32)**	**5.7**			

Grand Total

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
34	**Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29**	**18.62**	**12271**	**0**	

Selected Service Detail Addendum

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)	5	689	0	453
20a02	Nurse Practitioners	5	374	0	306
20a03	Physician Assistants	1	53	0	41
20a04	Certified Nurse Midwives	0	0	0	0

Substance Use Disorder Detail

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)	5	525		352
21b	Nurse Practitioners (Medical)	5	624		485
21c	Physician Assistants	1	29		27
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers	1	4		4
21h	Other Licensed Mental Health Providers				

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Table 6A - Selected Diagnoses and Services Rendered

Universal

Selected Infectious and Parasitic Diseases

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	124	30
3	Tuberculosis	A15- through A19-, O98.0-	13	12
4	Sexually transmitted infections	A50- through A64- (exclude A63.0)	88	56
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	8	4
4b	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	559	148

Selected Diseases of the Respiratory System

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
5	Asthma	J45-	657	259
6	Chronic lower respiratory diseases	J40- through J44-, J47-	122	72

Selected Other Medical Conditions

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	42	27
8	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	60	33
9	Diabetes mellitus	E08- through E13-, O24-(exclude O24.41-)	2264	639
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	130	52
11	Hypertension	I10- through I16-, O10-, O11-	2480	787
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	93	76
13	Dehydration	E86-	1	1
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-	0	0
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	5057	1648

Selected Childhood Conditions (limited to ages 0 through 17)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
15	Otitis media and Eustachian tube disorders	H65- through H69-	8	7
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22-through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	0	0
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3	5	3

Selected Mental Health Conditions and Substance Use Disorders

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
18	Alcohol-related disorders	F10-, G62.1, O99.31-	119	51
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	87	64
19a	Tobacco use disorder	F17-, O99.33-	1076	506
20a	Depression and other mood disorders	F30- through F39-	691	404
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	258	148
20c	Attention deficit and disruptive behavior disorders	F90- through F91-	15	9
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	547	283

Selected Diagnostic Tests/Screening/Preventive Services

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
21	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806	2239	1245
21a	Hepatitis B test	**CPT-4:** 86704 through 86707, 87340, 87341, 87350	56	50
21b	Hepatitis C test	**CPT-4:** 86803, 86804, 87520 through 87522	163	146
22	Mammogram	**CPT-4:** 77065, 77066, 77067 OR **ICD-10:** Z12.31	249	197
23	Pap test	**CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	151	135
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4:** 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	302	260
24a	Seasonal flu vaccine	**CPT-4:** 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756	314	298
25	Contraceptive management	**ICD-10:** Z30-	91	65
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99381 through 99383, 99391 through 99393 **ICD-10:** Z00.1-	79	63
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4:** 83655	4	3
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0050	2	2
26c	Smoke and tobacco use cessation counseling	**CPT-4:** 99406, 99407 OR **HCPCS:** S9075 OR **CPT-II:** 4000F, 4001F, 4004F	231	197
26d	Comprehensive and intermediate eye exams	**CPT-4:** 92002, 92004, 92012, 92014	0	0

Selected Dental Services

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
27	Emergency services	**ADA:** D0140, D9110		
28	Oral exams	**ADA:** D0120, DO145, D0150, D0160, D0170, D0171, D0180		
29	Prophylaxis-adult or child	**ADA:** D1110, D1120		
30	Sealants	**ADA:** D1351		
31	Fluoride treatment-adult or child	**ADA:** D1206, D1208 **CPT-4:**99188		
32	Restorative services	**ADA:** D21xx through D29xx		
33	Oral surgery (extractions and other surgical procedures)	**ADA:**D7xxx		
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

Sources of Codes:
ICD-10-CM (2019)-National Center for Health Statistics (NCHS)
CPT (2019)-American Medical Association (AMA)
Code on Dental Procedures and Nomenclature CDT Code (2019)-Dental Procedure Codes. American Dental Association (ADA)
Note: "X" in a code denotes any number including the absence of a number in that place. Dashes (-) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead, they are used to point out that other codes in the series are to be considered.

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Table 6B - Quality of Care Measures

Universal

[X]: Prenatal Care Provided by Referral Only (Check if Yes)

Section A - Age Categories for Prenatal Care Patients:

Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)

Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15-19	
3	Ages 20-24	2
4	Ages 25-44	4
5	Ages 45 and over	1
6	**Total Patients** (Sum of Lines 1-5)	**7**

Section B - Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7	First Trimester	4	1
8	Second Trimester	1	0
9	Third Trimester	1	0

Section C - Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	7	7	3

Section D - Cervical Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	753	753	438

Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented	144	144	109

Section F - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	2905	2905	2785

Section G - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention	1838	1838	1351

Section H - Use of Appropriate Medications for Asthma

Line	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	111	111	70

Section I - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	455	455	269

Section J - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	35	35	30

Section K - Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	879	879	209

Section L - HIV Linkage to Care

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis	17	17	15

Section M - Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented	2308	2308	1436

Section N - Dental Sealants for Children between 6-9 Years

Line	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	0	0	0

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Table 7 - Health Outcomes and Disparities

Deliveries and Birth Weight

Line	Description	Patients (a)
0	HIV-Positive Pregnant Women	
2	Deliveries Performed by Health Center's Providers	

Hispanic/Latino

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White	1			
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino	**1**	**0**	**0**	**0**

Non-Hispanic/Latino

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino	**0**	**0**	**0**	**0**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
h	Unreported/Refused to Report Race and Ethnicity				
i	**Total**	1	0	0	0

Controlling High Blood Pressure

Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American	1	1	1
1d	American Indian/Alaska Native			
1e	White	214	214	135
1f	More than One Race			
1g	Unreported/Refused to Report Race	9	9	6
	Subtotal Hispanic/Latino	**224**	**224**	**142**

Non-Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
2a	Asian	5	5	5
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American	447	447	256
2d	American Indian/Alaska Native	1	1	0
2e	White	23	23	19
2f	More than One Race	2	2	1
2g	Unreported/Refused to Report Race	7	7	5
	Subtotal Non-Hispanic/Latino	**485**	**485**	**286**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
h.	Unreported/Refused to Report Race and Ethnicity	10	10	4
i	**Total**	**719**	**719**	**432**

Diabetes: Hemoglobin A1c Poor Control

Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American	3	3	1
1d	American Indian/Alaska Native	1	1	1
1e	White	187	187	78
1f	More than One Race			
1g	Unreported/Refused to Report Race	6	6	4
	Subtotal Hispanic/Latino	**197**	**197**	**84**

Non-Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
2a	Asian	3	3	1
2b1	Native Hawaiian	1	1	0
2b2	Other Pacific Islander	0	0	0
2c	Black/African American	169	169	80
2d	American Indian/Alaska Native	1	1	1
2e	White	9	9	1
2f	More than One Race	2	2	0
2g	Unreported/Refused to Report Race	13	13	6
	Subtotal Non-Hispanic/Latino	**198**	**198**	**89**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
h	Unreported/Refused to Report Race and Ethnicity	8	8	5
i	**Total**	**403**	**403**	**178**

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Table 8A - Financial Costs

Universal

* Column c is equal to the sum of column a and column b.

Financial Costs of Medical Care

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
1	Medical Staff	980563	886696	**1867259**
2	Lab and X-ray	36112	41048	**77160**
3	Medical/Other Direct	186472	276012	**462484**
4	**Total Medical Care Services (Sum of Lines 1 through 3)**	**1203147**	**1203756**	**2406903**

Financial Costs of Other Clinical Services

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
5	Dental			**0**
6	Mental Health	22867	18915	**41782**
7	Substance Use Disorder	22866	18915	**41781**
8a	Pharmacy not including pharmaceuticals			**0**
8b	Pharmaceuticals	42134		**42134**
9	**Other Professional Specify:** Dietitian	11733	9705	**21438**
9a	Vision			**0**
10	**Total Other Clinical Services (Sum of Lines 5 through 9a)**	**99600**	**47535**	**147135**

Financial Costs of Enabling and Other Services

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
11a	Case Management	87848		87848
11b	Transportation			0
11c	Outreach	81860		81860
11d	Patient and Community Education			0
11e	Eligibility Assistance	55575		55575
11f	Interpretation Services			0
11g	**Other Enabling Services Specify:**			0
11h	Community Health Workers			0
11	**Total Enabling Services Cost (Sum of Lines 11a through 11h)**	**225283**		**225283**
12	**Other Related Services Specify:**			0
12a	Quality Improvement		186354	186354
13	**Total Enabling and Other Services (Sum of Lines 11, 12, and 12a)**	**225283**	**186354**	**411637**

Facility and Non-Clinical Support Services and Totals

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
14	Facility	208514		
15	Non-Clinical Support Services	1229131		
16	**Total Facility and Non-Clinical Support Services (Sum of Lines 14 and 15)**	**1437645**		
17	**Total Accrued Costs (Sum of Lines 4 + 10 + 13 + 16)**	**2965675**		**2965675**
18	**Value of Donated Facilities, Services, and Supplies Specify:**			
19	**Total with Donations (Sum of Lines 17 and 18)**			**2965675**

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Table 9D - Patient Related Revenue

Universal

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliati Wrap-Around Current Year (c1)**	**Collection of Reconciliati Wrap-Around Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, etc. (c3)**	**Penalty / Payback (c4)**	**Allowances (d)**	**Sliding Fee Discounts (e)**	**Bad Debt Write Off (f)**
1	Medicaid Non-Managed Care	341662	332128					-15627		
2a	Medicaid Managed Care (capitated)	1434820	1207648				193794	269996		
2b	Medicaid Managed Care (fee-for-service)	0								
3	**Total Medicaid (Sum of Lines 1 + 2a + 2b)**	**1776482**	**1539776**	**0**	**0**	**0**	**193794**	**254369**		
4	Medicare Non-Managed Care	234855	87576					128374		
5a	Medicare Managed Care (capitated)	70648	61633					-426		
5b	Medicare Managed Care (fee-for-service)									
6	**Total Medicare (Sum of Lines 4 + 5a + 5b)**	**305503**	**149209**	**0**	**0**	**0**	**0**	**127948**		
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care	106867	88066					21190		

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wrap-Around Current Year (c1)	Collection of Reconciliati Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									
9	**Total Other Public (Sum of Lines 7 + 8a + 8b)**	**106867**	**88066**	**0**	**0**	**0**	**0**	**21190**		
10	Private Non-Managed Care	39492	5722					59652		
11a	Private Managed Care (capitated)									
11b	Private Managed Care (fee-for-service)									
12	**Total Private (Sum of Lines 10 + 11a + 11b)**	**39492**	**5722**			**0**	**0**	**59652**		
13	**Self-pay**	226985	41563						177795	
14	**TOTAL (Sum of Lines 3 + 6 + 9 + 12 + 13)**	**2455329**	**1824336**	**0**	**0**	**0**	**193794**	**463159**	**177795**	**0**

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Table 9E - Other Revenues

Universal

BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)

Line	Source	Amount (a)
1a	Migrant Health Center	
1b	Community Health Center	962359
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum Lines 1a through 1e)	**962359**
1k	Capital Development Grants, including School-Based Health Center Capital Grants	
1	**Total BPHC Grants** (Sum of Lines 1g + 1k)	**962359**

Other Federal Grants

Line	Source	Amount (a)
2	Ryan White Part C HIV Early Intervention	
3	**Other Federal Grants Specify:**	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Provider	8500
5	**Total Other Federal Grants** (Sum of Lines 2-3a)	**8500**

Non-Federal Grants Or Contracts

Line	Source	Amount (a)

Line	Source	Amount (a)
6	**State Government Grants and Contracts Specify:**	
6a	**State/Local Indigent Care Programs Specify:**	
7	**Local Government Grants and Contracts Specify:**	
8	**Foundation/Private Grants and Contracts Specify:** LA Care HHP Initiative, PRP Cycle 3, TCN grant, and Provider performance incentives from IPAs	313100
9	**Total Non-Federal Grants and Contracts (Sum of Lines 6 + 6A + 7 + 8)**	**313100**
10	**Other Revenue (non-patient related revenue not reported elsewhere) Specify:** Interest income from bank and insurances, LADWP Rule 17 correction, medical records fee, prop 56 paid by Health Net, Regal bonus.	34603
11	**Total Revenue (Sum of Lines 1 + 5 + 9 + 10)**	**1318562**

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Health Center Health Information Technology (HIT) Capabilities

HIT

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?:

[X]: Yes, installed at all sites and used by all providers

[_]: Yes, but only installed at some sites or used by some providers

[_]: No

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?:

[X]: Yes

[_]: No

1a1.Vendor: eClinicalWorks, LLC

Other (Please specify):

1a2.Product Name: eClinicalWorks

1a3.Version Number: 11e

1a4.ONC-certified Health IT Product List Number: 15.04.04.2883.eCli.11.00.1.171228

1a1.Vendor: Select one

Other (Please specify):

1a2.Product Name:

1a3.Version Number:

1b. Did you switch to your current EHR from a previous system this year?:

[_]: Yes

[X]: No

1c. How many sites have the EHR system in use?:

1d. How many providers use the EHR system?:

1e. When do you plan to install the EHR system?:

[_]: a. 3 months

[_]: b. 6 months

[_]: c. 1 Year or more

[_]: d. Not planned

2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing.):

[X]: Yes

[_]: No

[_]: Not Sure

3. Does your center use computerized, clinical decision support, such as alerts for drug allergies, checks for drug-drug interactions, reminders for preventive screening tests, or other similar functions?:

[X]: Yes

[_]: No

[_]: Not Sure

4. With which of the following key providers/health care settings does your center electronically exchange clinical information? (Select all that apply):

[X]: Hospitals/Emergency rooms

[X]: Specialty clinicians

[X]: Other primary care providers

[_]: None of the above

[_]: Other (please describe)

Other (please describe):

5. Does your center engage patients through health IT in any of the following ways? (Select all that apply):

[X]: Patient portals

[X]: Kiosks

[X]: Secure messaging

[_]: Other (please describe)

[_]: No, we do not engage patients using HIT

Other (please describe):

6. Question removed.

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?:

[X]: We use the EHR to extract automated reports

[_]: We use the EHR but only to access individual patient charts

[_]: We use the EHR in combination with another data analytic system

[_]: We do not use the EHR

8. Question removed.

9. Question removed.

10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply):

[X]: Quality improvement

[X]: Population health management

[X]: Program evaluation

[X]: Research

[_]: Other (please describe)

[_]: We do not utilize HIT or EHR data beyond direct patient care

Other (please describe):

11. Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?:

[X]: Yes

[_]: No, but we are in planning stages to collect this information

[_]: No, we are not planning to collect this information

12. Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply):

[_]: Accountable Health Communities Screening Tools

[_]: Upstream Risks Screening Tool and Guide

[_]: iHELP

[_]: Recommend Social and Behavioral Domains for EHRs

[X]: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

[_]: Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)

[_]: WellRx

[_]: Other (please describe)

[_]: We do not use a standardized screener

Other (please describe):

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Submission Status: Accepted

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Other Data Elements

Other Data Elements

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

a. How many physicians, certified nurse practitioners, and physician assistants,[1] on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?: 2

b. How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?: 0

2. Did your organization use telemedicine to provide remote clinical care services? ***(The term "telehealth" includes "telemedicine" services but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.)*****:**

[_]: Yes

[X]: No

2a1. Who did you use telemedicine to communicate with? (Select all that apply):

[_]: Patients at remote locations from your organization (e.g., home telehealth, satellite locations)

[_]: Specialists outside your organization (e.g., specialists at referral centers)

2a2. What telehealth technologies did you use? (Select all that apply):

[_]: Real-time telehealth (e.g., live videoconferencing)

[_]: Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)

[_]: Remote patient monitoring

[_]: Mobile Health (mHealth)

2a3. What primary telemedicine services were used at your organization? (Select all that apply):

[_]: Primary care

[_]: Oral health

[_]: Behavioral health: Mental health

[_]: Behavioral health: Substance use disorder

[_]: Dermatology

[_]: Chronic conditions

[_]: Disaster management

[_]: Consumer health education
[_]: Provider-to-provider consultation
[_]: Radiology
[_]: Nutrition and dietary counseling
[_]: Other (Please specify)

Other (Please specify):

2b. If you did not have telemedicine services, please comment why (Select all that apply):
[X]: Have not considered/unfamiliar with telehealth service options
[_]: Policy barriers (Select all that apply)
[_]: Inadequate broadband/telecommunication service (Select all that apply)
[X]: Lack of funding for telehealth equipment
[X]: Lack of training for telehealth services
[_]: Not needed
[_]: Other (Please specify)

Other (Please specify):

Policy barriers (Select all that apply):
[_]: Lack of or limited reimbursement
[_]: Credentialing, licensing, or privileging
[_]: Privacy and security
[_]: Other (Please specify)

Other (Please specify):

Inadequate broadband/telecommunication service (Select all that apply):
[_]: Cost of service
[_]: Lack of infrastructure
[_]: Other (Please specify)

Other (Please specify):

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists: 0

[1] With the enactment of the Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs) and physician assistants (PAs).

Workforce

Workforce

1. Does your health center provide health professional education/training? Health professional education/training does not include continuing education units.:

[X]: Yes

[_]: No

1a. If yes, which category best describes your health center's role in the health professional education/training process?:

[_]: Sponsor [2]

[X]: Training site partner [3]

[_]: Other (please describe)

Other (please describe):

2. Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category within the last year.

	Medical	**Pre-Graduate/Certificate (a)**	**Post-Graduate Training (b)**
1.	Physicians	24	10
	a. Family Physicians		
	b. General Practitioners		
	c. Internists		
	d. Obstetrician/Gynecologists		
	e. Pediatricians		
	f. Other Specialty Physicians		10
2.	Nurse Practitioners		
3.	Physician Assistants		
4.	Certified Nurse Midwives		
5.	Registered Nurses		
6.	Licensed Practical Nurses/Vocational Nurses		
7.	Medical Assistants	4	

	Dental	**Pre-Graduate/Certificate (a)**	**Post-Graduate Training (b)**
8.	Dentists		
9.	Dental Hygienists		
10.	Dental Therapists		

	Mental Health and Substance Use Disorder	**Pre-Graduate/Certificate (a)**	**Post-Graduate Training (b)**

	Mental Health and Substance Use Disorder	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
11.	Psychiatrists		10
12.	Clinical Psychologists		
13.	Clinical Social Workers		
14.	Professional Counselors		
15.	Marriage and Family Therapists		
16.	Psychiatric Nurse Specialists		
17.	Mental Health Nurse Practitioners		
18.	Mental Health Physician Assistants		
19.	Substance Use Disorder Personnel		

	Vision	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
20.	Ophthalmologists		
21.	Optometrists		

	Other Professionals	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
22.	Chiropractors		
23.	Dieticians/Nutritionists		
24.	Pharmacists		
25.	**Other please specify**		

3. Provide the number of health center staff serving as preceptors at your health center.: 2

4. Provide the number of health center staff (non-preceptors) supporting health center training programs.: 4

5. How often does your health center implement satisfaction surveys for providers?:

[_]: Monthly

[_]: Quarterly

[X]: Annually

[_]: We do not currently conduct provider satisfaction surveys

[_]: Other (please describe)

Other (please describe):

6. How often does your health center implement satisfaction surveys for general staff?:

[_]: Monthly

[_]: Quarterly

[X]: Annually

[_]: We do not currently conduct staff satisfaction surveys

[_]: Other (please describe)

Other (please describe):

[2] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).

[3] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).

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Data Audit Report

Table 3A-Patients by Age and by Sex Assigned at Birth

Edit 03950: Numbers Questioned For Patients Aged 15 - 44. - Females age 15-44 is outside the typical range when compared to total patients age 15-44. Please correct or explain. Females aged 15-44 (576);Males aged 15-44 (1059);Ratio of Females age 15-44 to total patients age 15-44: (0.35)

Related Tables: Table 3A(UR)

Sonny Tran (Health Center) on 02/14/2020 2:16 AM EST: Amity Foundation is dedicated to the inclusion and habilitation of people marginalized by addiction, trauma, criminality, incarceration, poverty, racism, sexism, homelessness and violence. Our male population comes from the Amity Foundation who are male patients.

Table 4-Selected Patient Characteristics

Edit 05938: Inter-year change in Medicare patients - The proportion of Medicare patients to total patients has significantly decreased when compared to prior year. Current Year ((7.74)%, (240)); Prior Year ((9.62)% (340)). Please review the insurance reporting to ensure the information reported is patient's primary medical care insurance. Please correct or explain.

Related Tables: Table 4(UR)

Sonny Tran (Health Center) on 02/15/2020 3:58 AM EST: This is correct. Our Medicare population decreased. We are working on provider stability to maintain our medicare patients.

Table 5-Staffing and Utilization

Edit 00024: Family Physicians Productivity Questioned - A significant change in Productivity (visits/FTE) of Family Physicians Line 1 (3073.58) is reported from the prior year (4844). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Sonny Tran (Health Center) on 02/15/2020 3:43 AM EST: We had an issue with physician stability and as we hired new physicians we spent the time to train and

onboard each of the physicians thus the productivity change.

Edit 00158: PA Productivity Questioned - A significant change in Productivity (visits/FTE) of PAs on Line 9b (4164.71) is reported from the prior year (3028.57). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Sonny Tran (Health Center) on 02/15/2020 3:24 AM EST: This is correct as we got a productive PA and worked consistent hours.

Edit 04135: Substantial Inter-year variance in Providers - The number of Mid-Level FTEs reported on Line 10a Column a differs from the prior year. Current Year - (1.89). Prior Year - (1.29). Confirm that this is consistent with staffing changes and that the FTE is calculated based on paid hours.

Related Tables: Table 5(UR)

Sonny Tran (Health Center) on 02/15/2020 3:32 AM EST: This is correct. We hired more FTEs.

Edit 06349: Mental Health Visit per Patient in Question - On Universal - Mental Health visits per mental health patient varies substantially from national average. CY (1.26); PY National Average (4.80). Please correct or explain.

Related Tables: Table 5(UR)

Sonny Tran (Health Center) on 02/15/2020 3:26 AM EST: We had difficulty finding an LCSW in a very competitive market. We just hired a new Psychologist and LCSW

Table 6B-Quality of Care Indicators

Edit 05772: Line 10 Universe in Question - You are reporting (63.64)% of total possible medical patients in the universe for the Childhood Immunization measure (line 10 Column A). This appears low compared to estimated medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Christina Espersen (Reviewer) on 03/31/2020 5:37 PM EST: Table 6B edit 05772 You do not have dental so this number should be closer to 3a (even though it would not match exactly due to different definitions). Since you have such a small number of children this age I would recommend running a report to look at all of them, and then audit charts. Please correct. grantee corrected and small numbers contribute to variance

Edit 05790: Line 19 Universe in Question - You are reporting (87.38)% of total possible medical patients in the universe for the Colorectal Cancer Screening measure (line 19 Column A). This appears low compared to estimated medical patients in the age group being measured. Please review and correct or explain

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Christina Espersen (Reviewer) on 03/31/2020 5:50 PM EST: Table 6b edits 5774, 6155, 6157, 6161 and 5790 “This is/data are correct” is not sufficient explanation. These universes are different from last year and too low given that you do not offer dental and vision and you offer very low levels of mental health services. Please read the UDS manual, rerun the reports and correct your numbers, or explain your validation process and why these numbers make sense. I am available for a phone call if needed. grantee did manual validation of numbers and corrected

Edit 06161: Line 20 Universe in Question - You are reporting (0.55)% of total possible medical patients in the universe for Patients Seen Within 90 Days of First Diagnosis of HIV (Line 20 Column A). This appears high compared to medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Christina Espersen (Reviewer) on 03/31/2020 5:51 PM EST: Table 6b edits 5774, 6155, 6157, 6161 and 5790 “This is/data are correct” is not sufficient explanation. These universes are different from last year and too low given that you do not offer dental and vision and you offer very low levels of mental health

services. Please read the UDS manual, rerun the reports and correct your numbers, or explain your validation process and why these numbers make sense. I am available for a phone call if needed. per grantee serves high risk population

Table 7-Health Outcomes and Disparities

Edit 05088: Deliveries in question - A large difference between deliveries and births is reported. Please correct or explain. Deliveries (1); Births (0).

Related Tables: Table 7

Sonny Tran (Health Center) on 03/31/2020 1:25 PM EST: two are still pregnant and a few others had abortions

Table 8A-Financial Costs

Edit 04129: Cost Per Visit Questioned - Other Professional Cost Per visits is substantially different than the prior year. Current Year (119.77); Prior Year (152.32).

Related Tables: Table 8A, Table 5(UR)

Sonny Tran (Health Center) on 02/15/2020 3:44 AM EST: This is correct as our dietitian worked additional hours in 2019.

Edit 04136: Costs and FTE Questioned - Other Professional Services are reported on Table 8A, Line 9 (11733)(Dietitian) and Table 5, Line 22 (0.09)(Dietitian) . Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Sonny Tran (Health Center) on 02/15/2020 3:04 AM EST: This is correct. The dietitian's rate is $65/hour.

Edit 03772: Overhead Costs Questioned on Line 11 - You report direct costs for Table 8A Line 11 Column a (225283) but no overhead allocation has been made. Please check to see that the numbers are entered correctly.

Related Tables: Table 8A

Christina Espersen (Reviewer) on 02/26/2020 6:00 PM EST: Table 8, edits 3772, 6303 Do you mean enabling and other services operates efficiently? You have reported very high overhead in other categories, possibly because it is not distributed over this and other lines. Please take a look at all overhead lines 1 – 10, 11 and 12-13 and correct or provide detailed explanation on how you account for and distribute overhead. Also, if you have quality improvement FTEs, you should be reporting cost in column a in addition to the extremely high overhead you reported in column b (which you most likely will be correcting).

Edit 06303: Overhead Costs Questioned - You report (186354) on Table 8A Line 12a Column b, but no Direct costs in Column a. Please correct or explain.

Related Tables: Table 8A

Sonny Tran (Health Center) on 02/15/2020 4:06 AM EST: QI costs are not accrued

Edit 03727: Inter-Year Variance Questioned - Current Year Facility costs vary substantially from last years cost for Line 14 Column a on Table 8A. (Current Year: (208514); Prior Year: (157560)). Please correct or explain.

Related Tables: Table 8A

Christina Espersen (Reviewer) on 03/31/2020 5:55 PM EST: Table 8A edit 3727. This edit is referring to facility cost – you cite cost of providers which is not applicable. Please correct or provide explanation. Facility cost consists of building leases, depreciation expenses, and non-capitalized equipment. In 2019, we bought more equipment ($61,000) than in 2018 ($4,000)

Edit 03945: Inter-Year variance questioned - Current Year Non-Clinical Support costs, Line 15 Column (a) (1229131) varies substantially from cost on the same line last year (993158). Please correct or explain.

Related Tables: Table 8A

Christina Espersen (Reviewer) on 03/31/2020 5:56 PM EST: Table 8 edit 3945 You are reporting an increase in administrative costs of $235,973 for two new positions and a position (CEO) that is usually exempt and not paid hourly. Just want to make sure I understand that that this is correct? The increase is due to administration time of CMO nd another CEO's time . CMO administration time is allocated 50% of her exempt salary. CEO is paid exempt at Mental Health. However, it depends how many hours CEO contributed to Kedren Clinic.

Table 9D-Patient Related Revenue (Scope of Project Only)

Edit 03994: Accounts Receivable not equal to zero - Line 2a, Capitated Medicaid Charges - Collections - Allowances does not equal zero (-42824). Allowances for capitated plans are the difference between charges and payments unless payments are not received in the month of service. Please correct or explain.

Related Tables: Table 9D

Sonny Tran (Health Center) on 02/14/2020 10:43 PM EST: We are still collecting payments from Medicaid. Medicaid pays us within 2 weeks of claims submission.

Edit 05099: PMPM collections in question - Medicaid Capitation PMPM (58.21) is outside the typical range. Check to see that the revenue and member months are entered correctly or explain.

Related Tables: Table 9D, Table 4(UR)

Christina Espersen (Reviewer) on 02/26/2020 6:04 PM EST: Table 9d, edit 5099 Yes, most of your patients are Medicaid, but it is calculated per patient and this amount is high compared to state and national averages. Please explain how this number was validated.

Edit 03995: Accounts Receivable not equal to zero - Line 5a, Medicare Managed Care (capitated) - Collections - Allowances does not equal zero (9441). Allowances for capitated plans are the difference between charges and payments unless payments are not received in the month of service. Please correct or explain.

Related Tables: Table 9D

Sonny Tran (Health Center) on 02/14/2020 8:02 PM EST: We received payment after the month of service from our IPAs (Mediconnect and Medi Medi respectively)

Edit 02028: Large change in accounts receivable for Total Private is reported - Total Private, Line 12: When we subtract collections (Column b) and adjustments (Column d) from your total Private charges (Column a) there is a large difference (-65.54)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.

Related Tables: Table 9D

Sonny Tran (Health Center) on 02/14/2020 8:00 PM EST: We did an adjustment on private insurance from the last year 2018 as we expected to get paid less than what was expected.

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Comments

Report Comments

Not Available

Table 7 Comments

3 stillbirths, 2 still pregnant and 1 gave birth.

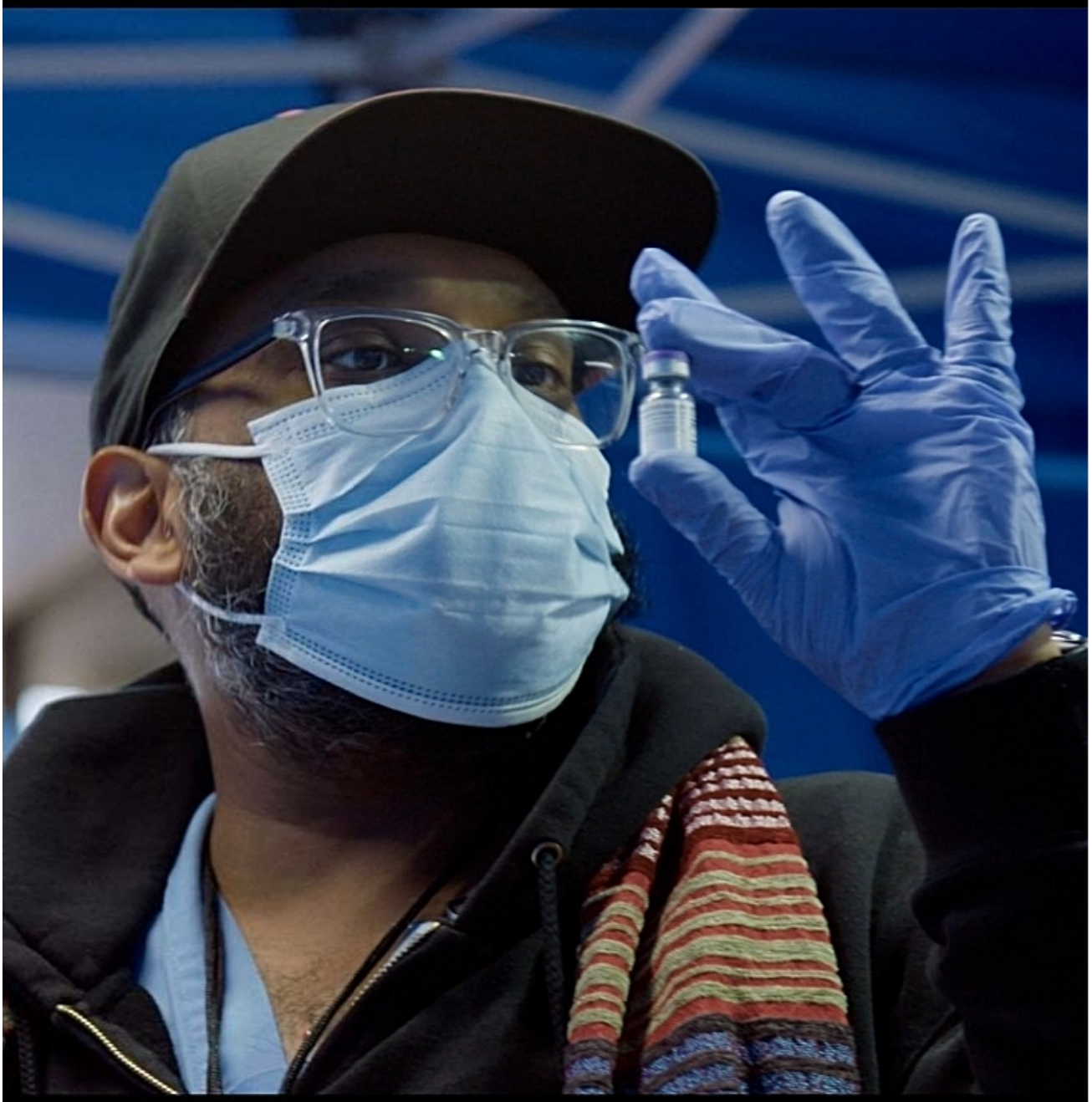
Table 8A Comments

Financial Cost reported in Table 8A = $2,965,675.04. Total expense per Statement of Rev and Exp = $ 2,965,675.04. No difference.

Table 9E Comments

The prior year 2016 UDS, we included MHLA payments here in Table 9E, instead of in Table 9D. However, after attending a seminar about UDS, we were advised to enter MHLA payments in Table 9D.

vicenews
Los Angeles, California



581 likes

vicenews Kedren Community Health Center serves people of color in South Los Angeles, and is taking the reins to vaccinate those who may otherwise be left behind. We visit on #VICENewsTonight at 11PM ET on @VICETV. 📸 @jefemercado

View all 9 comments

State of California

OFFICE OF THE GOVERNOR

Gavin Newsom

February 25, 2021

Dr. Jerry Abraham
Director of Vaccine Programs
Kedren Health
4211 S Avalon Blvd
Los Angeles, CA 90011

Dear Dr. Abraham,

Thank you again for hosting me and my team at the Kedren Community Health Center. I deeply appreciated having the opportunity to see first-hand the impressive work you have done to equitably vaccinate our most vulnerable communities.

Your clinic serves as a model for not only our state, but the entire nation on how to ensure no one gets left behind in our fight against COVID-19. I am grateful Californians can count on you to keep them healthy and safe in these unprecedented times

Sincerely,

Gavin Newsom
Governor of California

Vaccinate ALL 58
Together we can end the pandemic.

5 Point Plan for Vaccination Equity

Equity is the state's "North Star" and California is committed to health and racial equity.

The COVID-19 pandemic has highlighted not only the disproportionate impact of this virus, but also the importance of focusing interventions and resources to address the health of those disproportionately impacted, including communities of color and the disabled. Consequently, as part of the vaccine distribution process, a vaccine equity framework is proposed and includes the following components.

This is not only the right thing to do, but will also help reduce the severity of the pandemic.

These are the 5 concrete steps the state is taking to ensure equity.

Allocation. Experts including medical doctors and health equity experts at the Department of Public Health will determine an allocation formula where communities most impacted by COVID-19 receive a disproportionate share of vaccines. The state will also allocate appointments to local communities at many clinics via the My Turn appointment registration system.

Network. The third party administrator (TPA) will ensure that the state vaccine provider network includes appropriate access in disproportionately impacted communities and supplements this access with evening/extended hours, transportation services, translation services, home-bound services, mobile vaccine services, and physical accessibility features at vaccination events, for example. The TPA would also implement pay for performance payments to recognize a provider's success in vaccinating persons who live in these communities and vaccine providers who collect data to document racial/ethnic equity in vaccine distribution.

Community Partners. Community based organizations have been providing critical services and information to Californians during the pandemic and are key partners in reaching Californians who have been disproportionately impacted by COVID-19. To leverage the work they've been doing, the state will invest $30 million to support 150 community organizations to continue their outreach in target communities and to educate, motivate and activate Californians to get vaccinated when it's their turn.

Data Analytics. My Turn will be the lynchpin of the state's efforts to understand the demographics of vaccine recipients. The TPA will perform real-time data analytics to understand how the doses administered in certain zip codes compare to the age and sector prioritization framework that will be reviewed by health equity experts to adjust and intensify targeted efforts and resource allocations.

Public Education. State will provide consistent messaging through a public education campaign, create in-language content with cultural humility, and meet Californians where they are in order to reach California's diverse populations.

Additional details will continue to be shared they are finalized.

DRAFT

Vaccinate ALL 58
Together we can end the pandemic.

Talking Points for Black / African American Media Briefings
Updated 3.5.21

EMCEE (REGINA WILSON)

- My name is Regina Wilson with California Black Media, and I will be your emcee for this program.

- California Black Media is hosting a series of news briefings on COVID-19 vaccinations in partnership with the State of California and The Center at Sierra Health Foundation. These updates, targeted to African American and Black media in California, are designed to provide critical information about vaccine access, safety and equity for our communities.

- The series is nicknamed "Getting Smarter on COVID-19." It aims to equip Black journalists with quality data and new insights that enables you to provide readers with information that is truthful, trustworthy and authoritative.

- As we have learned throughout this pandemic, Black and African American communities are disproportionately impacted by COVID-19. Nationwide, Black people have died at 1.4 times the rate of white people. This panel will give context to these health disparities, and what the state is doing to address them.

- While the speakers are presenting, we request that you ask your questions in the chat. We will prioritize questions that were submitted in advance. Speakers and I will respond to the questions following the briefing.

- Now, I want to welcome our speakers who will discuss how communities can continue to stay safe, provide updates on the state's vaccine distribution process, and will discuss the safety and efficacy of the vaccine, as well as resources for our community.

- Our speakers include:
    - Secretary Yolanda Richardson from the California Department of Government Operations, who is the chief architect of the state's vaccine distribution process.
    - Kimberley Goode, Senior Vice President of External Affairs for Blue Shield of California and a key leader in vaccine distribution.
    - Dr. Oliver T. Brooks, chief medical officer of the Watts HealthCare Corporation, who is on the frontlines of care delivery, and

- Dr. Jerry P. Abraham, who is leading innovative and collaborative efforts to reach members of the community from the Kedren Community Health Center.

- Before we turn things over to Secretary Richardson, we are going to hear from recently vaccinated individuals [INSERT NAMES HERE] who will share their vaccination stories.

VACCINATED INDIVIDUALS (10 MINS)

REGINA WILSON TRANSITION: Thank you for sharing your stories. Next, I would like to introduce Secretary Richardson to discuss vaccine rollout.

NEWSOM ADMINISTRATION (SECRETARY RICHARDSON):

- Thank you for having me here for this important discussion. I am first and foremost focused on ensuring there are no barriers to the rapid, equitable delivery of vaccines in sync with supply arrival in our state.

- California has worked aggressively to accelerate vaccine distribution statewide. We are witnessing case rates and hospitalizations throughout the state continue to decrease and vaccinations continue to increase, which is exactly where we want to be. Yet, we must continue to all do are part by wearing our masks, washing our hands and staying six feet apart.

- It is encouraging that positivity rates, hospitalizations, and deaths continue to trend downward and vaccinations rise. By the end of February, more than 8.2 million Californians have been inoculated against the deadly virus.

- The addition of the Johnson and Johnson vaccine will help us get vaccines to the areas hardest to reach, including rural areas, community clinics and local physician offices and pharmacies.

- Our vaccine delivery system focuses on both speed and equity, ensuring our most vulnerable communities get vaccines.

- California is modifying the Blueprint for a Safer Economy to include a vaccine equity metric that allows for opening activities when vaccines have been deployed to the hardest-hit communities. This modification will shift Blueprint tier thresholds to allow slightly higher case rates per 100,000 population once more inoculations have occurred in the communities suffering the most, allowing counties to move to less restrictive tiers.

- The initial goal of the vaccine equity metric is to deliver a minimum of 2 million doses to the hardest-hit quarter of the state as measured by the Healthy Places Index. We expect to reach that goal sometime in the next two weeks.

- The vaccine eligibility standard currently prioritizes health care workers, individuals 65 and over, and workers in education and childcare, emergency services, and food and agriculture.

- From there, a statewide, age-based eligibility standard will apply, allowing for maximum vaccine distribution to communities, especially those communities hardest hit and most at-risk from COVID-19.

- The streamlined system is intended to cut any lag time and remove all barriers between vaccine arrival and getting those vaccines into arms quickly and equitably.

- The website, MyTurn.ca.gov, serves as the state's "front door" to getting vaccinated where Californians can learn when they are eligible, sign up for notifications, and schedule an appointment when eligible. Individuals can visit the website and register immediately to be notified when they're eligible.

- For those without internet or digital know-how, there is a hotline 1-833-422-4255 with multiple language options, materials translated into multiple languages and resources provided through community-based organizations directly to individuals.

- Getting a COVID-19 vaccine is free for everyone. Californians who lack insurance can get the vaccine at no cost, as can those who are undocumented.

- Real time data will inform where adjustments are to be made if priority groups and targeted inoculations aren't being met.
    - [INSERT DATA HERE]
    - If provided the opportunity, we encourage folks to share their demographic on My Turn. This information will remain protected data and gives the state a better understanding of its reach to different communities.

- For more information about the distribution of vaccines, go to VaccinateAll58.com, your local public health agency, or the state's website, MyTurn.ca.gov, where they can sign up to be notified when they are eligible to receive the vaccine.

REGINA WILSON TRANSITION: Thank you for your insights and joining us today. Next, I would like to introduce Kimberley Goode from Blue Shield of California.

DISTRIBUTION EXPERT: (KIMBERLEY GOODE)

Background on Blue Shield's partnership with California

What does an "equitable distribution" mean?

What is the state and Blue Shield doing to achieve an equitable distribution?

- Communicating the need to receive the vaccine, particularly for those in health care, seniors and those with compromised health is a key focus of our efforts. California's diverse population make-up requires this community approach, so everyone is reached and can fully understand the vaccine is safe, it is highly effective, and it is the only way to stop the pandemic.

- We are targeting high-risk and disproportionately impacted communities across the state through television and radio PSAs, digital and social media advertisements, billboards and signage. We are trying to educate and reach as many Californians as possible in a variety of ways.

- The state has also expanded outreach to community-based organizations working directly with disproportionately impacted communities. There are 170 community-based organizations funded to conduct outreach to vulnerable communities.
    - California Black Women's Health Project, Somali Family Service of San Diego, African American Family & Cultural Center and many more.

REGINA WILSON TRANSITION: Thank you Kimberley. Next, I would like to introduce Dr. Oliver Brooks from the Watts HealthCare Corporation.

MEDICAL EXPERT: (DR. OLIVER BROOKS)

- California is continuing to accelerate distribution of COVID-19 vaccine to individuals in all of California's 58 counties. An additional vaccine—the Janssen COVID-19 vaccine from Johnson & Johnson—requires only one shot and is now approved for use here in the U.S.

- What we really want people to know is that all three vaccines are safe and highly effective, and Californians should get the one most available to them as soon as they're eligible.

- When it comes to comparing vaccine efficiency, as the head of the National Institute of Allergy and Infectious Diseases, Dr. Anthony Fauci, points out that the three vaccines were "not compared head-to-head."

- All vaccines went through rigorous testing and weren't compared during trials, so their various efficacy rates can't be either. But remember, the new Johnson & Johnson vaccine is similar to the Pfizer and Moderna vaccines in offering high levels of protection against becoming severely ill (including hospitalization and death).

- On the days after receiving the COVID-19 vaccine, you may have a sore arm, aches, fatigue or fever, but these are not harmful.

- As with any other vaccine, medical experts remind us that mild symptoms are normal and are a sign that the body is building immunity. Not everyone may experience side effects; either way, the vaccines have proven to be effective for all of us.

- The arrival of a new vaccine is welcomed news, especially for those of us on the front lines of this crisis, like at the Watts HealthCare Corporation.

- The Johnson & Johnson vaccine is easier to distribute to hard-to-reach places that might not have access to the same types of freezers needed for the Pfizer and Moderna vaccines, as the new vaccine can be stored in a normal refrigerator. Hard-to-reach communities include people who may not be able to come back for a second dose of vaccine or want to complete the vaccine series with just one shot. Difficult to reach places also include rural areas, community clinics, small physician offices and pharmacies. Because of this, the new vaccine will be an important tool in our fight against COVID-19 and can lead to more efficient vaccine distribution and administration.

- Share experience operating a testing site at the Watts HealthCare Corporation. Questions to answer:
    - The duration of the vaccine; do you need to get tested after receiving the vaccination?

- All individuals, including those who have been vaccinated, should keep following the safety basics:
    - **Wear a mask** whenever outside your homes or indoors with people from outside your household.
        - An effective mask has a good fit – no gaps and does not fog up glasses – and good filtration, which means it has multiple layers.
        - "Double masking" is an effective way to improve fit and filtration.
    - **Wash your hands.**
    - **Watch your distance**.
    - **When it's your turn**, get vaccinated.

- Variants continue to be a threat and that's why we all need to get vaccinated with the COVID-19 vaccine that is available to us. I encourage all Californians to get vaccinated when it is their turn and keep wearing your mask, because the pandemic is not over yet.

REGINA WILSON TRANSITION: Thank you for your expertise and joining us today. Next, I would like to introduce Dr. Jerry Abraham.

COMMUNITY REPRESENTATIVE: (DR. JERRY ABRAHAM)

- Observations and experiences from Kedren Community Health Center.

- How Kedren Community Health Center is ensuring equitable distribution of the vaccines.

- Community vaccination events are only one way for eligible Californians to receive their vaccines. When available, the public can also go to their doctor or pharmacy to receive the vaccine.

- We want to reiterate the safety and efficiency of vaccines and utilizing My Turn and the call center to determine vaccine eligibility.

- We also want to underscore that vaccines are free and California law strictly limits how personal information about those who are vaccinated can be shared.

- Lastly, we encourage folks to visit the state's COVID19.CA.GOV website for all the latest information on COVID-19, vaccines as well as resources for financial help.

EMCEE (REGINA WILSON)

Thank you to our speakers. Before we start the Q&A, we want to take the time to show a brief video about an open and honest conversation between W. Kamau Bell and Black doctors, nurses and researchers that gets to the heart of Black people's questions about the COVID-19 vaccines.

https://www.youtube.com/watch?v=qp6S4C6zG_M&t=1s

We will now start the Q&A. Please submit your questions to the chat, and my colleague Tanu will facilitate the conversation.

African American Physicians Against COVID-19
Los Angeles, CA

March 6, 2021

United States Senate
Committee on Health Education, Labor, and Pensions
106 Dirksen Senate Office Building
50 Constitution Ave NE,
Washington, DC 20002

We are African-American physicians who have, and continue to, serve the predominantly African-American and Latinx men, women and children living in and around South Los Angeles or Service Planning Area 6 for decades. There has been a disproportionately negative impact of COVID-19 on these communities and, as of this past week the mortality rate from COVID-19 among African-Americans is 175 per 100 thousand, compared to 111 for non-Hispanic whites. The mortality rate for the West Adams area is 514 per 100 thousand, compared to 46 per 100 thousand in, the more affluent area, Westwood.

These dreadful statistics reflect our concern for the largely African-American and Latinx patients who have had little to protect themselves from contracting COVID-19. Relevant factors include inability to "stay at home" due to the need for income, living in multi-family and multi-generational housing, -employment as essential workers, or being unable to telework because of the nature of their jobs or the lack of high speed internet in their communities. Moreover, they are at greater risk for poor outcomes if infected with COVID-19 as South Los Angeles is a region where 18% of the population is uninsured, roughly 30% live below the federal poverty level, , and 33% of residents report difficulty accessing medical care. Additionally, there is a 34% adult obesity rate, 12% diabetes rate, and 25% of adults in the area have hypertension. According to the CDC, all of these conditions increase a person's risk of severe illness from COVID-19.

As such, accessing and receiving one of the three new EUA-approved vaccines is the only realistic option to address the racial and socioeconomic inequities in COVID -19 infection in these areas.

Interestingly, those among us who are community-based physicians and other health care workers were unable to receive the vaccines early in the vaccine period of Phase 1a because –the vaccines were distributed to hospitals and those hospitals only gave it to healthcare workers who were on their staffs. Many of the community-based physicians no longer maintain hospital privileges. The early rollout strategy neglected them and the other healthcare workers in their offices. Moreover, many of our patients who, having overcome barriers of mistrust and now wanting to be vaccinated, have also been unable to get vaccinated due to geographically inaccessible vaccine locations and inaccessible vaccine registration systems.

One bright light in the midst of this horror show of the COVID-19 pandemic, has been Dr. Jerry Abraham of Kedren Health who has proven that he and his staff excel at vaccinating against this scourge. He has done this by reaching out to those of us who are being left behind, those in our community who have been unable to overcome the obstacles of the mainstream vaccination hubs, or those who just trust their local providers. Kedren has been, and is, key to getting "shots into arms", especially Black and Brown arms, and has been a lifesaving hub through which we have been able to get ourselves, our colleagues, and our patients vaccinated. This South Los Angeles facility has provided over fifty-two thousand doses during the 2+ months since December 30th.

Given the cultural complexities of caring for African Americans, the excess risk noted above, and the demonstrated track record of success in vaccinating those in communities at greatest risk, granting the Kedren Clinic **FEMA status,** and providing them with vaccination volumes commensurate with others with high volume vaccine allocations, must be a priority. This is especially true when noting some of the other – sites with FEMA designation are serving communities with lower burdens of death, disease, and risk. This must be done with the immediate sense of urgency that the Federal Emergency Management Agency is supposed to, by definition, manage. If this is not an emergency, then please let us know what is.

Let's recognize and support Kedren's heroic efforts and stem the tide of this tragedy in the African American community.

Sincerely,

Oliver T Brooks, MD
Chief Medical Officer, Watts Healthcare Corporation
Past-President National Medical Association

Toni Chavez-Greene MD
Chief Executive Officer
De Novo Health

Willie H. Goffney, MD FACS
Advanced Surgical Associates
President, Charles R. Drew Medical Society

William D. King MD, JD, AAHIVS, FCLM
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W King Health Care Group

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Alexander Rodgers, MD
Assistant Professor, Family Medicine
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Roberto B. Vargas III, MD, MPH
Assistant Dean, Health Policy
College of Medicine, Charles R. Drew University

In humble admiration, gratitude, and solidarity:
Jerry P. Abraham, MD MPH CMQ
Family & Community Medicine Physician
Director, Vaccine Program, Kedren Health

RAND CORPORATION
OBJECTIVE ANALYSIS.
EFFECTIVE SOLUTIONS.

What Contributes to COVID-19 Vaccine Hesitancy in Black Communities, and How Can It Be Addressed?

by Laura M. Bogart, Lu Dong, Priya Gandhi, Samantha Ryan, Terry L. Smith, David J. Klein, Luckie-Alexander Fuller, Bisola O. Ojikutu

Related Topics: African-American Populations, Coronavirus Disease 2019 (COVID-19), Neighborhood Influences on Health, Racial Equity, Vaccination

Citation Embed View related products

Recent polls show that Black Americans are less willing than Americans of other races or ethnicities to be vaccinated for COVID-19. These lower vaccination rates among Black Americans would further widen COVID-19 inequities in diagnosis, hospitalization, and mortality. A main driver of hesitancy among Black Americans is thought to be general mistrust of health care systems and providers. Such mistrust has arisen in Black communities as an understandable, rational, and self-protective reaction to history, knowledge, and continuous and repeated discrimination, racism, and harmful experiences toward Black Americans by the health care system, health care providers, and the U.S. government. Such repeated, systemic discrimination experiences, as well as the perceived failure of health care organizations to take authentic measures to build trust and become more trustworthy, have led to avoidance of health care among Black Americans, which may translate further into unwillingness to accept COVID-19 vaccination.

Research Questions

1. Why are Black Americans less willing to get a COVID-19 vaccine than Americans of other races or ethnicities?
2. How trusted are health care providers and public health officials?
3. How trusted are elected local and federal officials?
4. What contributes to mistrust in the COVID-19 vaccine?
5. What messaging strategies would be effective in encouraging COVID-19 vaccine

acceptance in the Black community?

To support efforts to reduce COVID-19 vaccine hesitancy in Black communities, RAND Corporation researchers conducted a survey of Black Americans in November–December 2020 to better understand the drivers of such reluctance. The researchers also conducted follow-up interviews with survey respondents who expressed hesitancy. Based on the results of the survey and interviews, the authors engaged with community stakeholders to identify an initial set of public health messaging and communication strategies likely to be successful in addressing COVID-19 vaccine hesitancy and increasing vaccination in Black communities.

Key Findings

- This survey of a nationally representative sample of 207 Black Americans (conducted in November–December 2020) found high levels of vaccine hesitancy and mistrust of COVID-19 vaccines in the overall sample, and among health care workers in particular.
- Those who expressed vaccine hesitancy also showed high levels of overall mistrust, concerns about potential harm and side effects, and lack of confidence in vaccine effectiveness and safety.
- Participants reported higher trust in COVID-19 information from health care providers and public health officials than from elected local and federal officials.
- Mistrust of the government's motives and transparency around COVID-19, as well as beliefs about racism in health care, appear to be contributing to mistrust of the vaccine.
- Black Americans attribute their mistrust of vaccines in general and COVID-19 vaccines in particular to systemic racism, including discrimination and mistreatment in health care, as well as by the government.

Recommendations

- Public health messages and communication strategies to address vaccine hesitancy should be tailored through authentic community engagement over the short term. In addition, it is critical to increase the trustworthiness of health care organizations, pharmaceutical companies, and the government over the long term.
- COVID-19 vaccine messaging should first acknowledge systemic racism as a justifiable reason for mistrust before providing information about the vaccine.
- Education and dialogue to address health care providers' concerns are essential, because these providers have the credibility to address vaccine hesitancy in Black communities, but many Black health care workers in our survey reported hesitancy to take the vaccine themselves.

Research conducted by

RAND
HEALTH CARE

Funding for this research was provided by gifts from RAND supporters and income from operations. The research was carried out within the Access and Delivery Program in RAND Health Care.

This report is part of the RAND Corporation research report series. RAND reports present research findings and objective analysis that address the challenges facing the public and private sectors. All RAND reports undergo rigorous peer review to ensure high standards for research quality and objectivity.

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Senate HELP testimony: California Heat Maps for Vaccine Distribution

1 message

Elizabeth McNeil <emcneil@cmadocs.org> Thu, Mar 4, 2021 at 5:16 PM
To: Jerry Abraham <ba8355a8-c6b3-4168-b195-6ccd8c8c13d9@exch030.domain.local>, Anthony York <AYork@cmadocs.org>, Janus Norman <JNorman@cmadocs.org>, Cynthia Brown <Cynthia.Brown@ama-assn.org>, "AMA (jason.marino@ama-assn.org)" <jason.marino@ama-assn.org>

See below

From: Dustin Corcoran <dcorcoran@cmadocs.org>
Sent: Thursday, March 4, 2021 3:59 PM
To: Elizabeth McNeil <emcneil@cmadocs.org>
Subject:

Here is Version 3.3 of the CMA Map Book. This mid-day revision focuses on disabled populations and adds or revises the following:

- Heat Map of HPI Scores* by Census Tract with Number of Disabled Populations (All Ages), (Page 21)
- Map of Drive Time Rings to County Fair Locations (including OES Mobilization Sites) within 1 hour shown with Number of Disabled Populations (All Ages), (Page 23)
- Heat Map of IHSS Recipients Age 16 – 64 by Zip Code, (Page 24)
- Heat Map of Metro/Central Los Angeles HPI Scores* with Numbers of IHSS Recipients Age 16 – 64, (Page 25)
- Proportion of IHSS Consumers (All Ages) by Housing Type, (Page 26)
- Number of IHSS Consumers (All Ages) by Zip Code with Lowest HPI Quartile by Census Tract, (Page 27)
- Heat Map of IHSS Recipients Age 16 – 64 in Proximity to Clinics with Total Drive Time Rings (10/20/30 minutes, (Page 30)

To download the CMA Map Book (PDF file 16.6 Megabytes) following this link:

Download CMA Map Book v3.3 (PDF)

MAP BOOK

Demographic Considerations for COVID-19 Vaccine Distribution

Revision 3.4 – March 4, 2021

MAP BOOK

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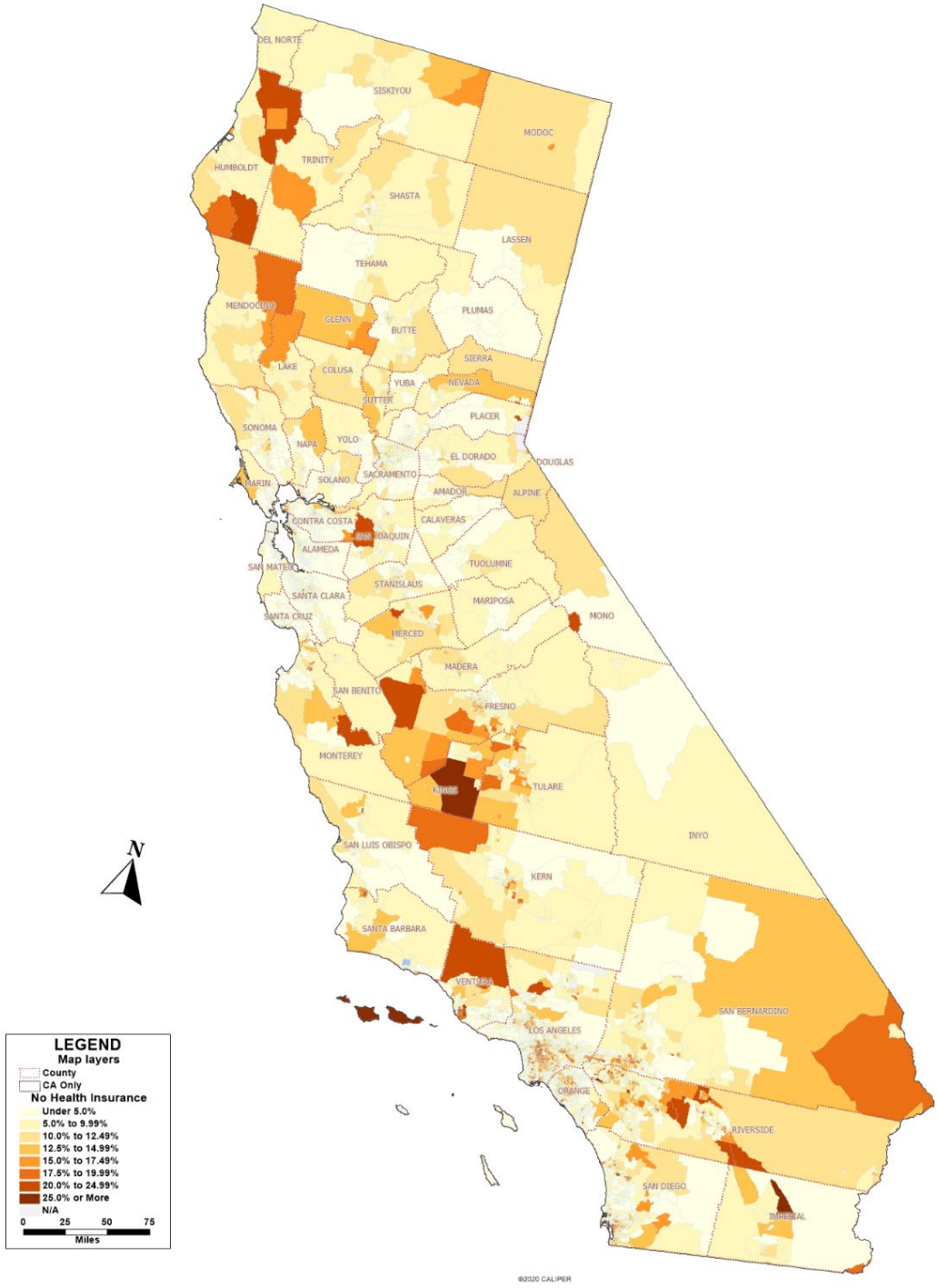
NOTE TO THE READER & LEGAL DISCLAIMER:

The information contained in these maps was sourced from various commercial and government agencies deemed to be reliable, but accuracy is not guaranteed. Each user of this Map Book information is responsible for determining the suitability for their intended use or purpose.The information contained in this Map Book should not be used as a "legal description". Original source material should be consulted. . Base maps and layers used in this publication were developed in Maptitude 2020 GIS software. Any errors or omissions should be reported to Lance Lewis at llewis@cmadocs.org.

Uninsured Populations
Heat Map of California Uninsured
(Red areas represent higher rates of uninsured)



(Rev. 04/27/18)

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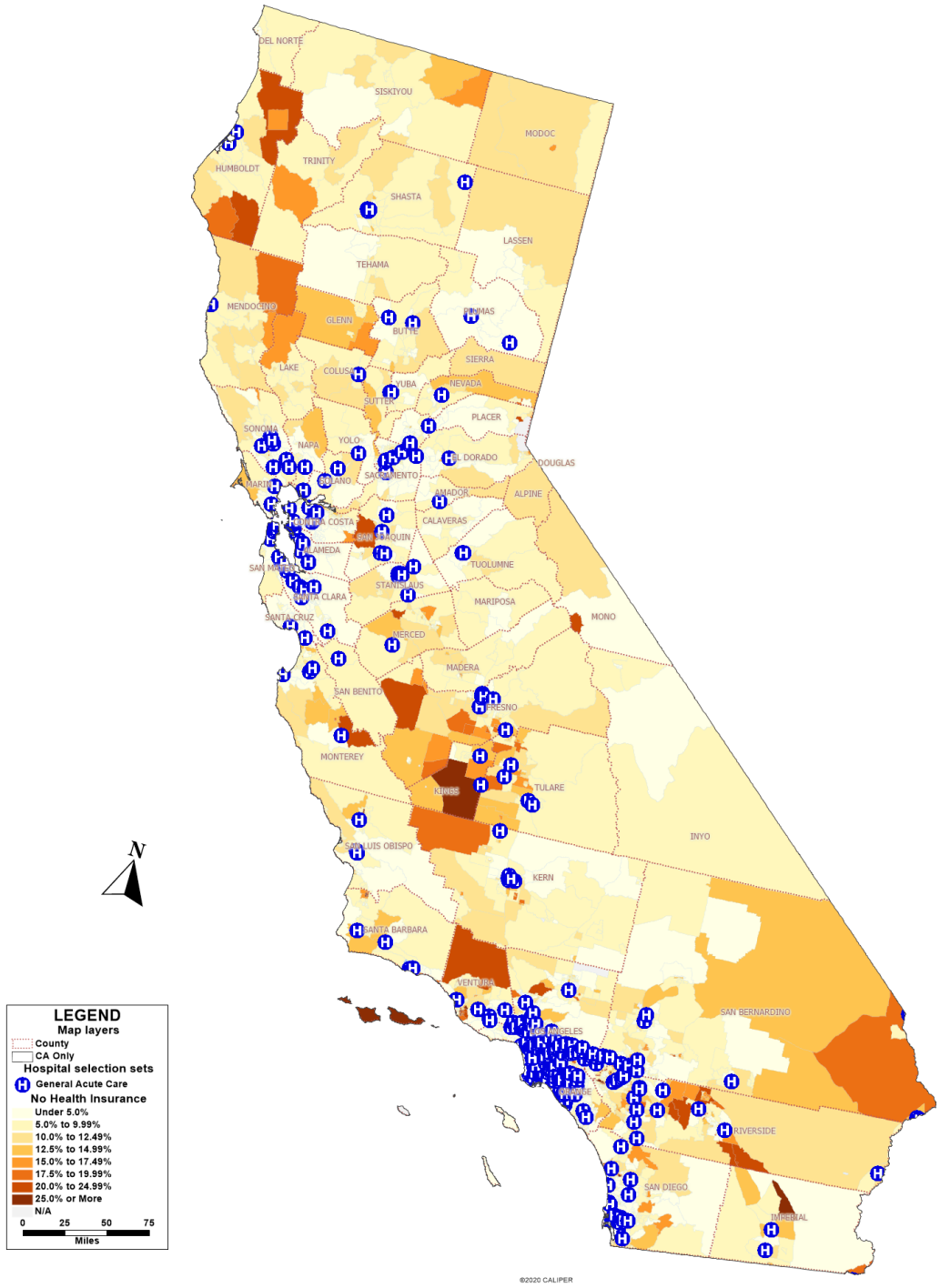
Heat Map of California Uninsured and Location of General Acute Care Hospitals
(Red areas represent higher rates of uninsured)



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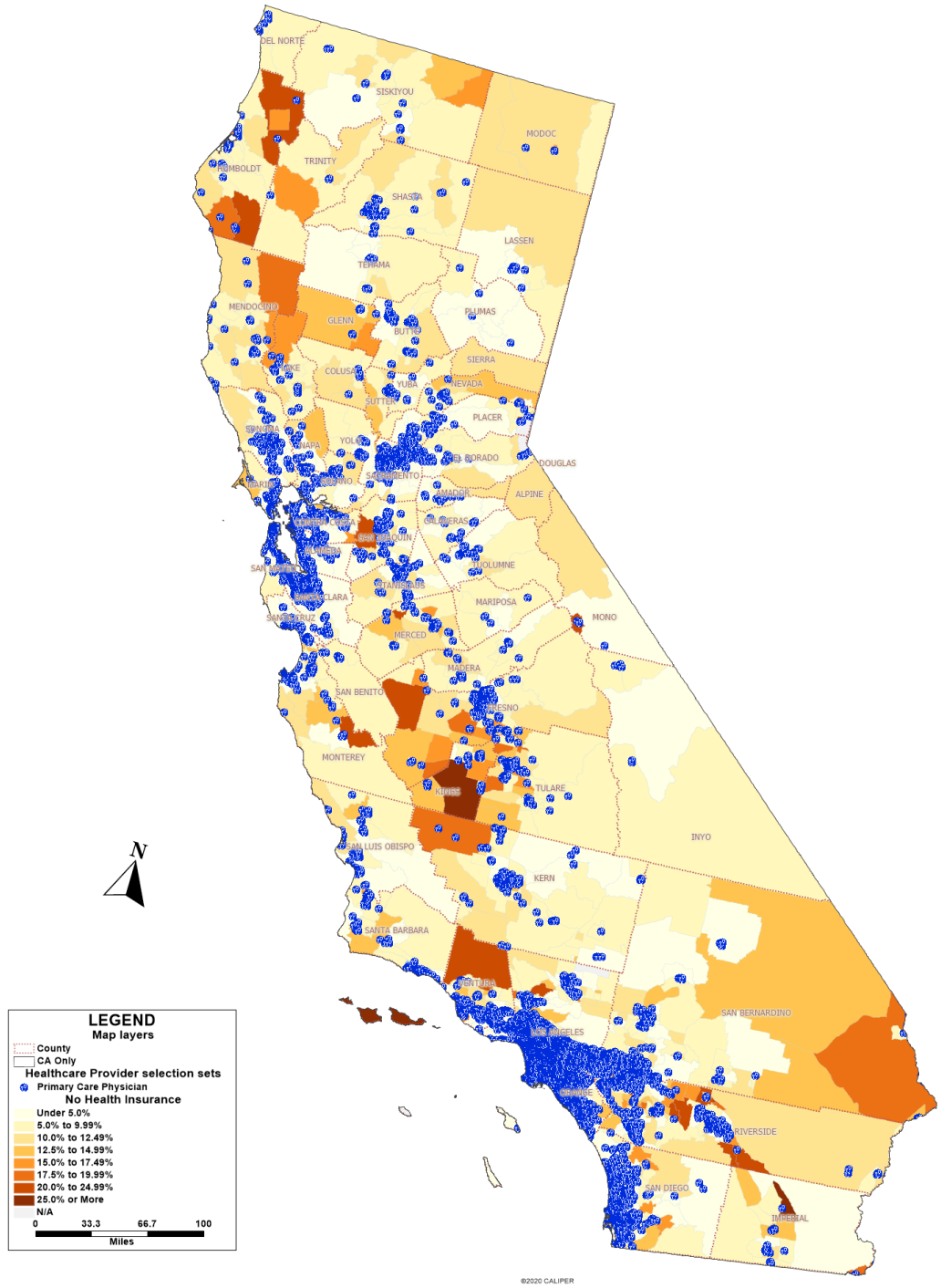
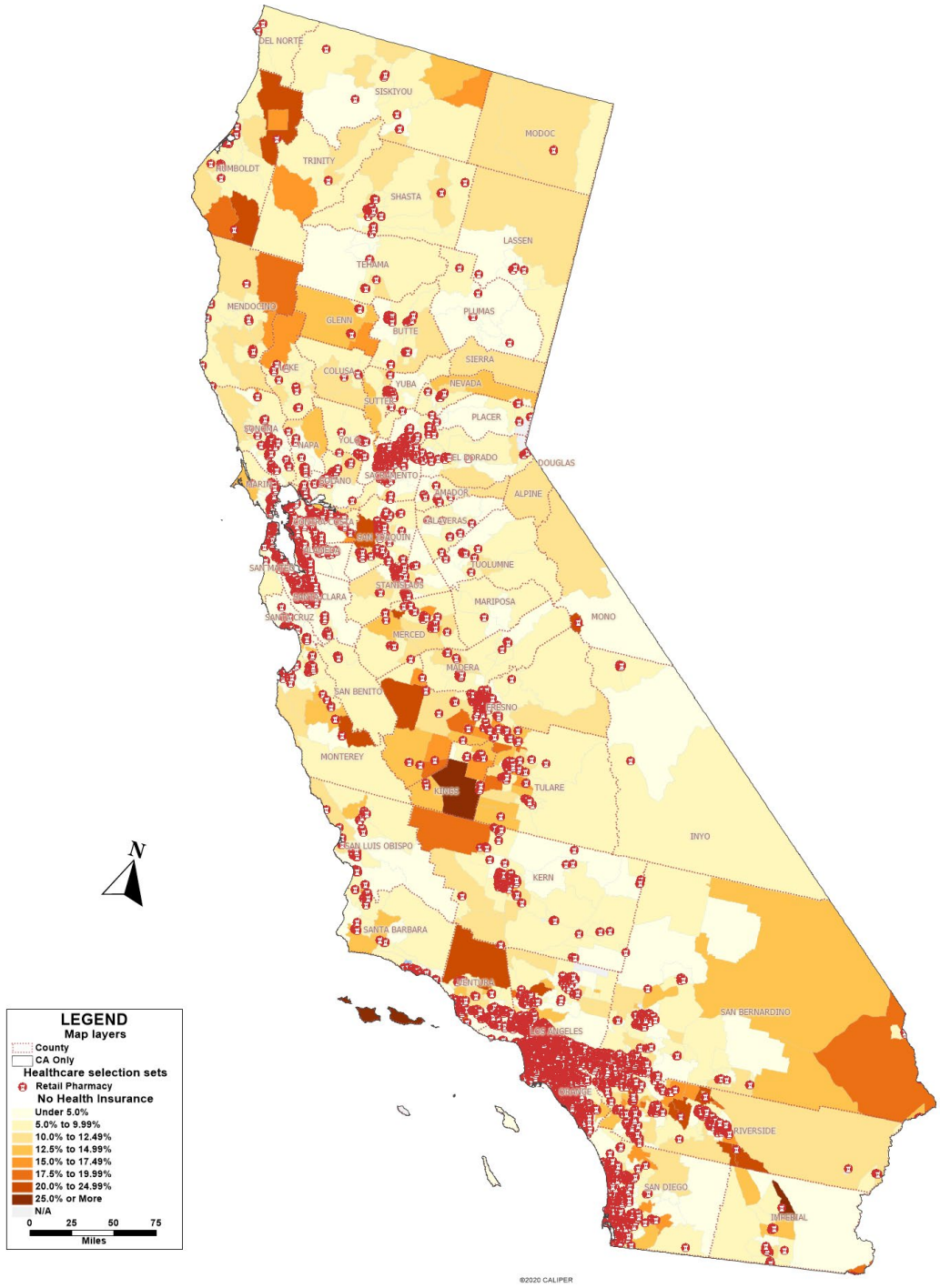
Heat Map of California Uninsured and Location of Primary Care Physician Practices
(Red areas represent higher rates of uninsured)



Heat Map of California Uninsured and Location of Retail Pharmacies
(Red areas represent higher rates of uninsured)



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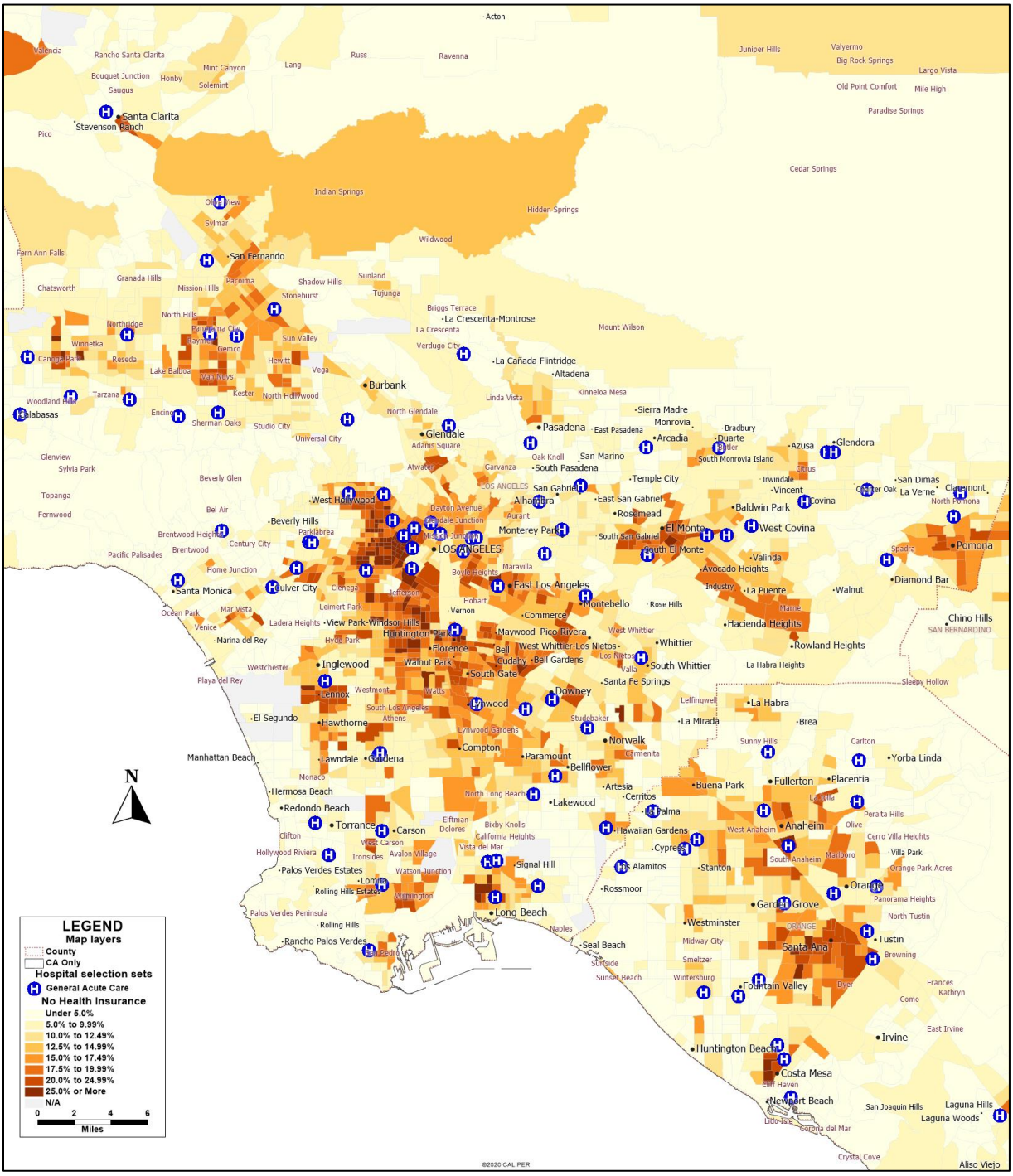
Heat Map of Greater Los Angeles Area Uninsured and Location of General Acute Care Hospitals
(Red areas represent higher rates of uninsured)



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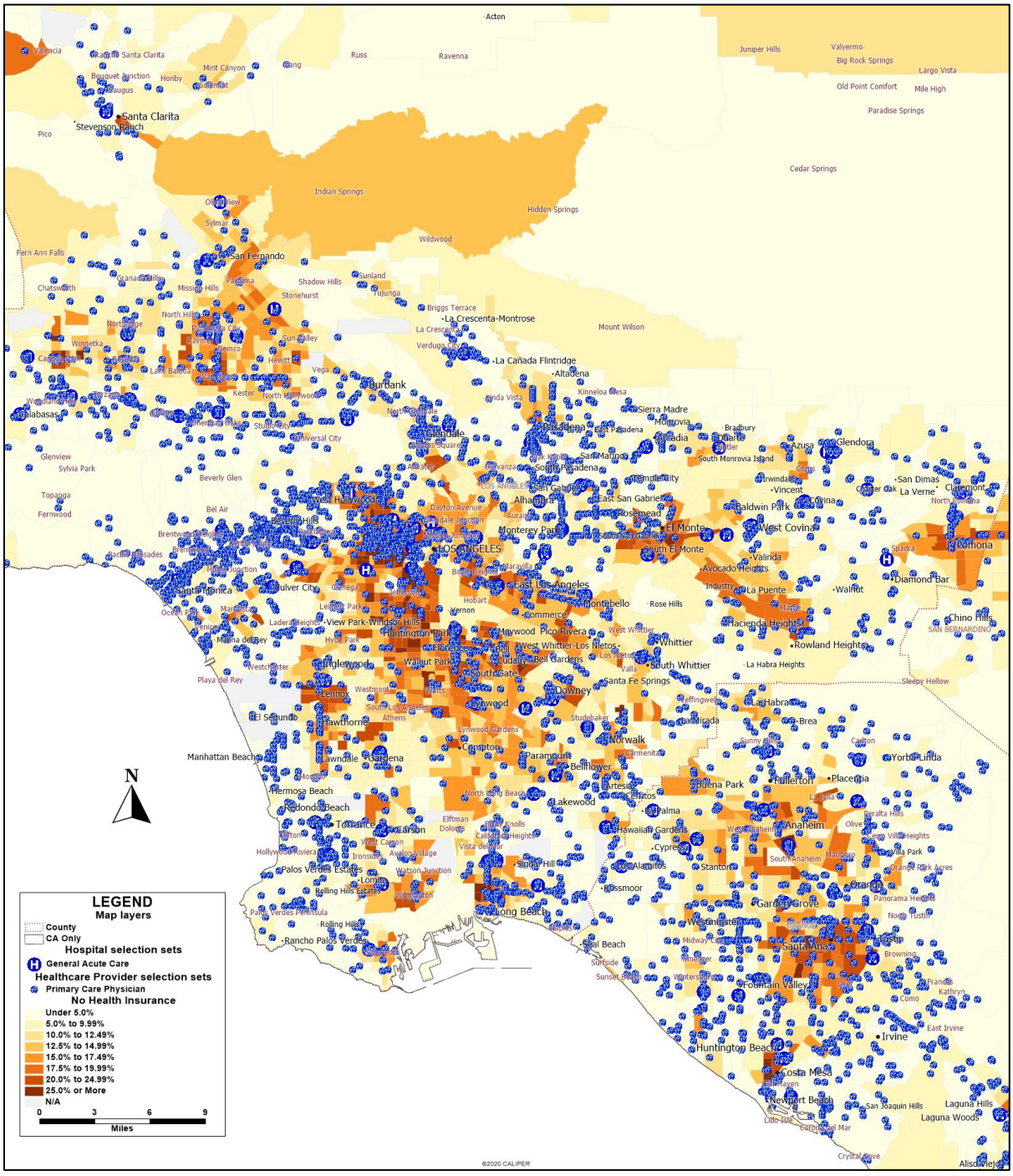
Heat Map of Greater Los Angeles Uninsured and Location of Primary Care Physician Practices and GAC Hospitals
(Red areas represent higher rates of uninsured)



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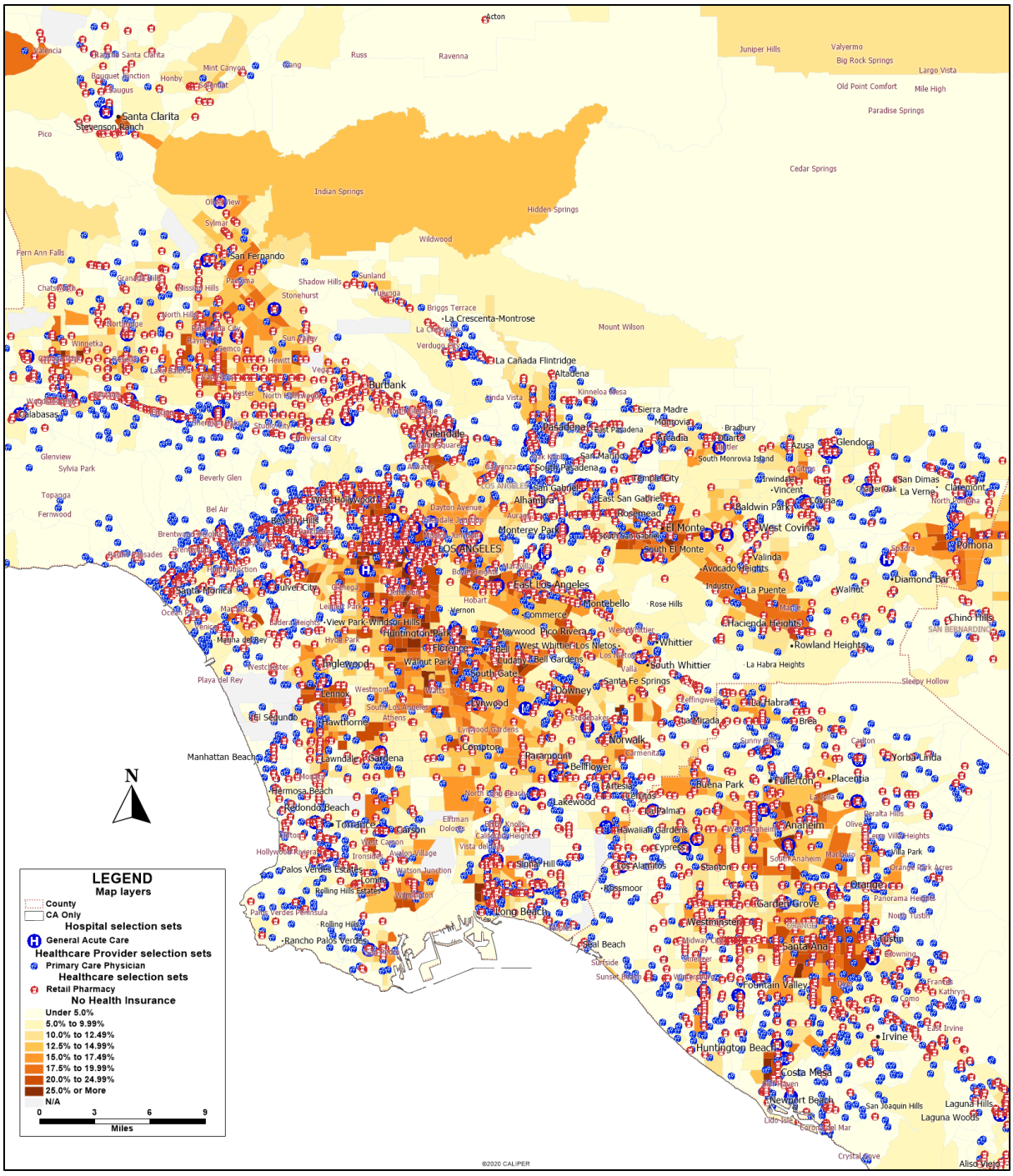
Heat Map of Greater Los Angeles Uninsured and Location of Primary Care Physician Practices, GAC Hospitals and Retail Pharmacies
(Red areas represent higher rates of uninsured)



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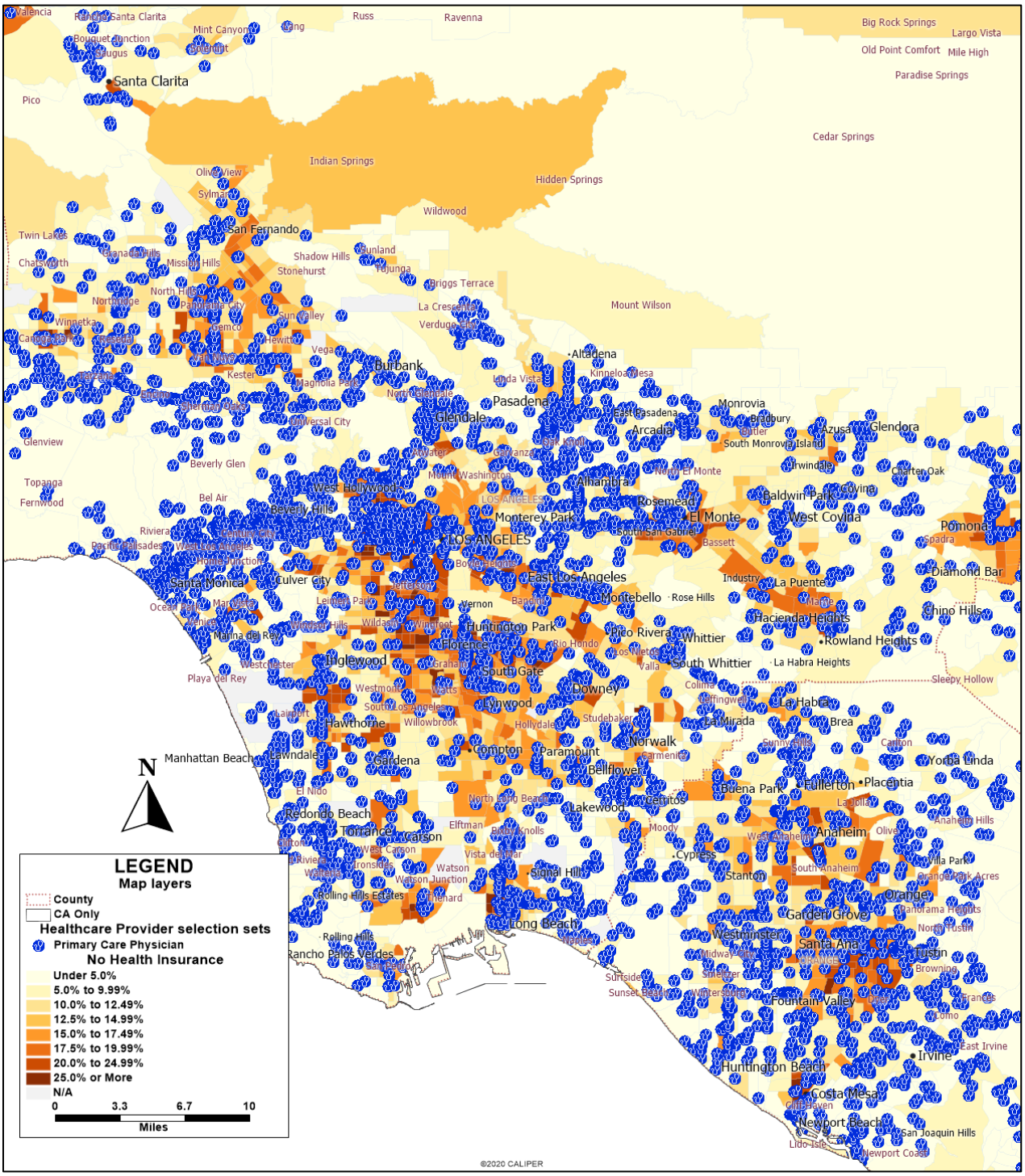
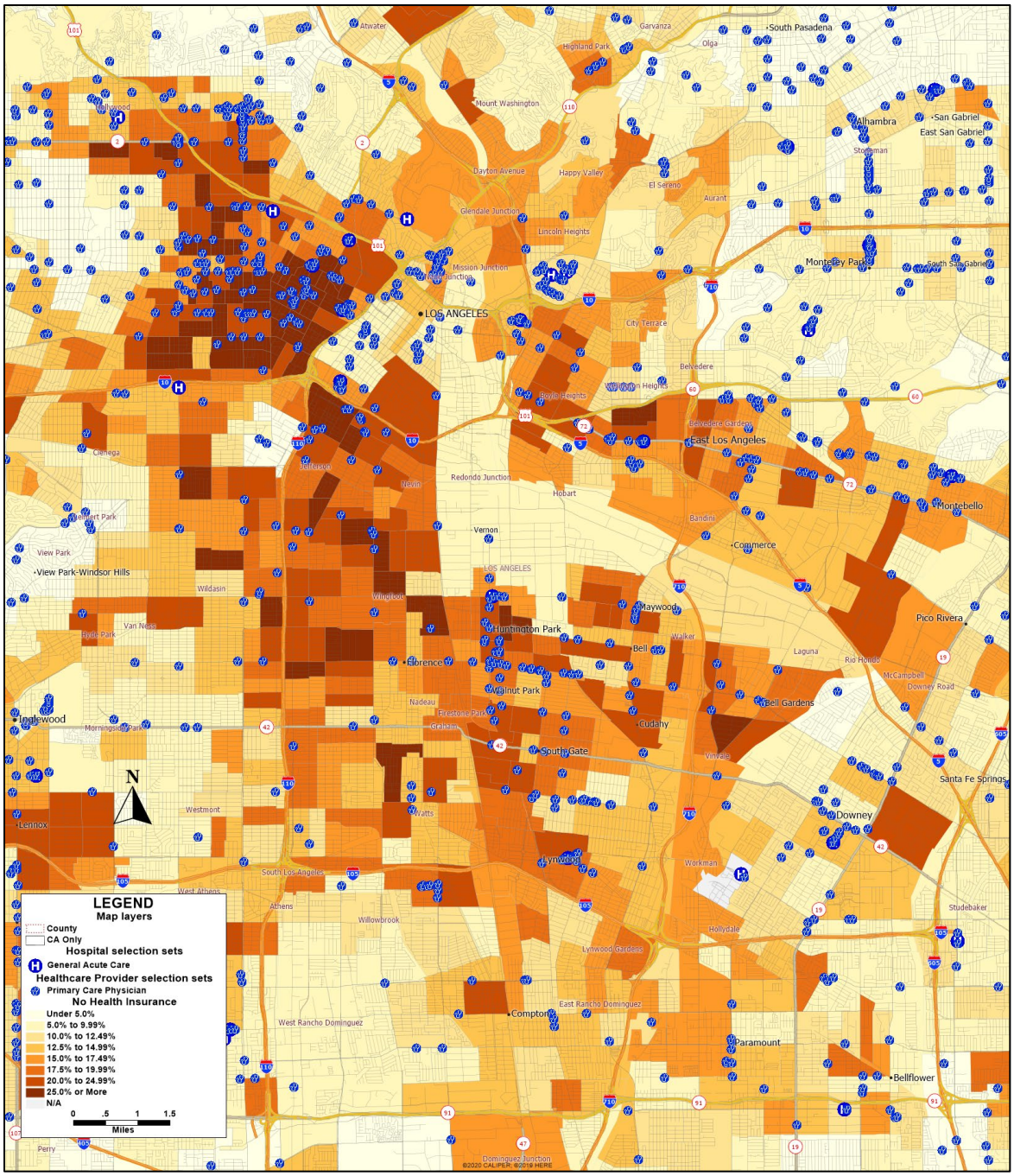
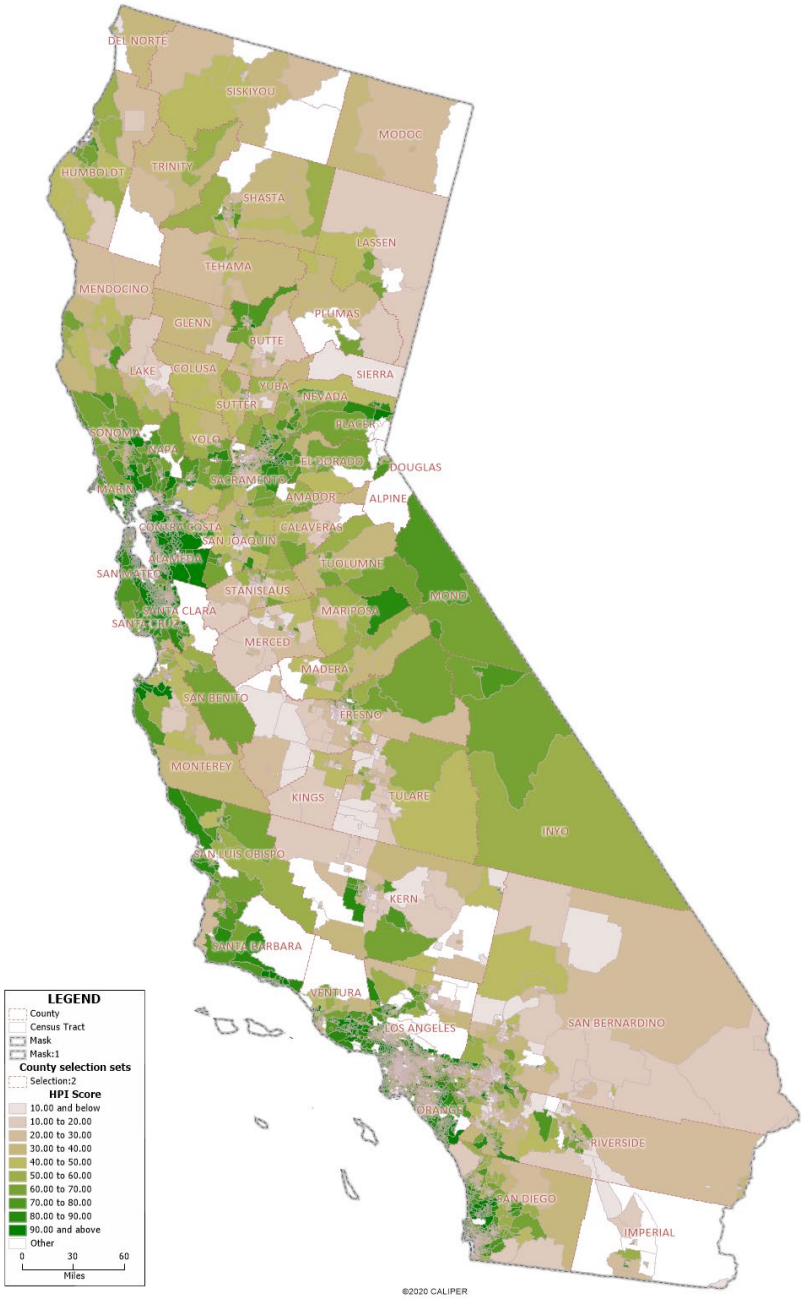


Heat Map of Metro/Central Los Angeles Uninsured Populations and Location of Primary Care Physician Practices and GAC Hospitals
(Red areas represent higher rates of uninsured)



Healthy Places Index
Heat Map of California HPI Scores* by Census Tract
(Green areas represent higher [better] scores, brown areas represent lower scores)



*The California Healthy Places Index (HPI) showcases community conditions that predict life expectancy and influence health. The index takes into account "non-health" policies and community characteristics, such as housing, education, economic, environmental, and social factors and known as social determinants of health. See https://healthyplacesindex.org/

Heat Map of California HPI Scores* by Census Tract with Locations of General Acute Care Hospitals
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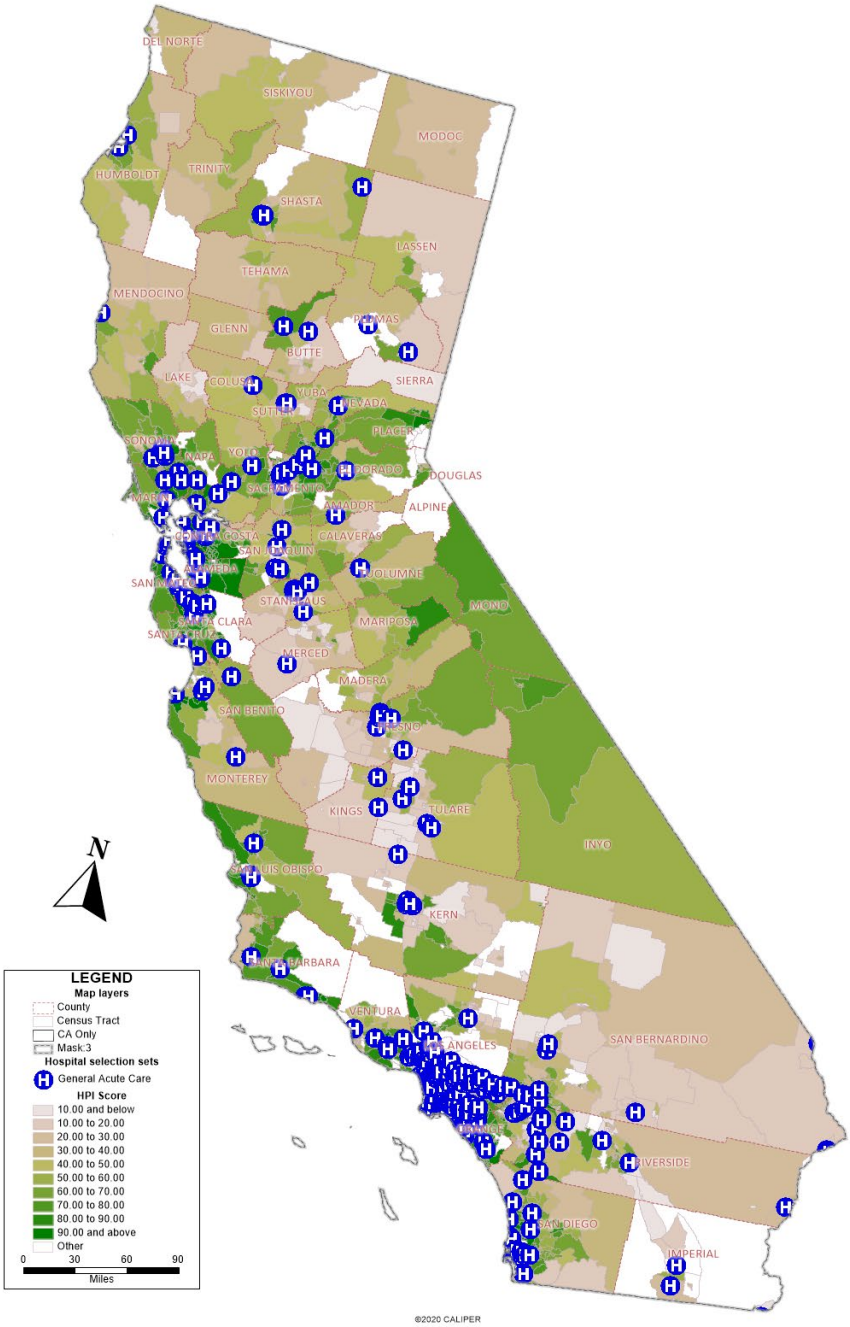

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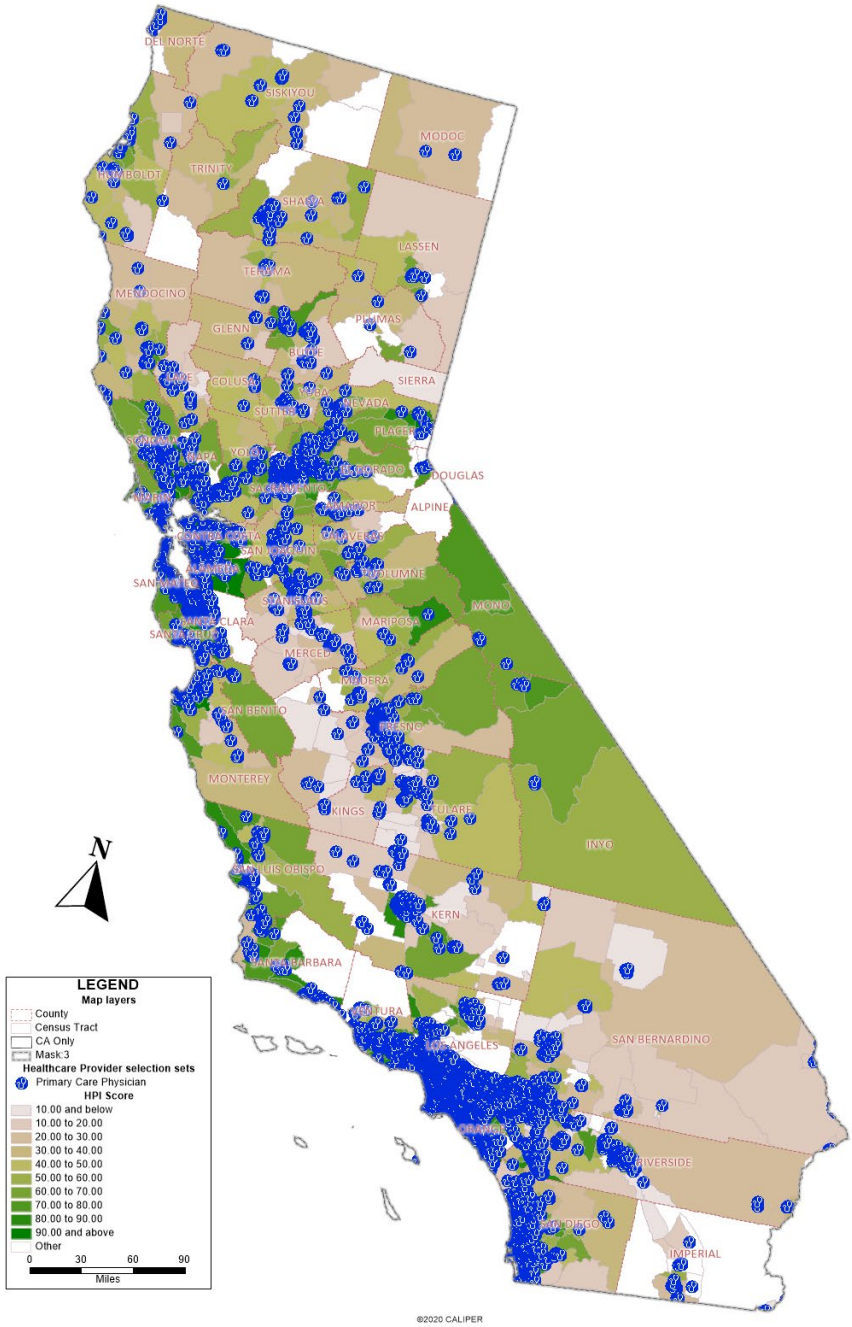
Heat Map of California HPI Scores* by Census Tract with Locations of Primary Care Physician Practices
(Green areas represent higher [better] scores, brown areas represent lower scores)



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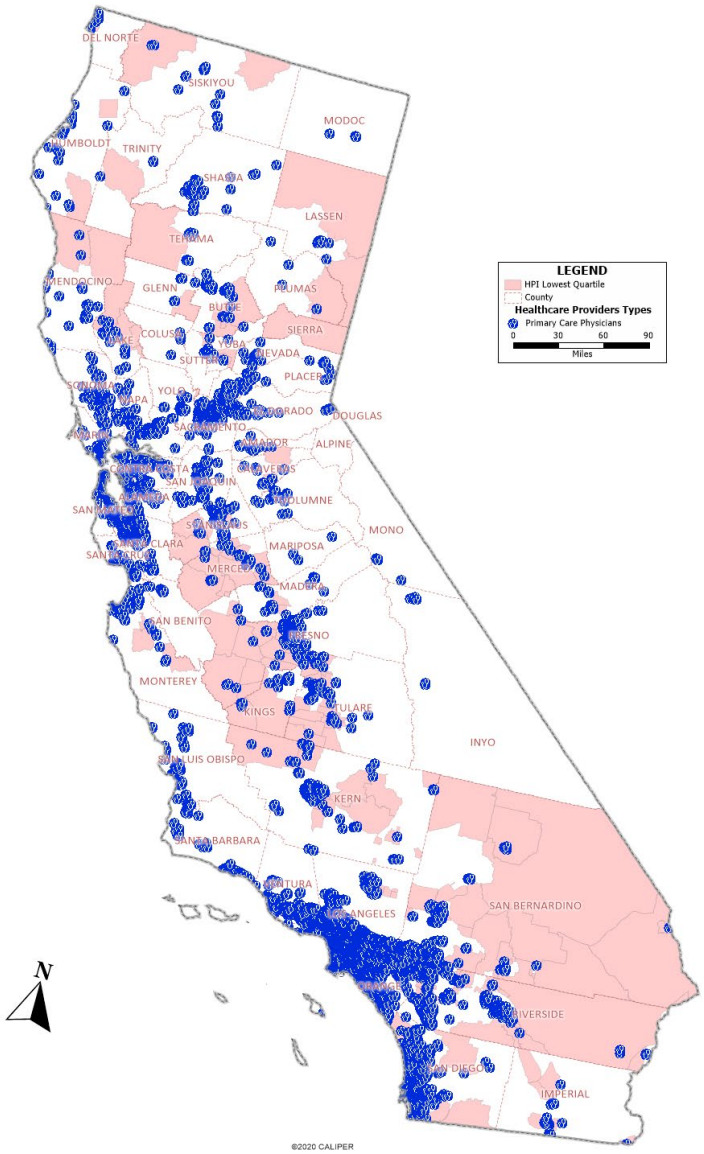
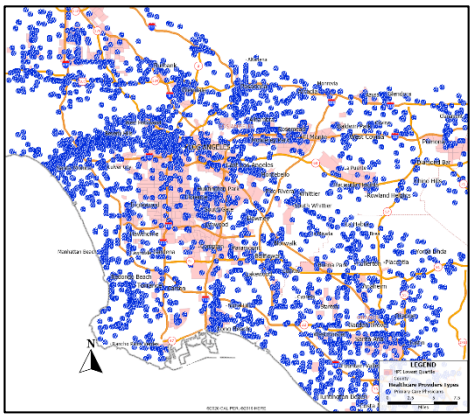
Primary Care Physician Practice Locations and Lowest Quartile HPI Census Tracts
(Green areas represent higher [better] scores, brown areas represent lower scores)



KEY TAKEAWAYS:

- 49,000 practice locations
- Primary Care universe includes General, Family, Internal Medicine, Pediatrics and OB/GYN
- Many independent physicians practice in or near census tracts with the state's most vulnerable populations

Los Angeles Area



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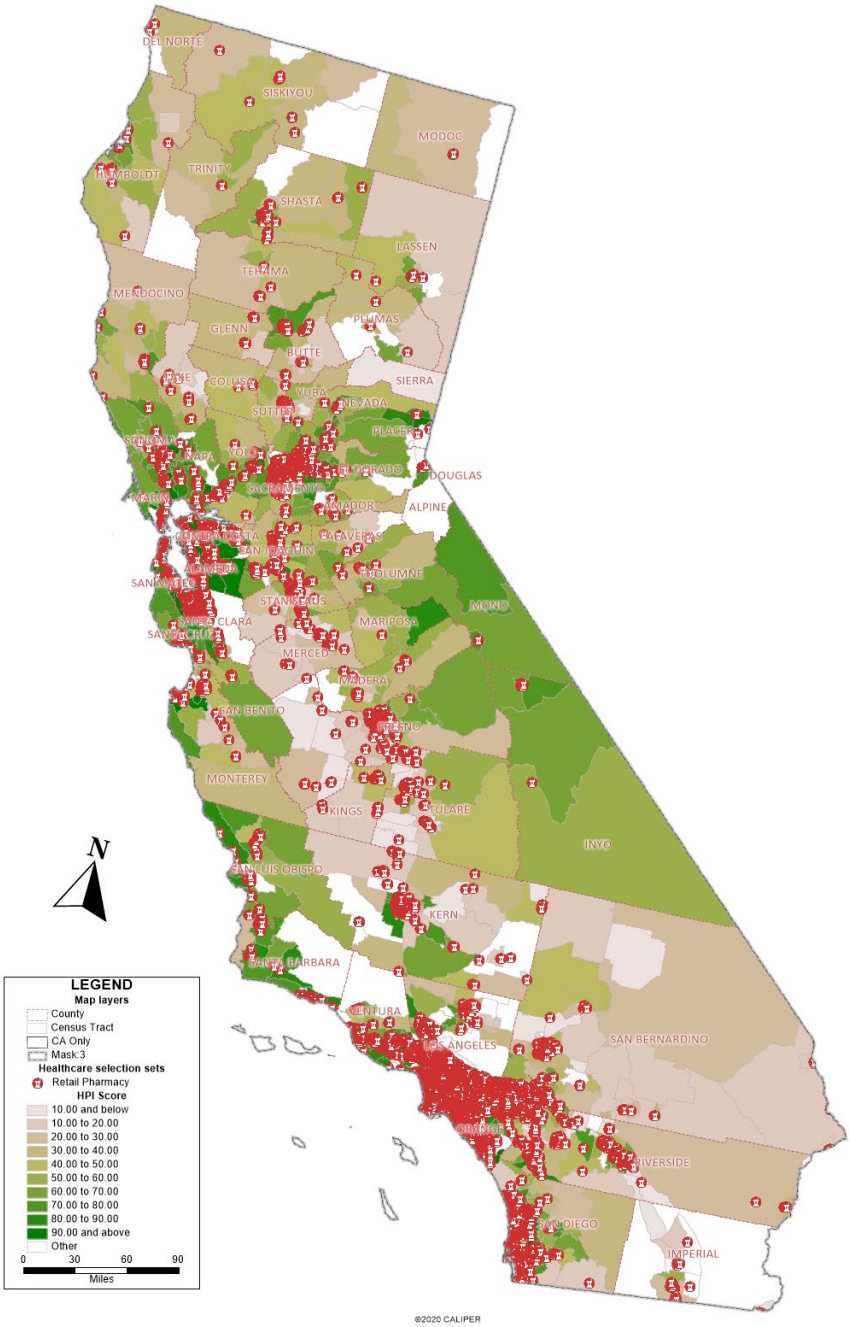
Heat Map of California HPI Scores* by Census Tract with Locations of Retail Pharmacies
(Green areas represent higher [better] scores, brown areas represent lower scores)



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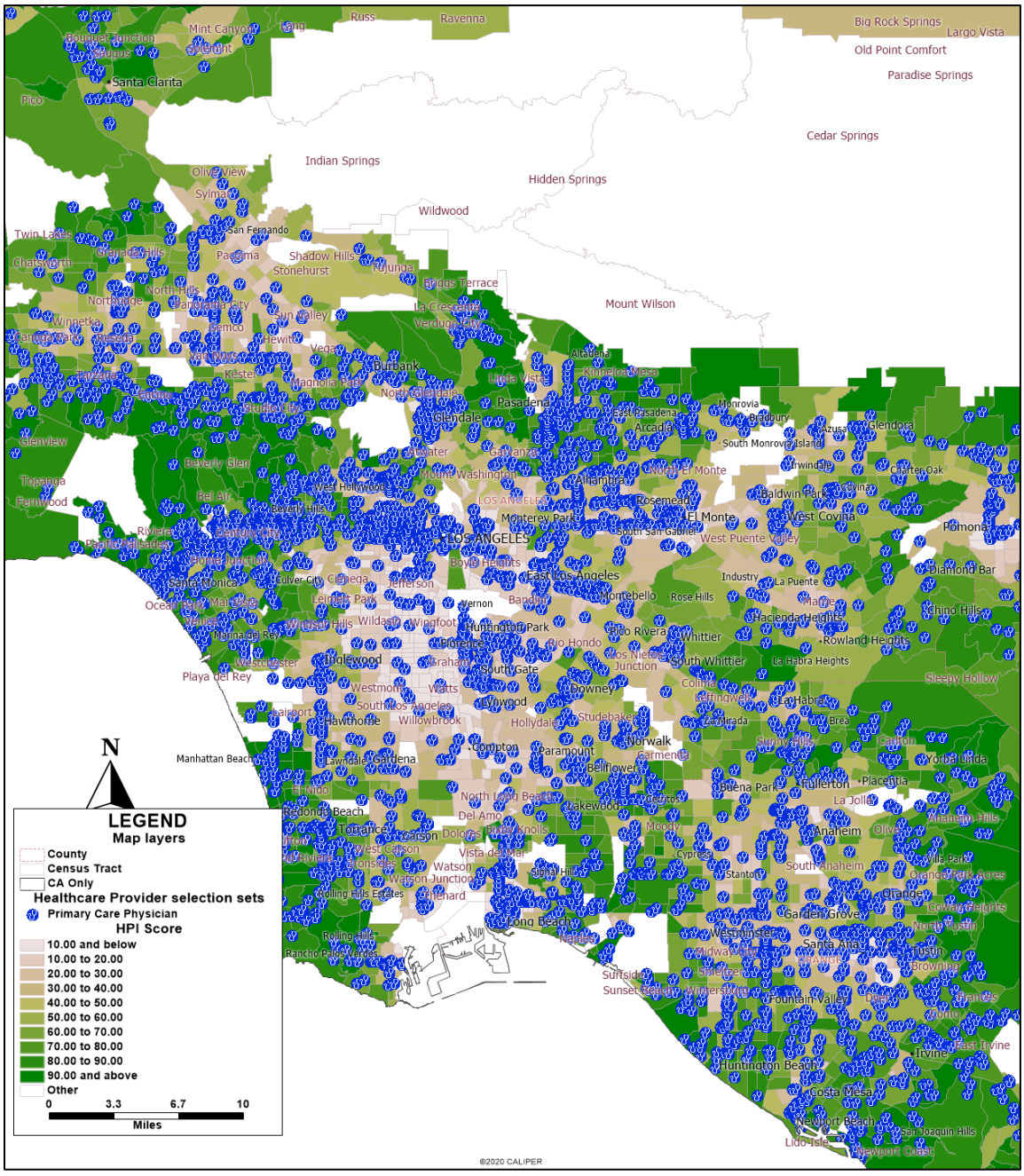
Heat Map of Greater Los Angeles HPI Scores* with Locations of Primary Care Physician Practices (Green areas represent higher [better] scores, brown areas represent lower [worse] scores)



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Heat Map of Metro/Central Los Angeles HPI Scores* with Locations of Primary Care Physician Practices
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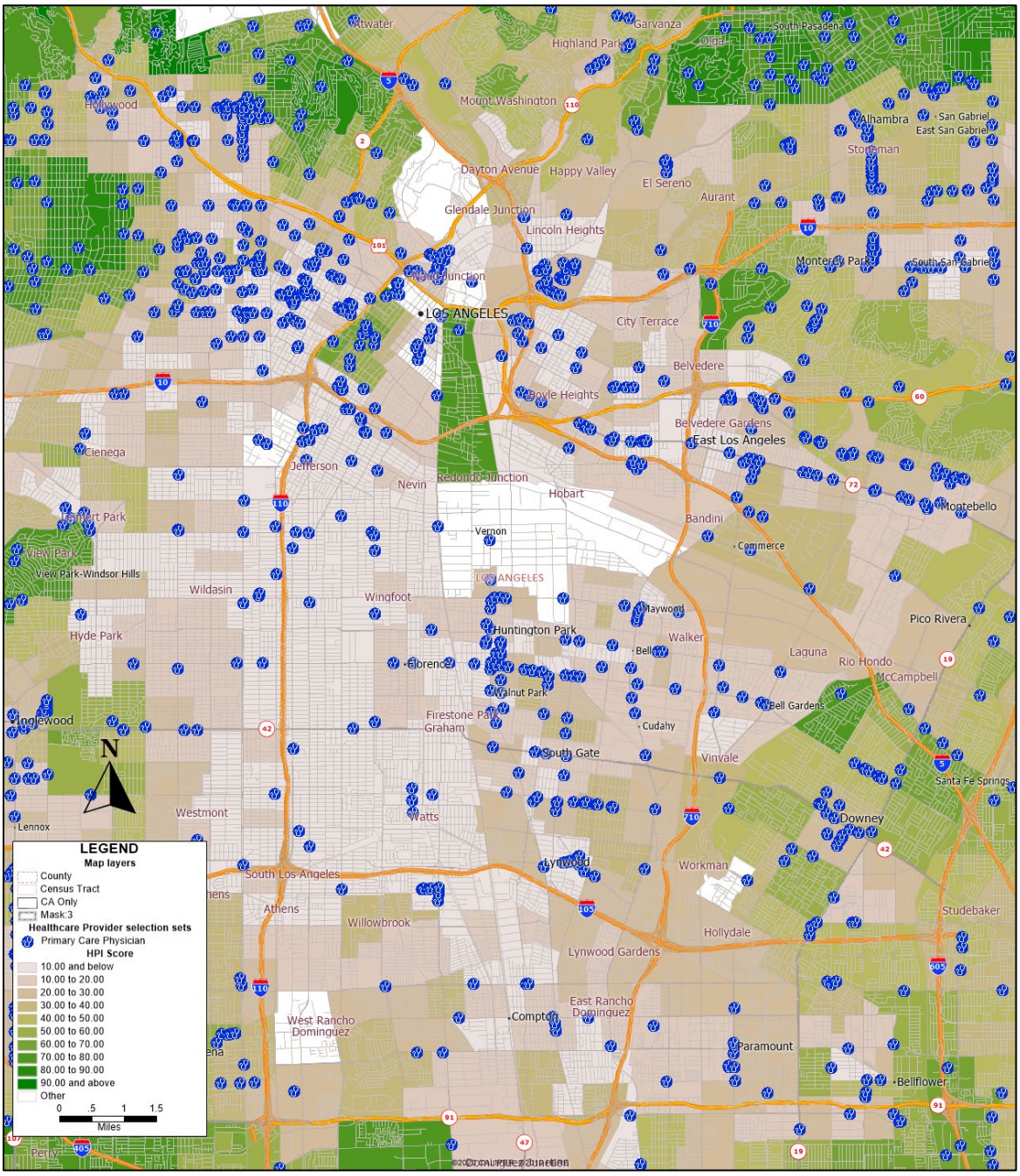

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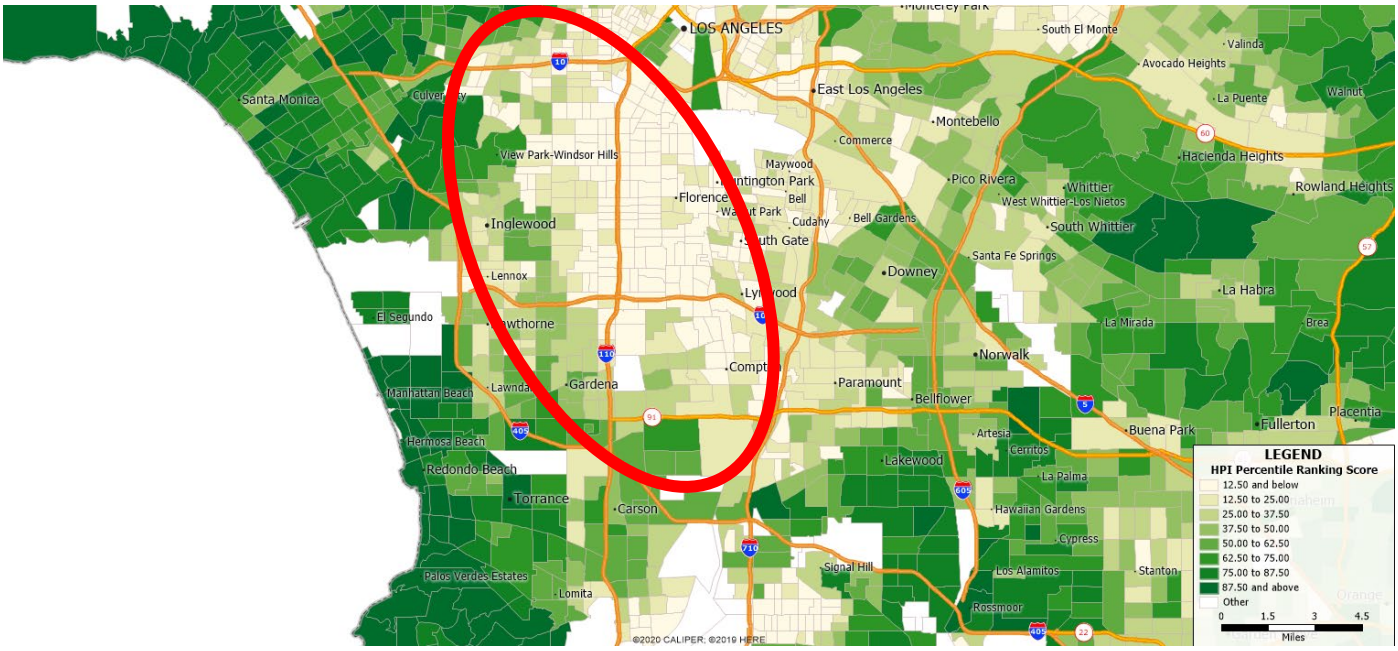
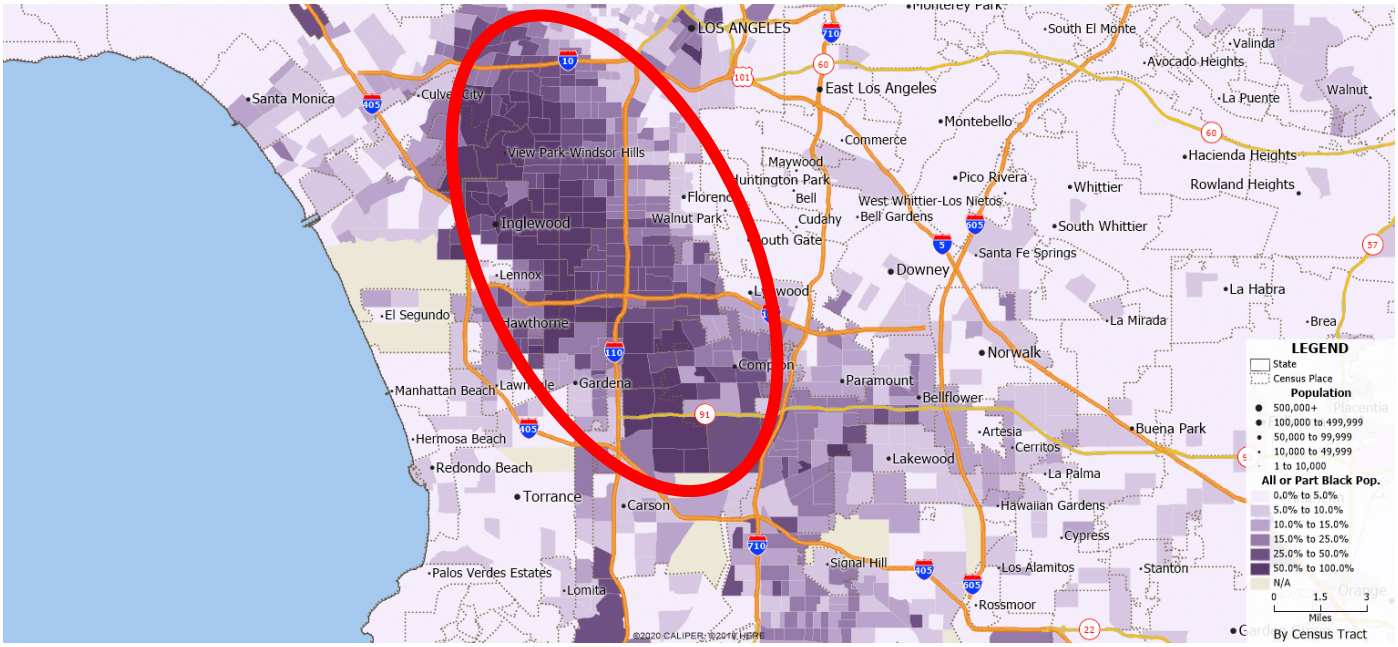
Comparison of HPI Scores* by Census Tract with Locations of African Americans by Census Tract





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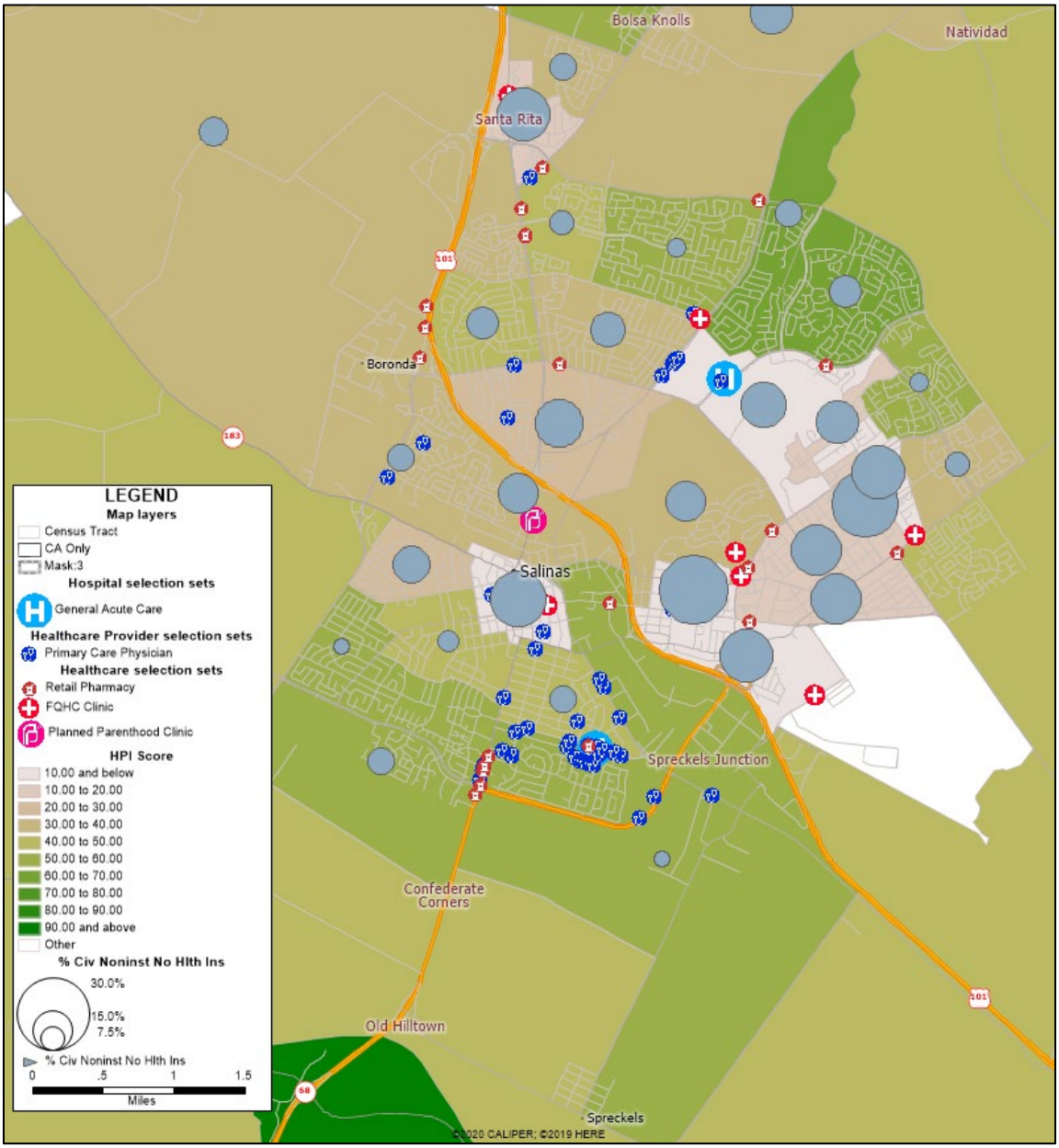
Heat Map of Salinas (Monterey County) HPI Scores*, Number of Uninsured and Locations of Primary Care Physician Practices, Primary Care Clinics, Hospitals and Planned Parenthood
(Green areas represent higher [better] scores, brown areas represent lower [worse] scores)



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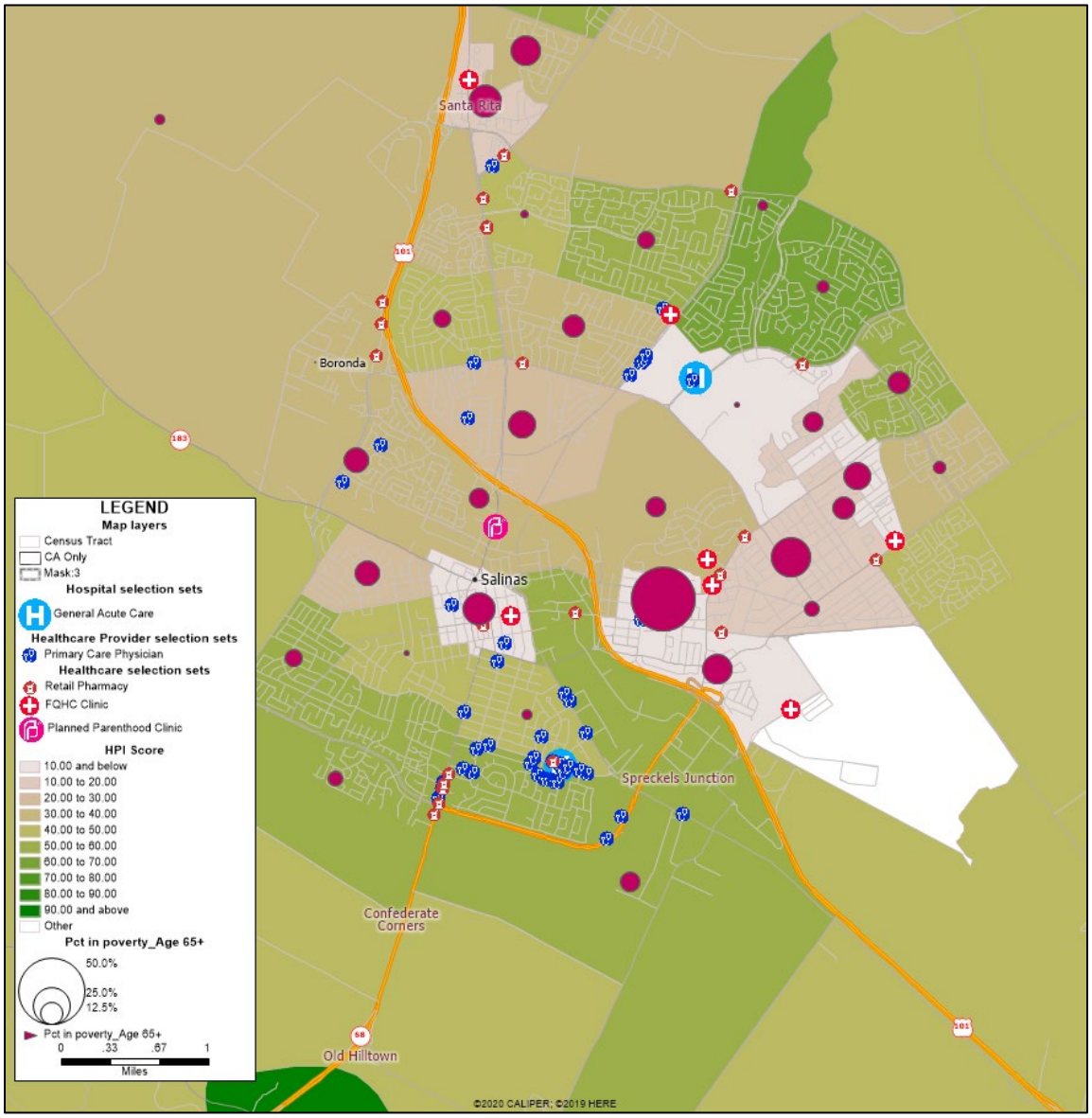
Heat Map of Salinas (Monterey County) HPI Scores* by Census Tract, Population Age 65+ in Poverty and Locations of Primary Care Physician Practices, Clinics, Hospitals and Planned Parenthood
(Green areas represent higher [better] scores, brown areas represent lower [worse] scores)



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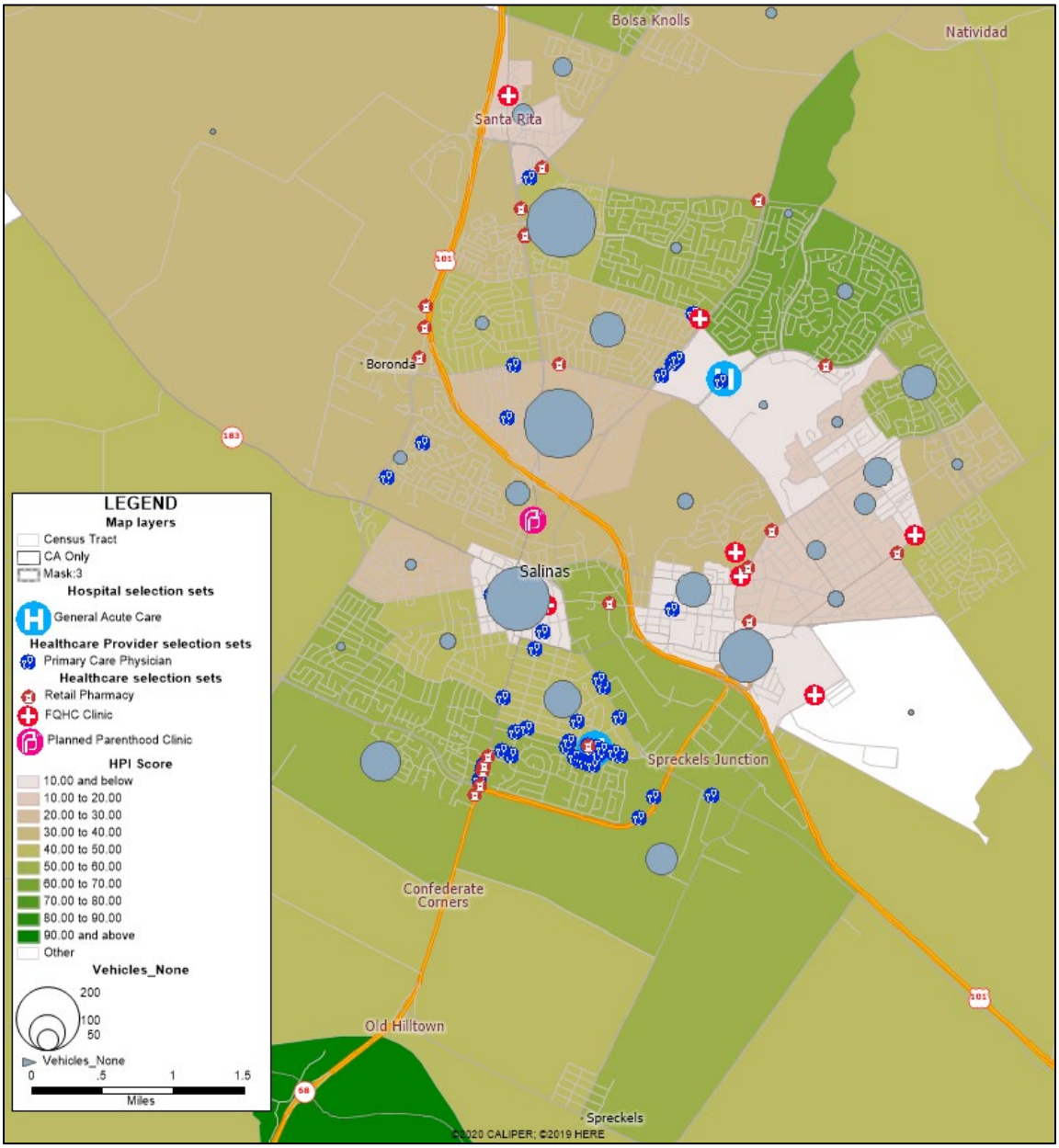
Heat Map of Salinas (Monterey County) HPI Scores* by Census Tract, Households without an Automobile and Locations of Primary Care Physician Practices, Clinics, Hospitals and Planned Parenthood
(Green areas represent higher [better] scores, brown areas represent lower [worse] scores)



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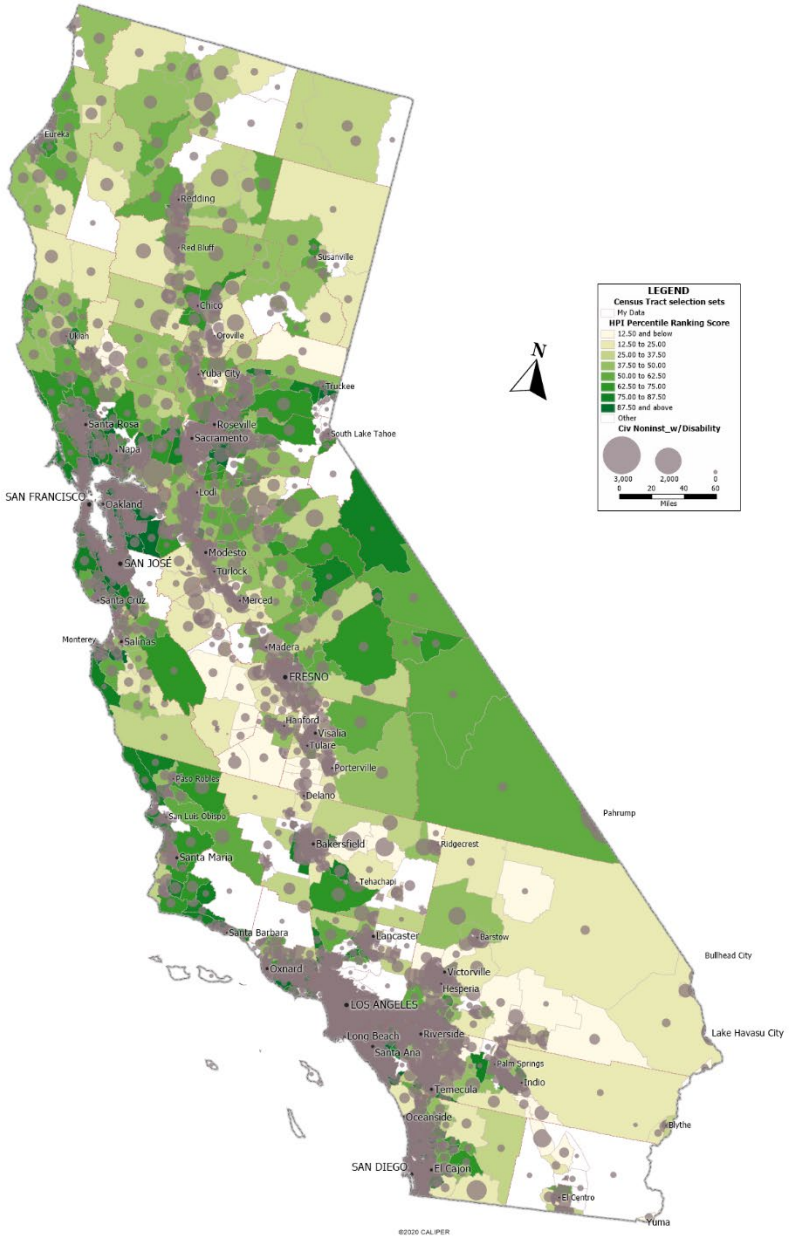
Disabled Populations

Heat Map of HPI Scores* by Census Tract with Number of Disabled Populations (All Ages)
(Green areas represent higher [better] scores, brown areas represent lower [worse] scores)



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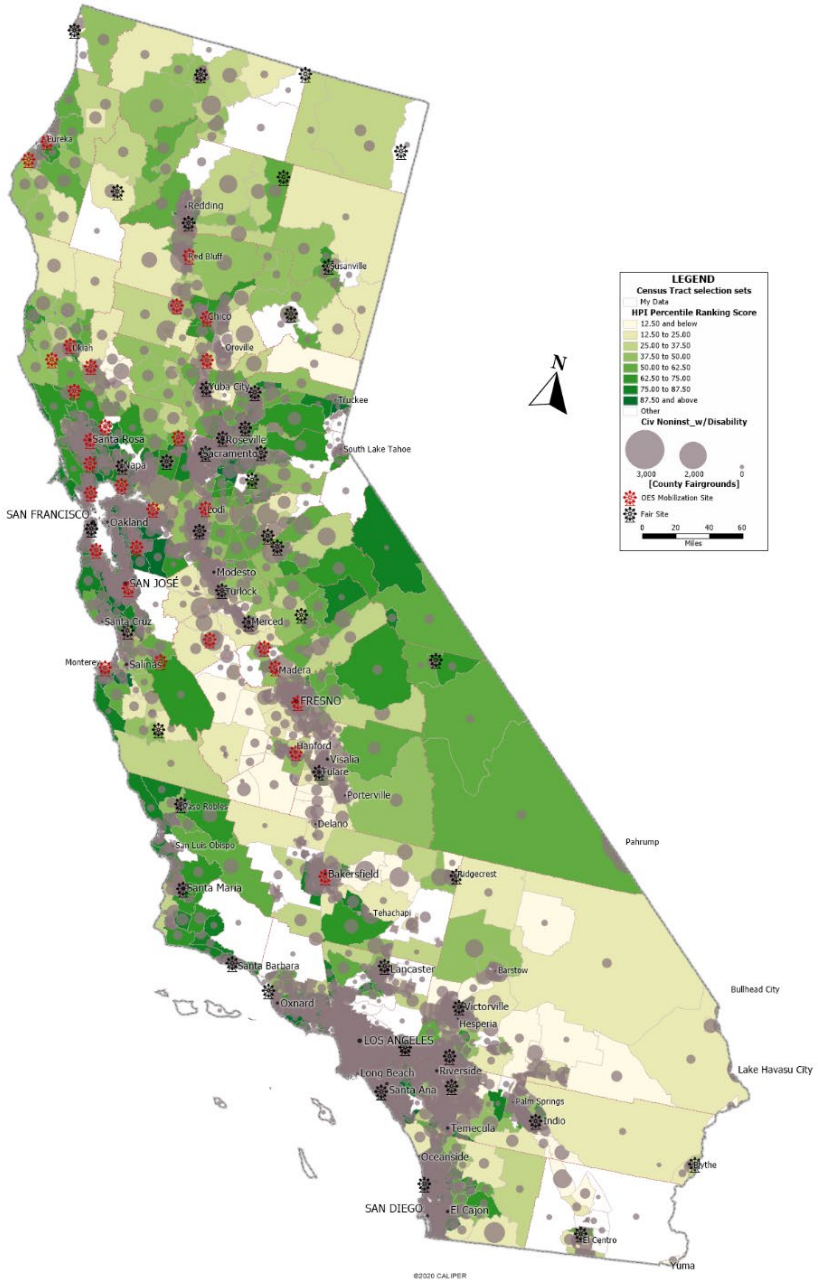
Heat Map of HPI Scores* by Census Tract, Number of Disabled Populations (All Ages), and County Fair Locations (including CalOES Mobilziation Sites) and Healthy Places Index Scores*
(Green areas represent higher [better] scores, brown areas represent lower [worse] scores)



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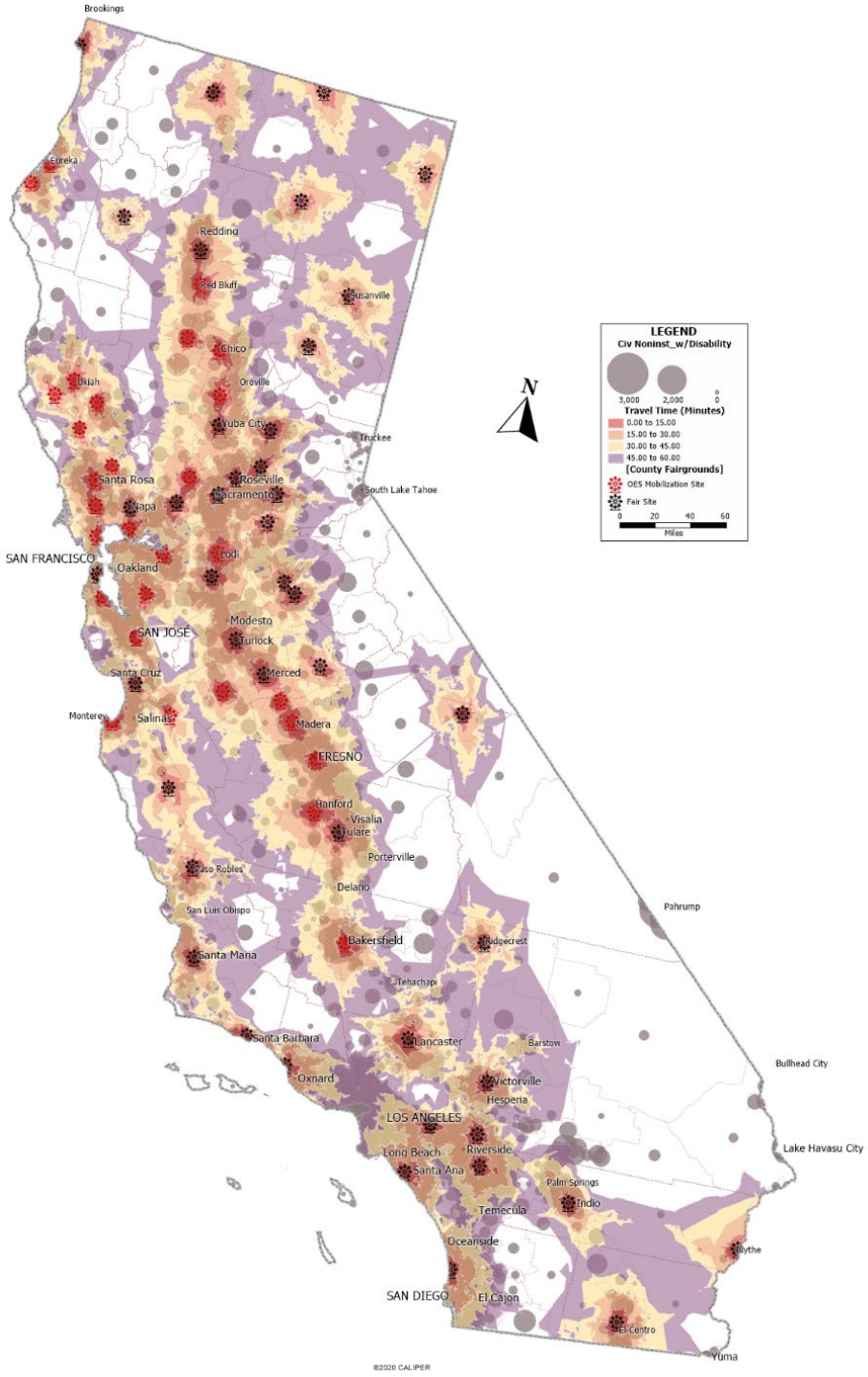
Map of Drive Time Rings to County Fair Locations (including OES Mobilization Sites) within 1 hour shown with Number of Disabled Populations (All Ages)



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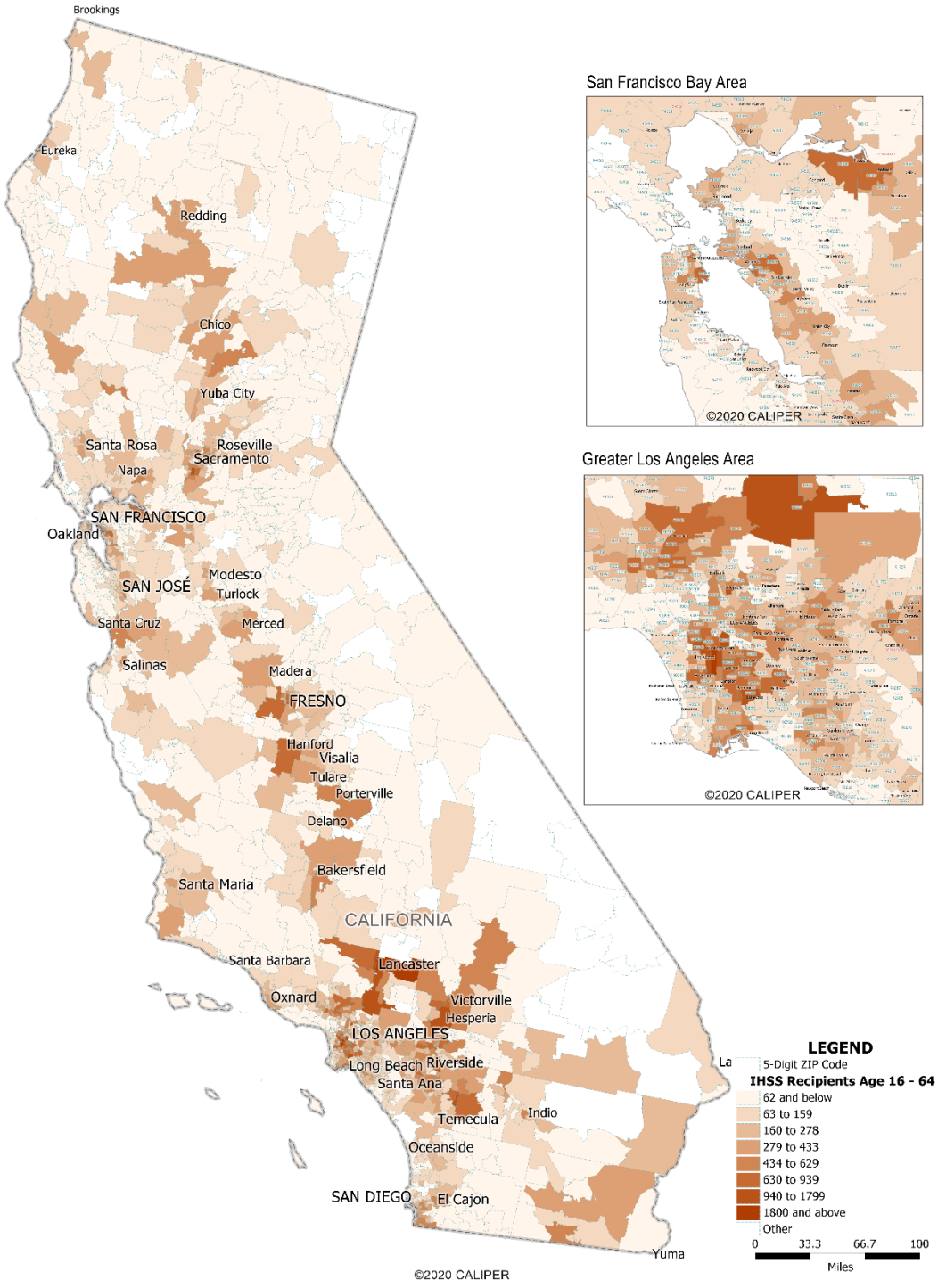
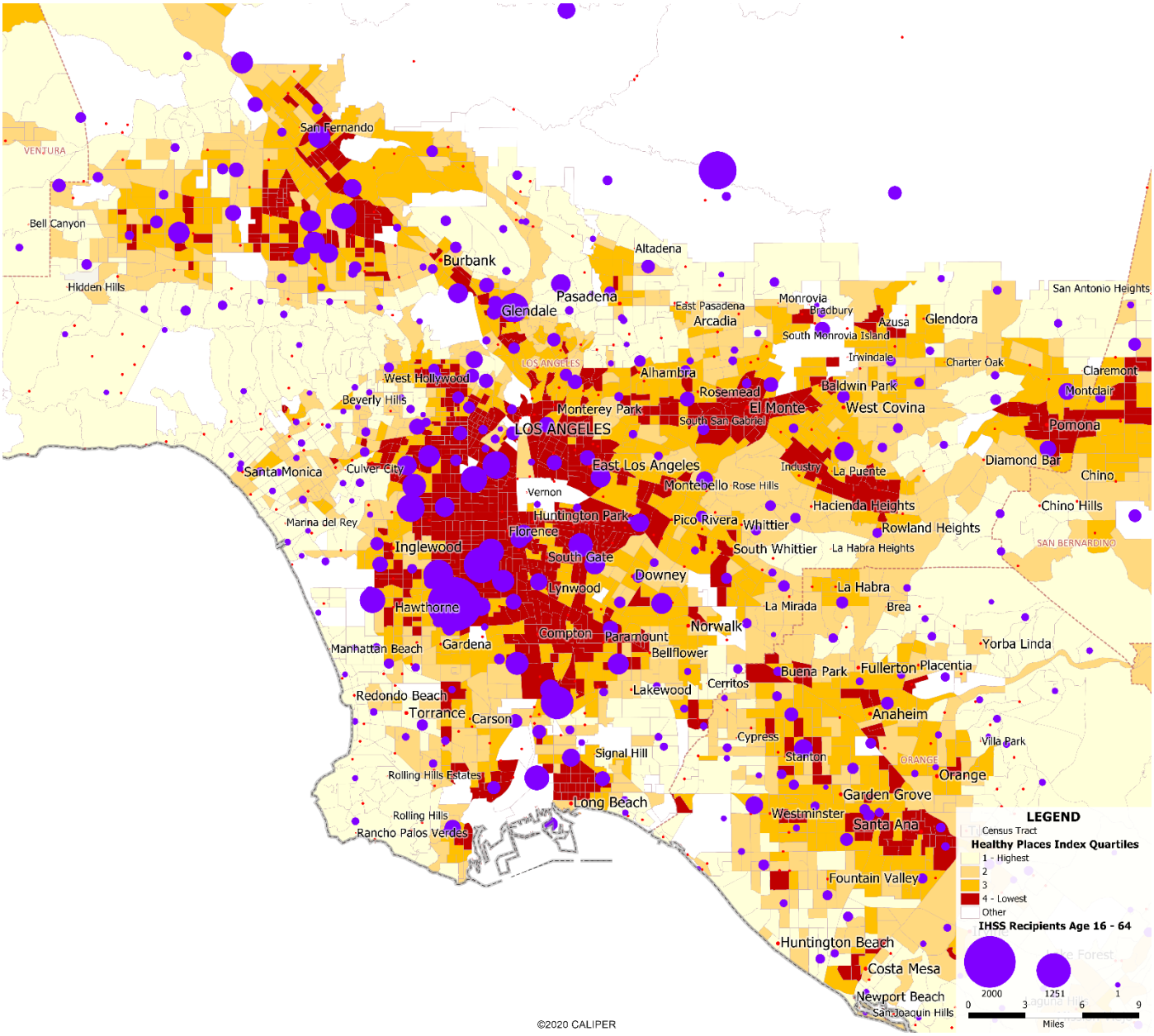
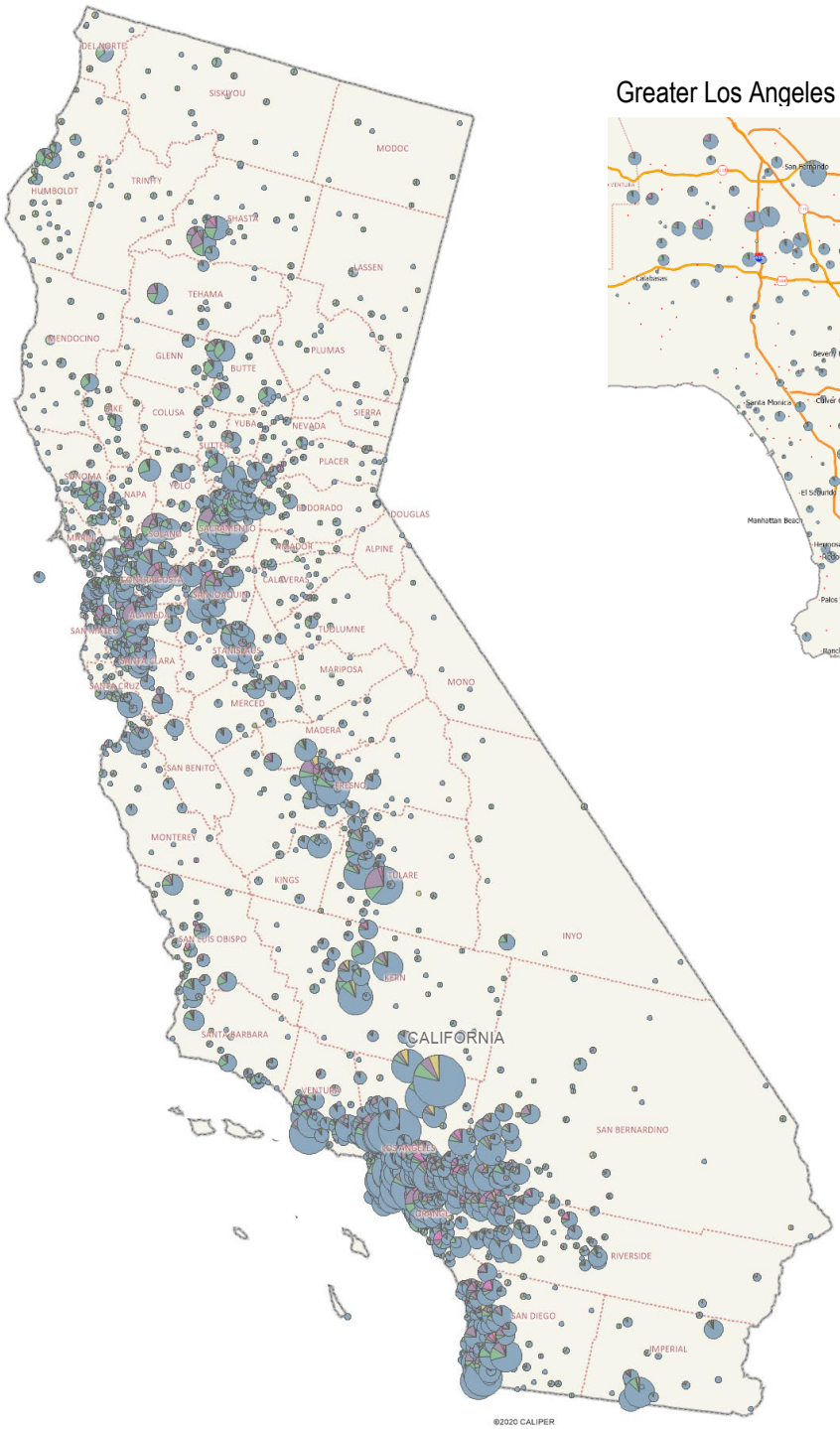
Heat Map of IHSS Recipients Age 16 – 64 by Zip Code



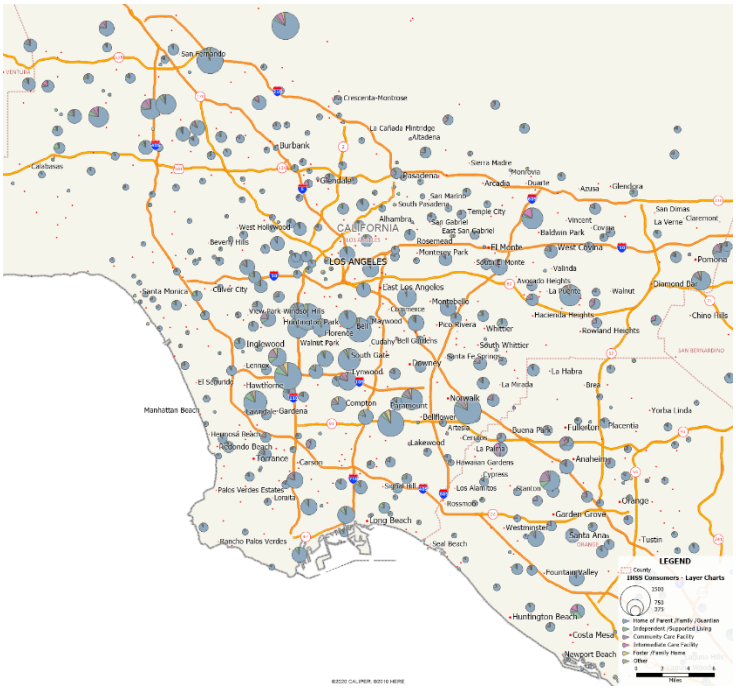
Heat Map of Metro/Central Los Angeles HPI Scores* with Numbers of IHSS Recipients Age 16 – 64
(Red areas represent the lowest [worst] HPI quartile)



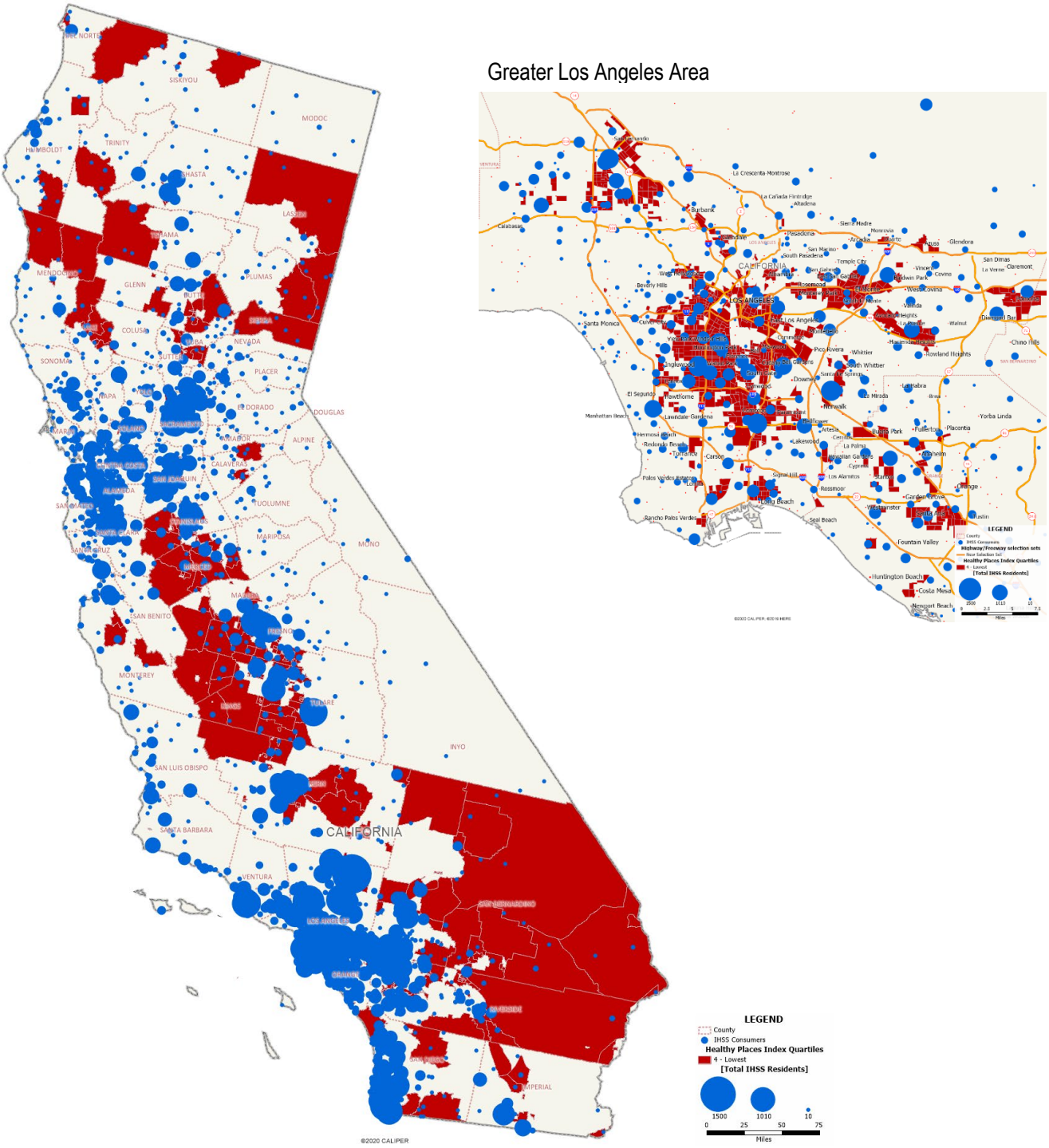
Proportion of IHSS Recipients (All Ages) by Housing Type



Greater Los Angeles Area

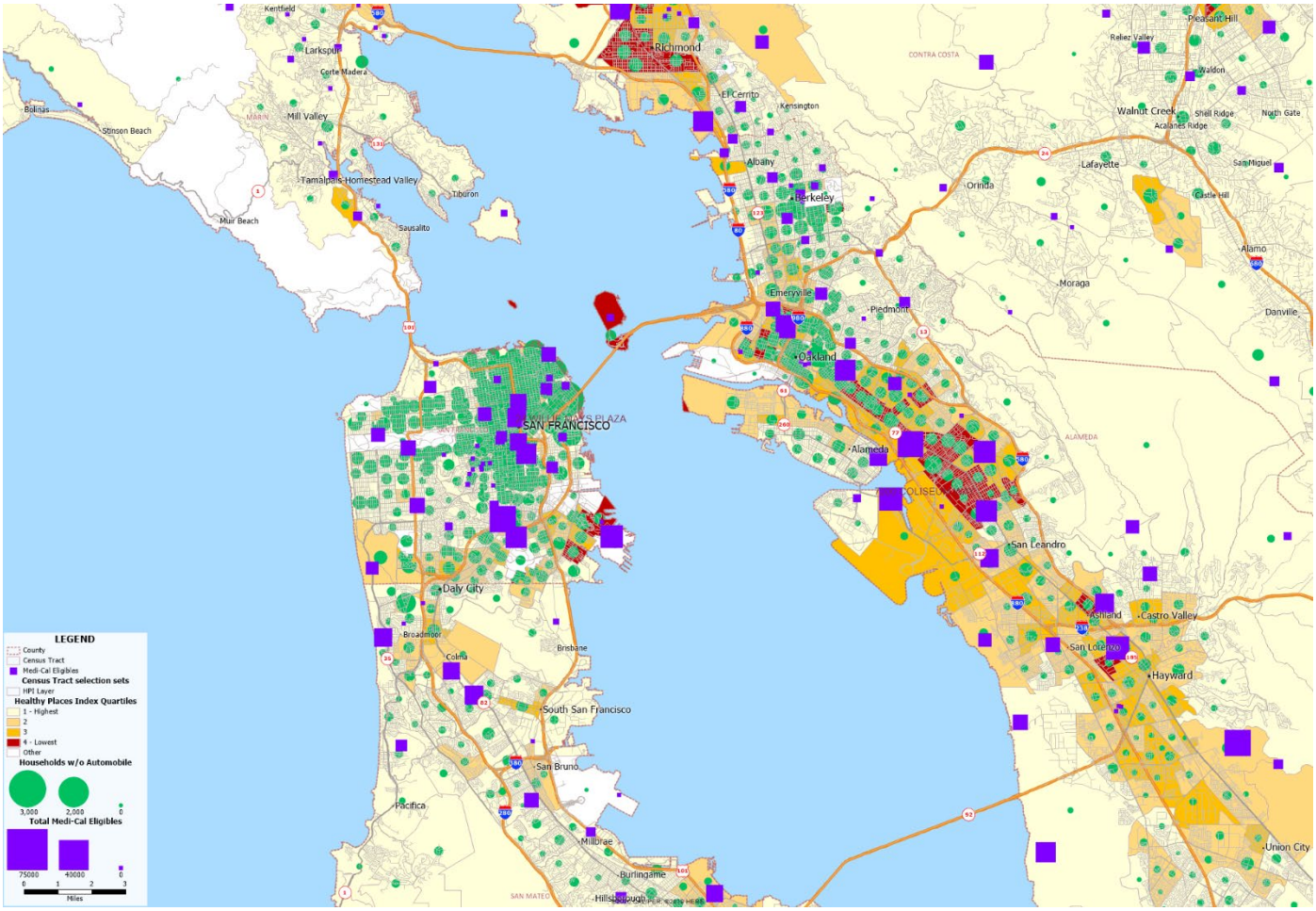


Number of IHSS Recipients (All Ages) by Zip Code with Lowest HPI Quartile by Census Tract
(Red areas represent the lowest [worst] HPI quartile)



(Rev. 04/27/18)

Medi-Cal Eligibles
Heat Map of San Francisco Bay Area HPI Scores* with Numbers of Medi-Cal Eligibles and Households without an Automobile



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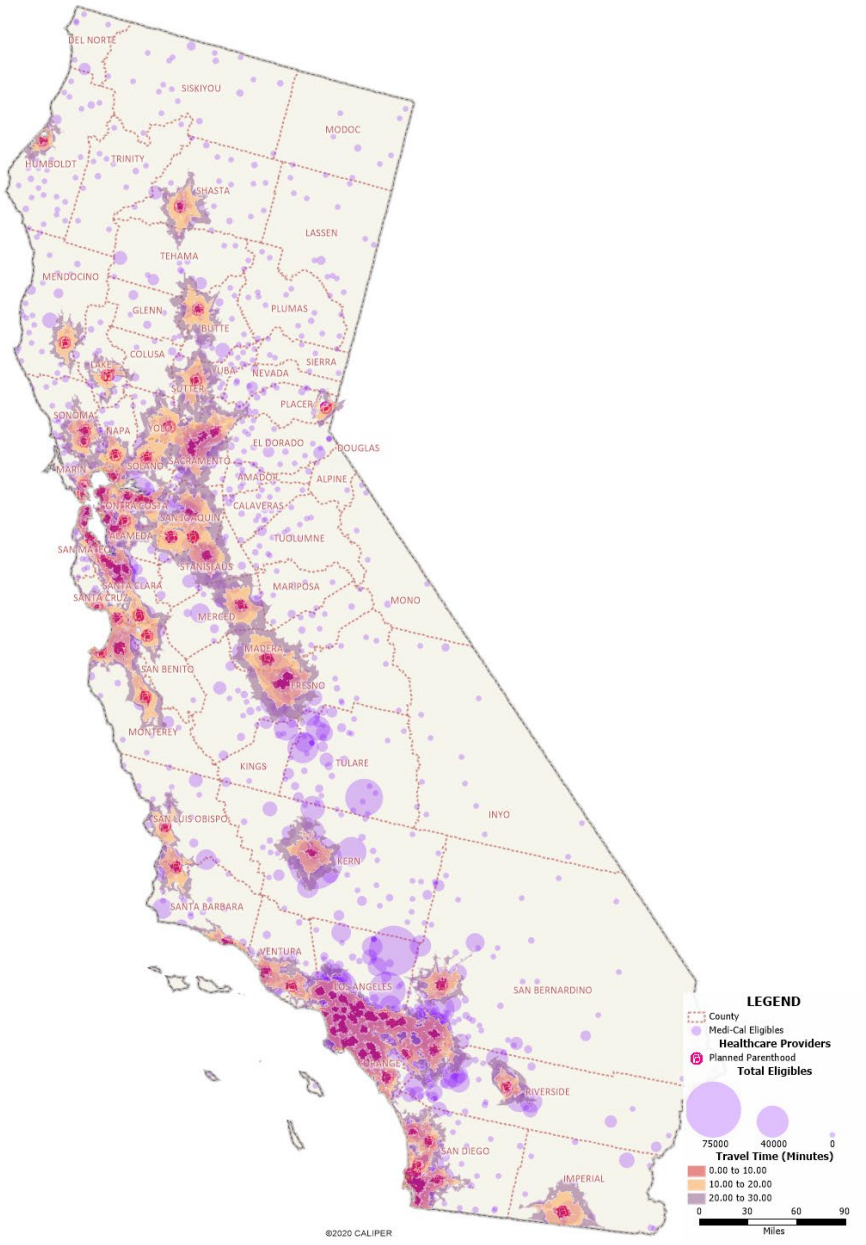
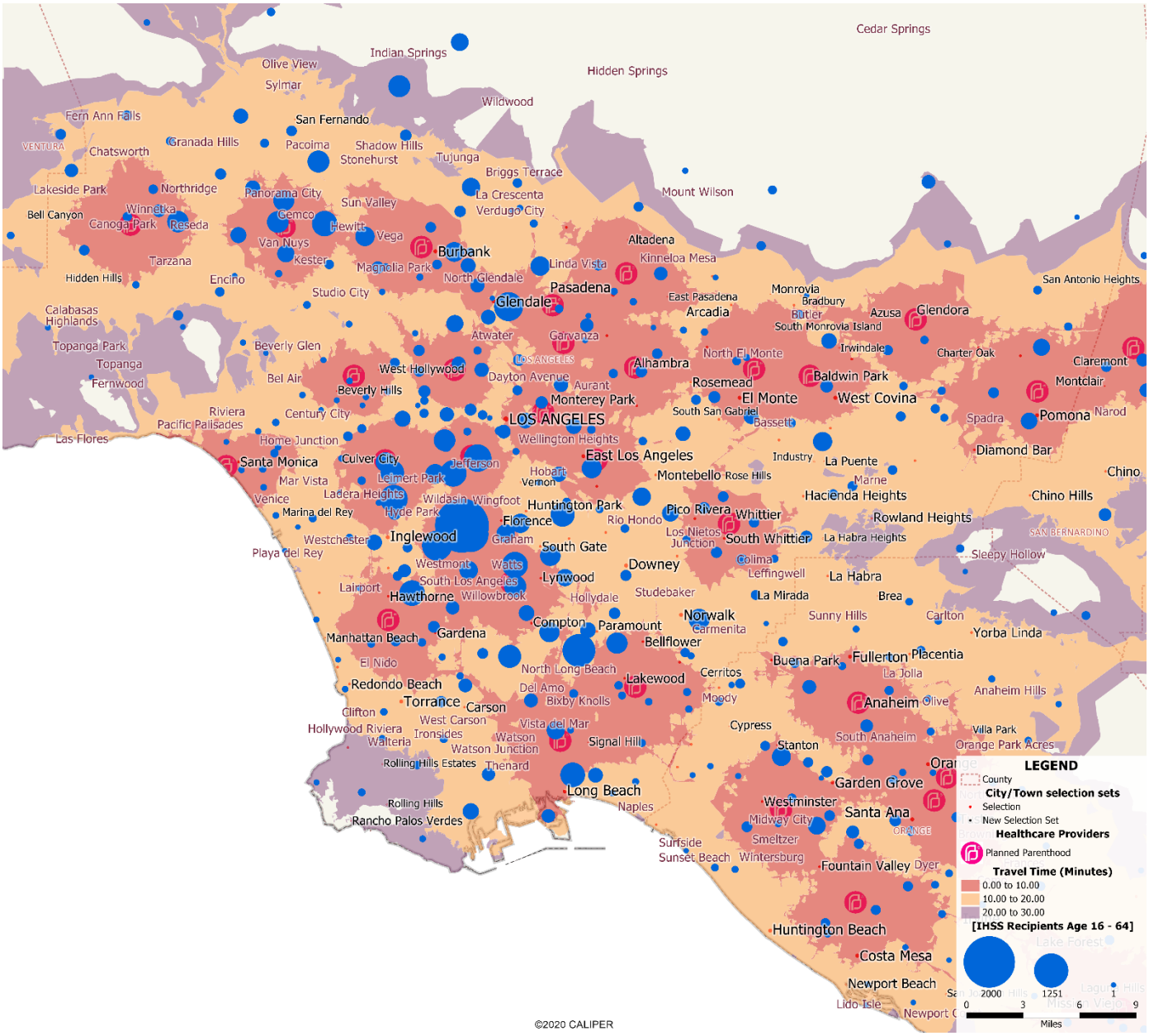
Numbers of Medi-Cal Eligibles by Zip Code and Drive Time to Planned Parenthood Clinics
(Pink is within 10 min., orange within 20 min., purple within 30 min.)



Access Impairment Due to Drive Time or Distance
Heat Map of IHSS Recipients Age 16 – 64 In Proximity to Planned Parenthood Clinics with Total Drive Time Rings to Clinics (Pink is within 10 min., orange within 20 min., purple within 30 min.)



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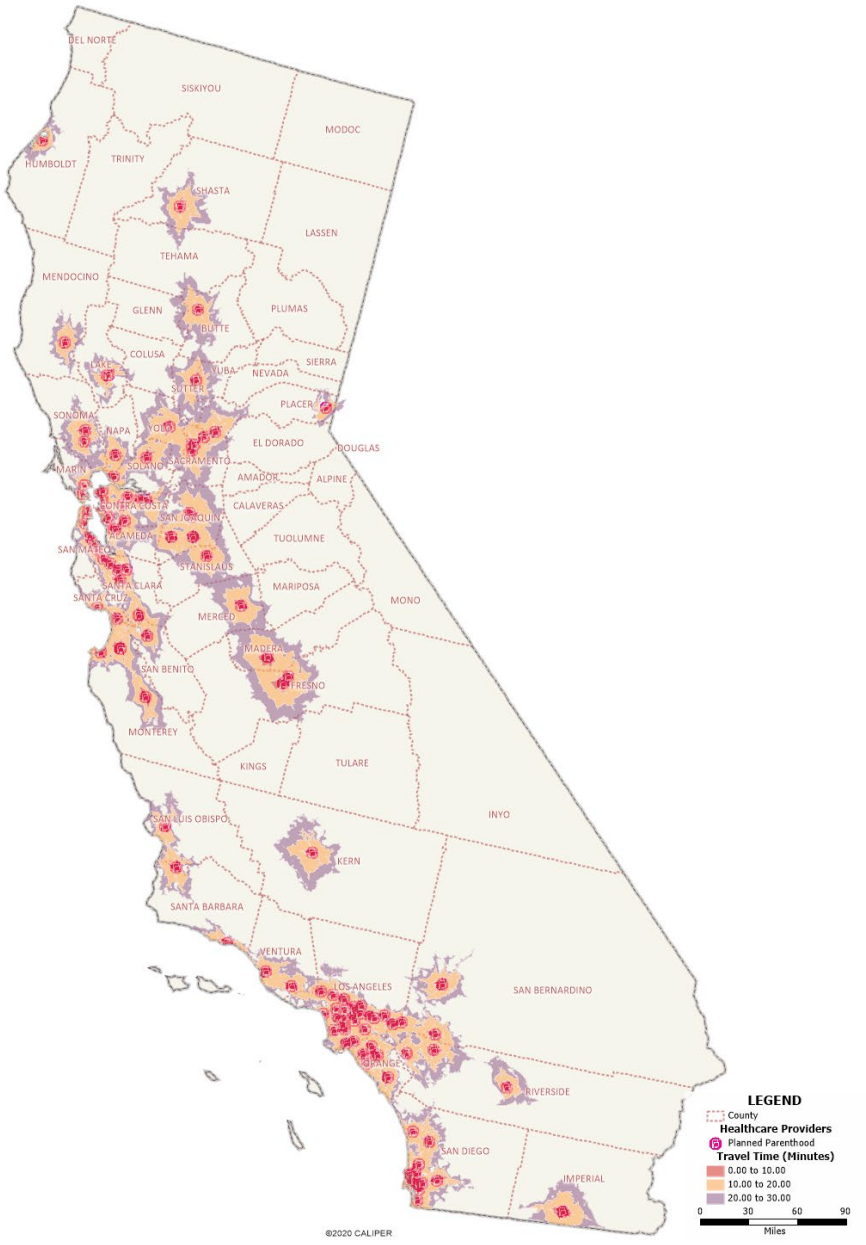

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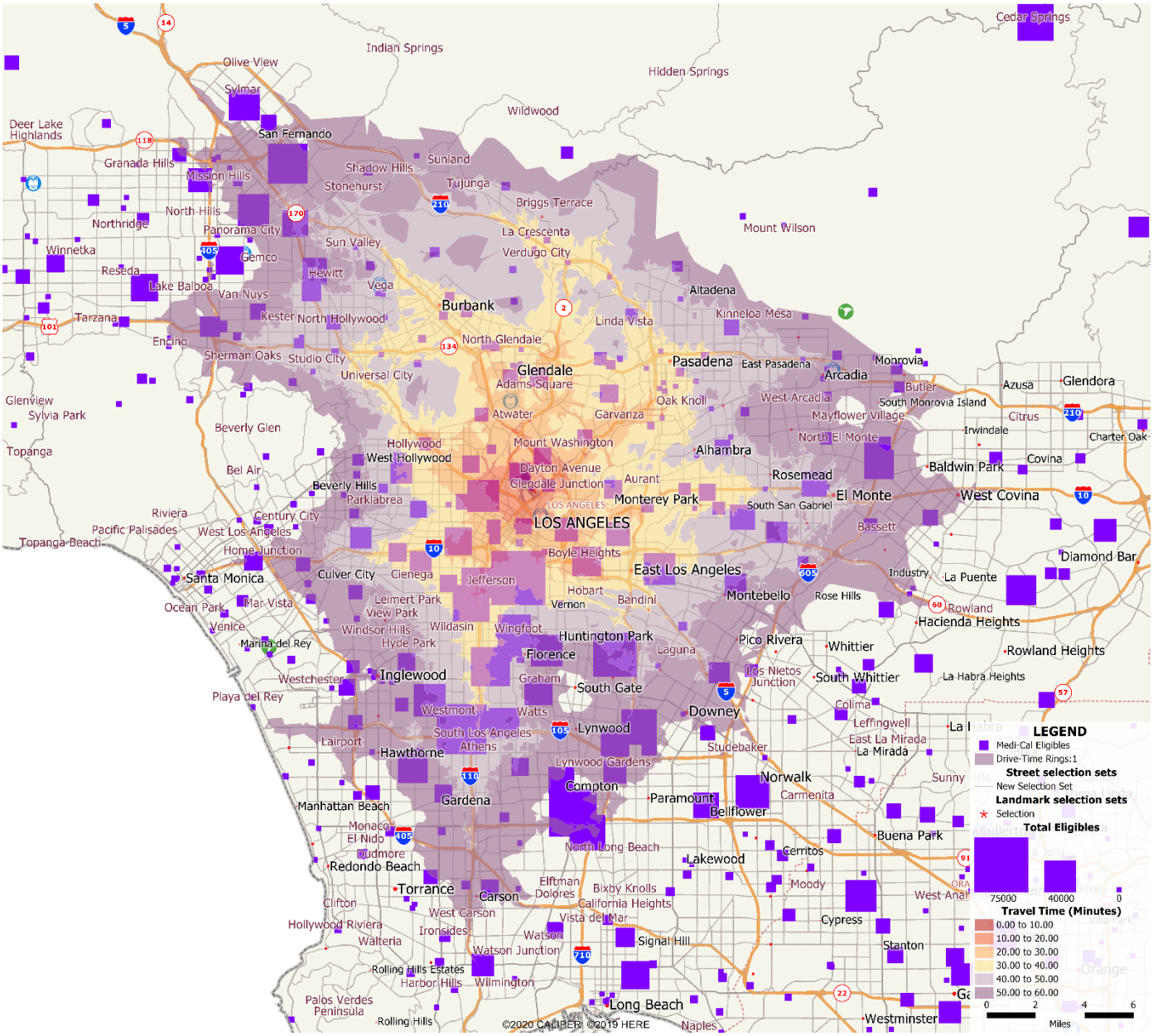
Heat Map of Medi-Cal Eligibles by Zip Code with Total Drive Time Dodger Stadium Vaccination Site
(Time to travel showin in 10 minute increments up to 1 hour)



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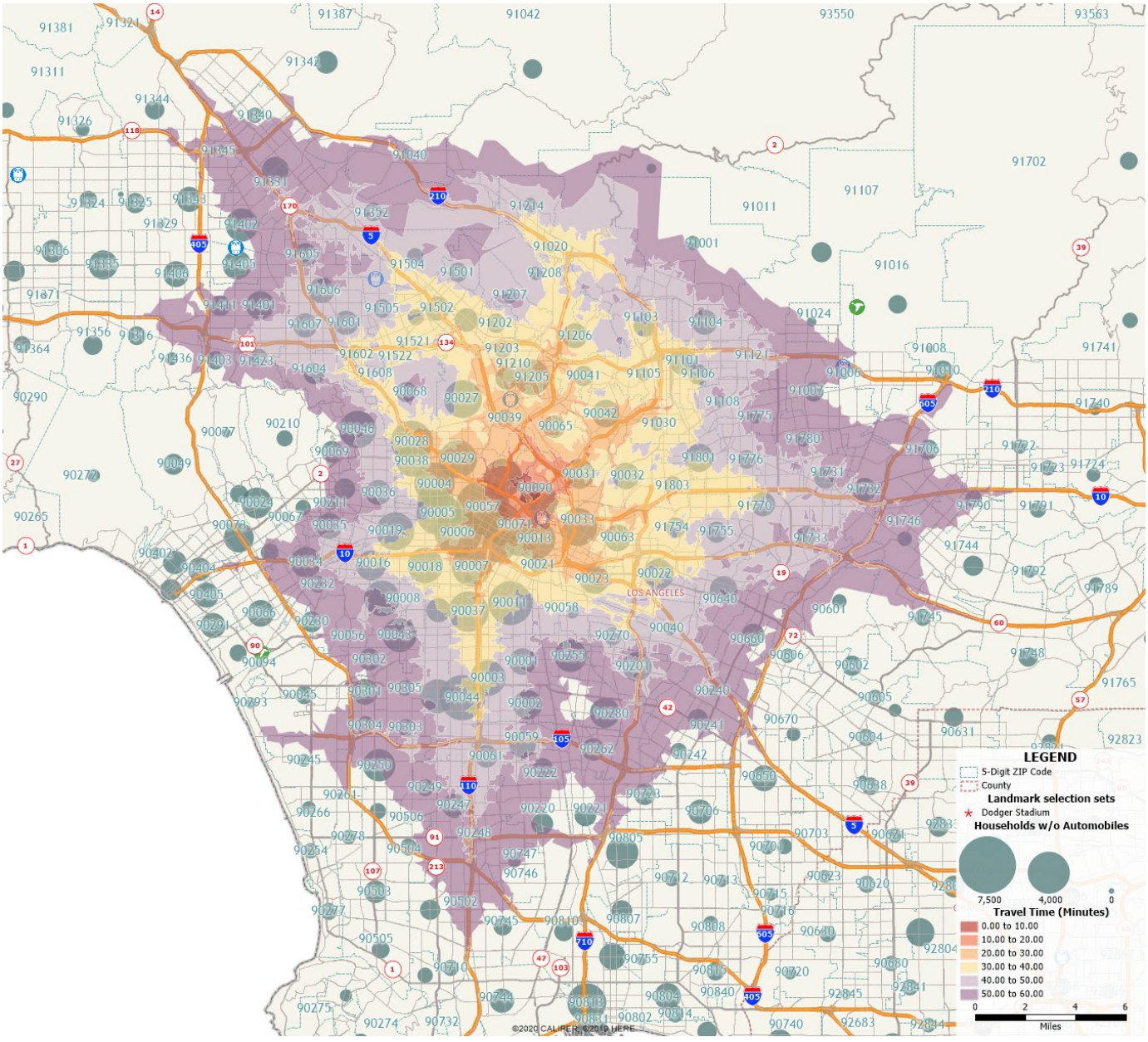
Heat Map of Households by Zip Code Without an Automobile shown with Total Drive Time Dodger Stadium Vaccination Site
(Time to travel showin in 10 minute increments up to 1 hour)



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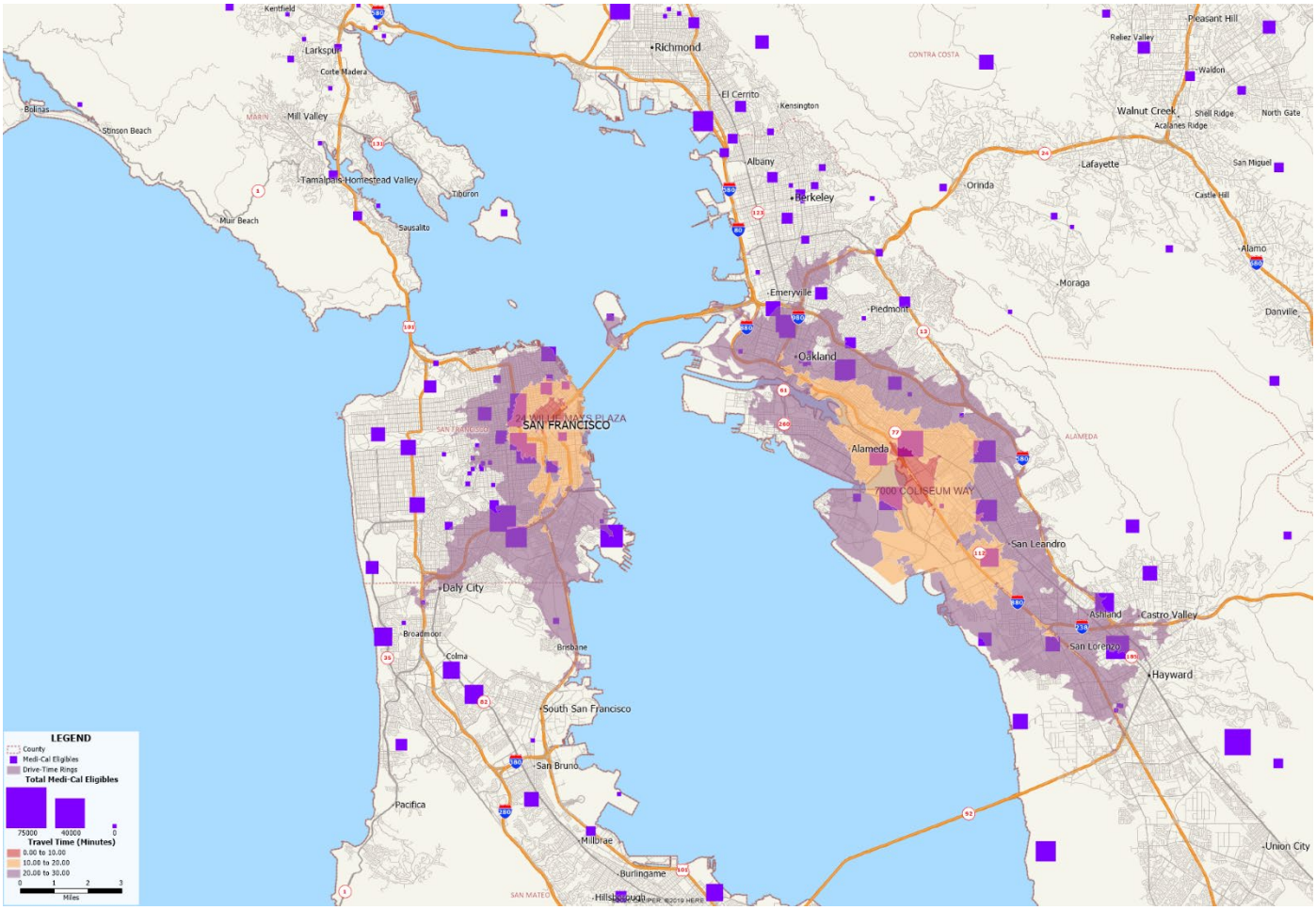
Heat Map of Medi-Cal Eligibles by Zip Code with Total Drive Time Mosconi Center and Oakland Coliseum Mass Vaccination Sites
(Time to travel showin in 10 minute increments up to 30 minutes



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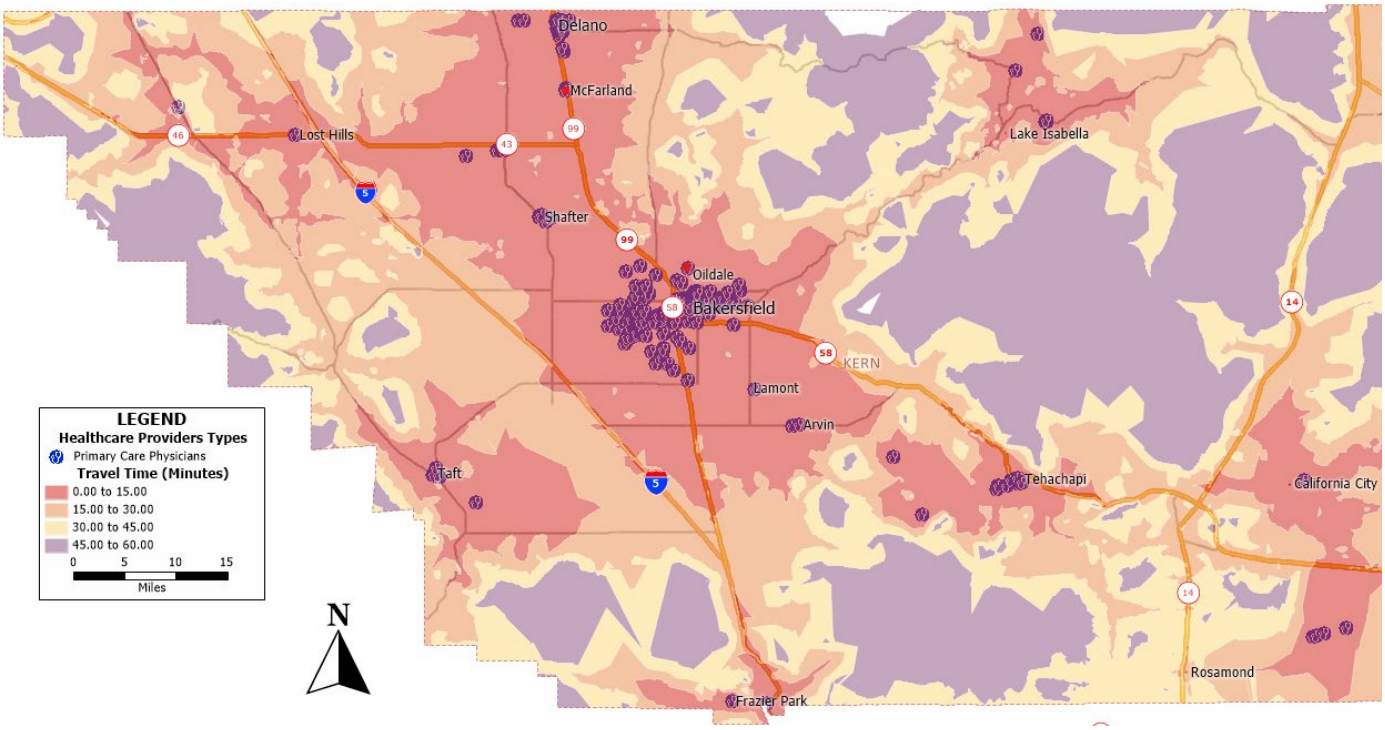
Network Access: Travel Distance to Primary Care Physician Offices in Kern County
(Time to travel showin in 15 minute increments up to 1 hour)

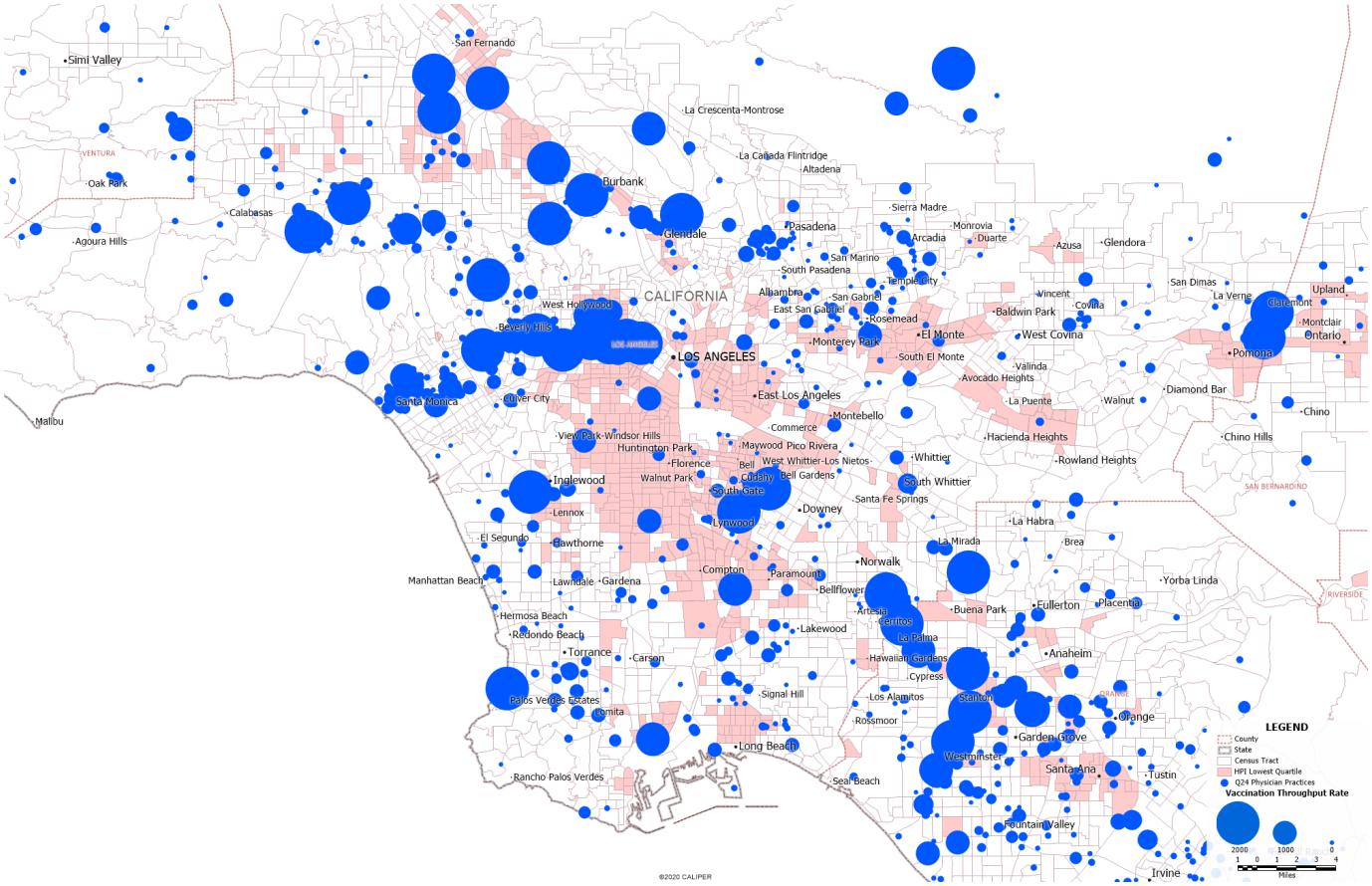


KEY TAKEAWAYS:

- **Accessibility** is measured by average travel time in urban and rural settings to primary care providers
- While many providers are located in Bakersfield, the network should consider enrolling physicians in outlying rural areas in order to achieve **travel time of <60 minutes**

Vaccine Throughput Rates

Los Angeles Area Primary Care Physician Practice Locations and Estimated Vaccine Throughput Rates Based on CMA Practice Survey



KEY TAKEAWAYS:

- CMA uses a geo-coded, data-driven approach to thinking about the network and vaccine distribution
- **4,240 community physician practice sites** in Los Angeles Metropolitan Area could be targeted to reduce transportation drive-time
- **1.8 million vaccine doses per month** could be administered by community physicians in LA County*

** CMA calculation based on survey 4,014 practices conducted Jan 6-11, 2021. Confidence Level = 95% | Margin of Error ± 1.48%*

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Vaccine Roll-out Issues and Suggestions of Action Items

The Last Mile

Perhaps the single largest issue with the slow initial roll-out but the current ability to get shots in arms was the lack of planning in the previous year for the last mile. As those familiar with vaccination programs know all too well, the last mile is hands down the hardest part of large-scale vaccination programs. It involves cold chains, logistics, training, dedicated human resources, human behavior changes, outside influences, political interventions, education, and an infusion of rapid financial support. Most all of this was missing until January 2021.

Local health jurisdictions built an infrastructure for vaccine delivery to their populations in 6 weeks with no infusion of funding, no clear guidance, no knowledge of how to operationalize priority populations, no federal strategy, nor any money. All the while experiencing the largest surge (in some areas of the country) since the pandemic began. This was nothing if not a top-down exercise based on assumptions and lack of understanding of what that last mile takes.

Let us learn this lesson form this experience: Never plan a national campaign for any vaccine without intimate and meaningful consultation with the last mile- the local health jurisdictions and the on-the-ground community providers. We must acknowledge the term "local" is often used to allude to states, but the last mile in this sense, really means the county health jurisdictions, community healthcare organizations, and providers. Let us start with acknowledging and addressing the hardest situations and most complex problems instead of starting with the low-hanging fruit because it is easier. Let us ensure we don't have every representative who sites on a federal or state level healthcare entity at the table but few to none of the last mile representatives. Anyone who works in vaccine preventable disease control, had they been allowed any insight into this program, would have easily been able to flag the missing pieces and why this would not meet the outlined goals.

Action items:

- To ensure this never happens again, CDC, HHS, FEMA, and other entities involved in the planning and distribution of vaccines will create a county-level advisory Board to inform all planning for population-level vaccination and other pandemic plans.
- The White House will include a current County-employed Medical Epidemiologist involved in vaccination allocation and distribution on the Pandemic Response Team
- The USG will not only currently invest in COVID vaccine infrastructure, but will double its financial support for Federally Qualified Health Centers (FQHC) as the key resources for the distribution of vaccines to our most COVID impacted communities, who also happen to be our communities of color and those who are disproportionately uninsured and underinsured. The additional funding will:
    - Aim to double the network of FQHCs across the US, with an emphasis to increase the coverage proportional to the population whoa re uninsured and underinsured in the US.
    - Small grant support to community clinics in the most impacted communities based on a social vulnerability Index who need that "last mile financial support" to get them over the barriers to qualify for FQHC funding
    - Higher CMS re-imbursement rates per vaccine administration, with a sliding scale for those population groups who are harder to reach, are traditionally vaccine-hesitant or

have been experienced institutional racism through the healthcare system. This acknowledges the previously non-quantified but hardest work of getting those people to trust and into the door to administer the vaccine.

Equity Issues

Ensure legislation guides and puts in place metrics that hold states accountable for their use of COVID vaccine funds by limiting their ability to move a large proportion to the private sector. Achieving equity is a direct reflection of investment and funding. If you send a billion dollars to states, it must be clear that local health jurisdictions must receive a large amount of it, FQHCs, and non-traditional partners for local innovation around service delivery. It is hard to achieve equity when a small number of people and providers are doing most of the actual work on equity and ye the money does not follow. Government funding for public goods and services should reflect the values and the targets of the services. Funding consultants and external entities to come into communities where local knowledge and know-how is concentrated in local leaders, has always and will remain inefficient and ineffective. The US Senate should support vaccine and continued essential public health with more equitable funding approaches, ensuring diversity of leadership and interventions is the loudest voice in the room.

Action items:

- Ensure funding that goes to states for public health responses, has a cap on how much can flow to private consultant agencies, insurance companies, and other entities that lack the local know-how and provide an additional bureaucratic layer.
- Create an Equity Innovation Fund executed by a small pilot of local health jurisdictions at the County level to allow regional flexibility to identify and support local innovation in vaccine efforts that address community-specific barriers to be lifted up, invested in, and shared and scaled to other partners.
- Create metrics and re-imbursement schemes for the non-quantified work FBOs, CBOs, and other community partners undertake to help create and disseminate information in a culturally-appropriate way, register these communities in appointment system platforms that exacerbate the digital divide instead of negate it, and facilitate transport and other necessary support to these communities to ensure vaccine administration and completion of the series, where applicable.
- Create and adopt metrics that quantifies how much money follows talking points of elected officials

Local Determination

Each state in the US can vary on how they implement public health, it can be a centralized state or a decentralized state. In California, we have a decentralized state so the local public health departments do all of the implementation. When a state has 61 local health jurisdictions, some incredibly small, and other like Los Angeles County- 88 cities plus more than 10 unincorporated areas, approximately 10 million people, 63,000 PEH, 13 routinely spoken threshold languages- the state necessity to standardize processes is understandable, and yet less than ideal for most local health jurisdictions. Part of equity is acknowledging the diversity of populations with very different experiences and needs. Nowhere does this manifest more in public health than the need to tailor vaccination education, services and interventions to the local context. While a more streamlined approach at a state level can make

implementation and tracking and reporting easier to the federal entity, it strips away the flexibility both in terms of funding and implementation. This highlights the disconnect between equity talking points, and equity implementation actions and must be addressed.

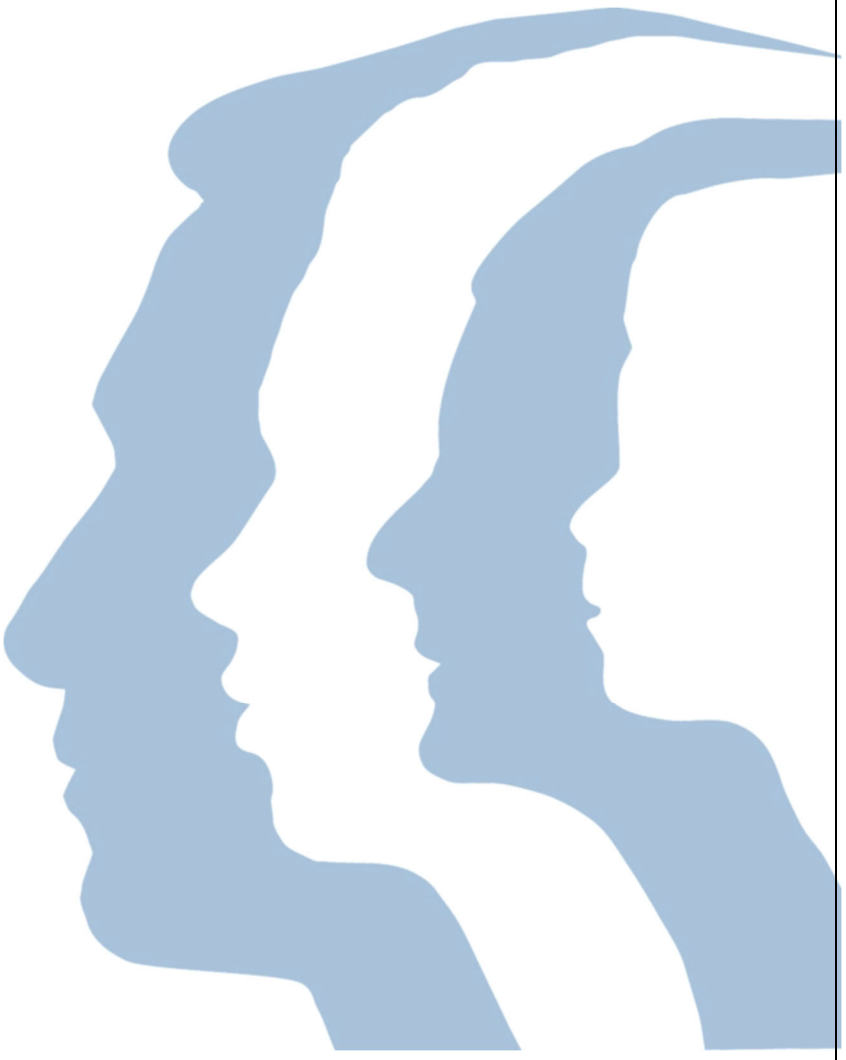
Action items:

- Undertake a review state and local health jurisdiction funding processes and systems in HHS, HRSA, CDC
- Ensure 1 local health jurisdiction representative is involved in each programmatic build out of each grant cycle
- Build out infrastructure for large counties over the threshold of 3 million people to be able to decide if they would like to be direct awardees of vaccination funds or be a part of the larger state grant.

County of Los Angeles Public Health

COVID-19 Vaccine Equity Committee Assessment and Recommendations

Prepared for the Los Angeles County Board of Supervisors
February 2021



Acknowledgements

"For there is always light. If only we're brave enough to see it, If only we're brave enough to be it."
Amanda Gorman, Poet Laureate

Thanks to the entire committee for sacrificing their time and advocating for vulnerable voices that could not be at the table. During the darkest days of the pandemic, your optimism and belief that we can effect change towards equitable vaccine distribution remains a guiding light.

A sincere thanks to the Committee Co-Chairs, Dr. Hector Flores, MD (White Memorial) and Roberto Vargas, MD, MPH (Charles R. Drew University) for their patience and tireless efforts to ensure all voices are heard and recommendations actionable.

Thanks also to the scribes and subcommittee chairs for facilitating weekly sessions and notes:

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- Carolyn Buenaflor, Cedars Sinai- Communications Subcommittee Chair
- Sonya Vasquez, Community Health Councils- Mass Vaccination & Resource Alignment Subcommittee Chair
- Kara Crew, MPH, Los Angeles County Public Health Outbreak Team- Committee Scribe
- Kimberly Cooper, MA, Los Angeles County Public Health Senior Analyst- Committee Scribe
- Fatu Amara, Watson Fellow Intern- Committee Scribe

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From Tracey Veal. DrPH, MBA- Equity Committee Chair and Los Angeles Public Health Executive Advisor

COVID-19 Vaccine Equity Committee Assessment and Recommendations

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Preface

COVID-19 inequities are inextricably linked to disproportionate impact on vulnerable populations and those disadvantaged by race, ethnicity, occupation, residence and socio-economic factors (See **Appendices A, B and C**). Los Angeles County Public Health Department (LAC DPH) convened an Equity Committee and Workgroups to provide actionable recommendations to ensure equity is addressed in COVID-19 vaccine distribution. Equity Committee meetings initiated in December 2020 and continue as of January 31, 2021, the date of this report. The Vaccine Equity Committee catalyzed community, academic, public and private sector partners with a shared, vested interest in a continued effort to ensure effective vaccine communication and distribution reach Los Angeles County vulnerable populations.

Due to considerable interest in participation, the Vaccine Equity Committee organized into four sub-committees (a total of 50 representatives). Equity sub-committees are comprised of a diverse group of nationally known healthcare and equity experts, physicians, community-based organizations (CBOs), and government representatives. The Subcommittees listed below were organized based on the number of committee members, initiative scope and existing Workgroups (Communication and Community Engagement and Mass Vaccination and Resource Alignment) for consolidated feedback:

- Equity: Addressing Challenges & Solutions — Section 1
- Process and Outcomes for Monitoring & Assessment — Section 2
- Communications and Community Engagement — Section 3
- Mass Vaccination and Resource Alignment — Section 4

Highly acclaimed equity frameworks supported organizing feedback and recommendations. The National Academies of Sciences, Engineering and Medicine (NASEM) Equity Framework[1] provided foundational principles to ensure recommendations: (1) were easily understood by diverse audiences; (2) included widely accepted social and ethical principles; (3) can be operationalized; and (4) aim to impact, not perpetuate, discrimination and inequities. In addition, the Big Cities Health Coalition Health Department equity methodology was utilized for CBO assessment of the impact of decisions on different groups.[2]

Two key challenges adversely impact vaccine equity but are beyond the scope of the Workgroup. However, these challenges are important considerations for LAC DPH and Los Angeles County residents. Current vaccines available, by the nature of cold chain supply requirements, are inherently inequitable because clinicians serving vulnerable communities do not customarily have the infrastructure, equipment and funding to meet vaccine administration requirements for these types of vaccines.

Another challenge to addressing equitable vaccine distribution is the constantly evolving landscape, with unpredictable daily changes in policies, allocations, phases, tiers and sequencing. In addition, multiple stakeholders (federal government, state, and local political leaders) hold varying degrees of decision-making authority and influence impacting equitable distribution. At the time of this report submission, the State of California announced contract negotiations with Blue Shield of California, a private insurer assigned as a third-party administrator for vaccine distribution. Blue Shield's role was described as creating, contracting and managing statewide vaccine administration networks to speed equitable vaccine delivery. Despite Blue Shield 's public statements regarding inclusion of equity metrics, the Workgroup raised concerns regarding the insurer's capacity to balance volume (shots in arms), a key

vaccine allocation metric, with vaccine distribution in smaller, disproportionately impacted communities.

The Committee recommendations are based on the expectation that LAC DPH retains authority to influence local public health policy and infrastructure for equitable decision making. The report is a living document with the expectation that recommendations may change over time to adapt to environmental needs.

Executive Summary

Disparities in mortality among Blacks, LatinX, Asian Americans (AAs), Native Hawaiians and Pacific Islanders (NHPIs), and Native Americans and those who live in poverty, highlight the dire need for an immediate and persistent response from the Los Angeles County Department of Public Health to develop, implement, and continuously assess strategies to equitably allocate, administer, and surveil vaccination against COVID-19 in Los Angeles County. As of January 30th, 2021, Los Angeles (LA) County reported over 1 million (1,104,393) COVID-19 cases and over 16 thousand (16,332) deaths during the pandemic; making it the California County with the highest number of cases. The mortality rate per hundred thousand (100K) was highest among Latinos at 235 followed by African Americans at 139, then Asians at 101, compared to 83 per 100K for non-Latino Whites. The death rate for individuals from communities where 30% to 100% of the population live in poverty was 280 per 100K compared to 81 per 100 those in communities with less than 10% living in poverty and 243.[i]

The recent approval of vaccination as a tactic to stem the tide of severe disease and death from this public health crisis, while encouraging, is tempered by limited availability of this life-saving therapy. The limited vaccine supply has required development of eligibility criteria as a strategy for fair resource allocation. The process includes prioritization recommendations from the Advisory Committee on Immunization Practices to the Centers for Disease Control. Currently, the federal government provides State governments the authority to determine allocation and distribution practices. At the time of this report, LAC DPH in conjunction with the State of California, has the capacity to allocate a select number of vaccines for County distribution. In addition to this DPH allocation process, vaccines are also administered in Los Angeles County through other means, not controlled by DPH, such as multi-County entities receiving vaccine distribution directly from the state. The recent announcement that the State is contracting with a third-party entity will ultimately influence the lines of authority and responsibility for vaccine policy. However, our observations and recommendations will largely remain unchanged. Committee leadership has committed to remain engaged to advocate for equitable vaccination practices for County residents regardless of the outcome of third-party policy decisions.

On December 9th, 2020 DPH convened the first meeting of the COVID-19 vaccine equity committee (VEC). This committee, in an advisory capacity, is co-led by a LAC DPH assigned Executive Advisor, and two external community members, with a broader membership of 50 committee members (See **Appendix H**). Since December, the committee has met weekly to gain insights from the collective stakeholders, review current allocation recommendations, and provide guidance to LAC DPH leadership on actions and plans to ensure (1) distribution of vaccinations occurs in an equitable manner, and (2) that the process is informed objectively and assessed transparently.

The structure of weekly meetings includes a general session in which members bring feedback and direct observations from constituents and communities regarding immediate concerns for inequity and

disparity in vaccine distribution. The second part of the meeting is reserved for subcommittee breakout sessions to collaboratively develop recommendations for this report as well as address topics categorized as priority intervention. Committee leadership is committed to continue convening throughout the vaccine roll-out, as noted earlier. The commitment supports rapid responses, facilitates communication of community needs to DPH leadership, and allows the committee to collaboratively and iteratively design solutions to address the immediate crisis.

The committee is structured into four working groups that provided key observations, including the following:

1. Assessment of the Challenges to Achieve Equity: This sub-committee received feedback from the larger VEC on challenges and threats to equity in the vaccine roll out. In addition to documenting feedback, the sub-committee addressed immediate concerns, identified ways to leverage existing resources and VEC relationships as a collaborative response. Early examples of gaps identified included the absence of an effective tier 1A approach for identifying and supporting healthcare providers not affiliated with integrated delivery systems, and federally qualified health centers designated as "Look-Alike" FQHCs, or disproportionately impacted hospital systems that received insufficient allocations. A process to assist in coordination of essential healthcare workers' access to vaccines for themselves and their staff was developed and implemented in the disproportionately impacted areas referenced above. Committee membership support, outreach to the Los Angeles County Medical Association and direct relationships with current provider hubs, helped alleviate the challenge. Additional immediate and priority challenges observed include:

    - The need to factor in the impact of COVID-19 exposure and mortality for equitable allocation prioritization
    - The need to address racial and ethnic communities' heightened risk for vaccine access disparities
    - The need to clarify phase, tier definitions within categorizations, and expand verification of eligibility
    - Implementation of a communications campaign targeting the most adversely impacted communities and populations
    - Target vaccine distribution to disproportionately impacted population hotspots

2. Equitable Assessment and Monitoring of Vaccination for High-Risk Populations: The most urgent concern observed by the group was lack of transparency in decision-making processes. Specifically, determining which area would receive vaccines, how distribution was related to needs, how many an area would receive, and related resource allocation to support vaccination via DPH-designated points of distribution (PODs). This included whether decisions adequately assessed which communities were at most risk for disparity. Key committee suggestions included:

    - A need for clear lines of accountability of who has decision making authority for determining vaccine allocation and vaccination sites
    - The committee must have representation when and where decisions are made regarding vaccine distribution. When it may not be feasible to have external parties at the table, having access to minutes and other records of relevant committees at

intervals to allow for comment on decisions that determine allocation of vaccines is important.

- Addressing limitations of the Healthy Place Index[ii] (currently recommended by the state for vaccine distribution decisions) as it can underestimate risk for poor outcomes in African-American communities[iii]
- Other factors not included in the HPI should be incorporated into a tool to identify locations for vaccine distributions, including race, ethnicity, limited English proficiency/language, immigration status, and multigenerational households.
- Clarify if and how consideration of regional disparities in hospital resource availability, percent positive infection rates, and COVID-19 death rates were factored into considerations.
- Support targeted outreach and vaccination efforts for populations dispersed outside of designated and measured geographies such as Native Americans, Native Hawaiians, and Pacific Islanders and those experiencing homelessness and/or disabilities
- Provide ongoing publicly accessible dash-boarding of:
  - Vaccine allocation amounts to PODs by site geography
  - Vaccination rates (1st and 2nd doses, where applicable) by neighborhood, age group, gender, and race/ethnicity of individual
  - DPH responses to Vaccine Equity Committee requests and recommendations

Representatives within DPH's vaccination leadership and data science unit met with the committee representatives to address several concerns. Assurances were given that DPH will provide representation on an ongoing basis to the committee for more decision-making transparency moving forward. In addition, DPH will have regular representation at future equity committee meetings for collaboratively development of a process for real time data reporting and dash-boarding to promote transparency and trust. Committee members see themselves as key partners for DPH, but as one member stated: "We can't advocate for what we can't see."

3. <u>Communications, Community Engagement, Education and Awareness (CCEEA):</u> This equity subcommittee aligns with the Communication Committee (CC) in the greater DPH vaccination effort. In addition to providing direct feedback to the CC on multilingual materials, support for disabled persons, and culturally appropriate services, the committee and broader VEC members delineated additional observations. In addition, CC members collaborated to engage in listening sessions with various constituent groups deemed high risk to identify messages and strategies as noted below:

    - There is an immediate need to engage with trusted providers and community members in messaging, in recognition of historical barriers and discrimination as well as account for immigration status and other anxieties, in anticipation of vaccine criteria expansion
    - Need to engage community health workers, churches, and schools and other trusted sources of information
    - Need to include the use of social media influencers in education communication and awareness, in addition to traditional ethnic and mass media
    - There needs to be a better definition of who qualifies within the initial tiers

This sub-committee will be available to serve as a future bi-directional channel of communication to share community needs and observations with DPH leadership. Specifically, the sub-committee will address challenges to equity, and the continued need to educate the community on the evolving decision-making process of DPH resource allocation. In addition, the members can facilitate consumer education on vaccine access, provide updates on tier eligibility, and disseminate evidence-based information to reduce hesitancy for those who were eligible but did not receive the vaccination during the initial eligibility period.

4. Operations and Prioritization to Maximize Vaccine Access and Use for High Risk Populations:
This equity subcommittee also has a partner track within the larger DPH Vaccination effort with the Aligning Resources for Mass Vaccination committee (ARMV). ARMV shared their preliminary report approach with VEC. The collaboration aided the subcommittee in assessing threats to equitable vaccinations, supported identifying shared resources and on the ground approaches. It is within this collaborative framework that this sub-committee also offered additional suggestions to aid in identifying areas of greater need, and recommendations for both current and future allocation plans that pose equity threats or potential solutions to equity challenges noted by the larger group summarized below:

    - We recommend funding for equity metrics that reflect the unique characteristics of Los Angeles County's populations, including racial and ethnic composition. UCLA Brite has an effective working model inclusive of race and ethnicity. Similarly, financial support should be available for academic partners (USC, Charles Drew University, Kedren Health, MLK Community Hospital and the MLK Outpatient Center) to expand testing and vaccination capacity for the most disproportionately impacted areas.
    - The County should expedite a vaccine training and certification program for community groups/non-medical professionals and seek temporary waivers on regulatory limitations for disproportionately impacted areas.
    - The County needs to identify vaccination sites in low-income, diverse communities and hard to reach areas throughout the county, including areas with seniors that are non-mobile (e.g., Asian and Latinx elderly in Chinatown apartment buildings).
    - These sites need to be determined soon for readiness to support Phase 1b and 1c.
    - The committee wants to understand the current vaccination site distribution plan. We need an overlay of the current and anticipated points of distribution in advance, with heat maps so that we can understand gaps and provide more strategic recommendations. Such as:
        - Employ mobile units similar to American Red Cross blood drive infrastructure to reach homebound, disabled, or homeless clients;
        - Locate sites near transportation hubs, parking access, language access, and disability access; and
        - Sites must be ADA compliant. If site meets other requirements, the City Department on Disability can assist with digital and physical accessibility needs.
    - The plan must include financial and nonfinancial support to assist organizations with readiness, creating collaborations, trainings and more.
    - Provide community support and education on how to become a certified vaccination site.

Finally, the committee reiterated the need for procurement and distribution of Personal Protective Equipment (PPE) to essential workers and corresponding worksites in high-risk, low income communities. In addition, continued testing and contract tracing in these high risk communities is critical as distribution of COVID-19 vaccines is limited.

As of January 31st, the timing of this report submission, a great deal of uncertainty and ambiguity about what vaccine allocation and distribution policies will be implemented moving forward exists. We acknowledge DPH's limitations in anticipating state and federal level regulations that may impact DPH's ability to implement our recommendations. However, we also believe: (1) the recommendations will have an immediate impact, pending the release of new state and federal level plans and (2) several recommendations will also be relevant in any future effort to ensure equity in vaccination and sustainable infrastructure in Los Angeles County.

Moreover, this period of flux is also an opportunity for leadership to review committee recommendations and for the committee to continue reviewing new policies as they evolve. Continued review ensures currently recommended strategies provide vulnerable communities and their advocates agency, accountability, transparency, and relevance in informing allocation and distribution policies for this life-saving therapy. On behalf of the committee, as we submit our full report, we greatly appreciate their contributions to this effort. We are grateful to the Department of Public Health leadership for engaging us on equity issues and responsiveness to our requests and recommendations in our collaborative efforts in this pandemic.

I. COVID-19 Vaccine Equity: Assessment of Challenges and Solutions

COVID-19 exacerbates inequities and disproportionately impacts L.A. County's most vulnerable residents Appendices A, B and C). Mortality rates for people of color are more than double White residents', with adults over the age of 65 representing nearly 75% of the 16,000 deaths (**Appendix A**) .[3] Given these disparities, it is critical that the County's vaccine distribution efforts are guided by equity considerations. Health equity is defined by the Health and Human Services Office of Minority Health as, "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities."[4] The Assessment of Challenges to Achieve Equity sub-committee focused on identifying key populations at risk of inequity (**Appendix D**) and developing recommendations to advance COVID-19 vaccine equity. A high-level description of the workgroup's recommendations is summarized below (a detailed recommendations list is available in **Appendix E**):

Factor impact of exposure and mortality for equitable prioritization

The workgroup recommends the County incorporate exposure risk in setting priorities for vaccine distribution as a key equity indicator. Specifically, the County DPH should prioritize residents with low-autonomy or agency to protect themselves who are at high risk of COVID-19 exposure in disproportionately impacted communities (**Appendix D**). These residents include workers, primarily of color, interfacing with the public daily and unable to work from home; multigenerational households with individuals dependent on a caretaker or an essential worker, incarcerated residents, and residents of group or rehabilitative homes. Furthermore, the workgroup recommends the County DPH include

morbidity and mortality risk in vaccine distribution decision-making for the above populations. The risk assessment involves granting priority to individuals and populations at greater risk for morbidity and mortality if they contract COVID-19, including individuals with certain underlying conditions and persons with disabilities.

Address vulnerable populations and communities of color vaccine accessibility barriers

Key challenges and solutions for vulnerable populations in vaccine planning:

1) Provide ongoing, consistent in-language and culturally specific messaging regarding:
    a. Clear and expanded definitions of Phases and Tiers and how they apply to the public
    b. Clarity of vaccination eligibility and the process for obtaining a vaccination when an individual's tier is eligible
    c. Vaccine availability to all residents regardless of immigration status
    d. Vaccine is free and no insurance required
    e. Ensure all facts about post vaccination experiences and second dosage is understood and provided before the individual exits the vaccination site
2) Address equity in the set-up of vaccination accessibility for individuals without cars and who may have mobility considerations, technological issues and the digital divide in
    a. Vaccine sign-up (online and via phone). Ensuring the online platform is operable via smartphone, aligns to Asian Americans broad use of smart phones versus computers and addresses the current smart phone navigation challenge with the county vaccine appointment website.
    b. Ensuring adequate telephone staffing, community health workers, and community-based organization (CBO) ambassadors are available to act as formal navigators.
    c. Clearly state that email is not required for sign-up in multiple languages.
3) Address equity in the set-up of vaccination accessibility for those without cars and who may have mobility considerations. Many of LA County's most vulnerable populations are transit-dependent and utilize public transit for essential trips. These residents have been particularly impacted by the pandemic as a significant portion of the transit workforce contracted COVID-19, resulting in service cuts or cancellations and ultimately leaving transit-dependent residents with few transportation options. Thus, equitable access needs to be considered and includes options for walk-up sites, transportation to vaccination sites and bringing vaccines into these communities for individuals unable to travel to a site. In addition, the workgroup recommends transit worker prioritization for vaccination based on high risk due to daily contact with the public.
4) Recognize that some high-risk populations are dispersed, e.g., urban Native American and Pacific Islander populations, and customize messaging through trusted, traditional means.
5) Confirm and identify flexible documentation requirements beyond government and employment identification. Provide an expansive list of identification options incorporating these options. Ensure public and staff understanding of the requirements.
6) Clear messaging on personal information confidentiality and that it will not be shared with law enforcement, including immigration enforcement.
7) Ensure flexibility in appointment times to expand the 8 am - 8 pm and weekend appointments for essential worker shifts for disproportionate impacted areas and worksites.

Clarify phase and tier categorizations and expand verification of eligibility

In the current vaccination distribution plan, it is unclear where certain categories of individuals particularly vulnerable to COVID-19 fit. The County must develop ways for individuals to verify eligibility that does not deter vaccine uptake in the most disproportionately impacted populations and communities.

For example, redefining essential worker to include highly vulnerable workers who do essential work, but do not meet the strict definition of essential worker (i.e., unpaid caregivers). The labor of these individuals requires close proximity to others, placing them at high risk for exposure. These individuals include unlicensed caregivers, health aides not employed by an agency, and undocumented workers performing vital services. If exposure is included in the prioritization criteria, even if these vulnerable individuals do not meet the essential worker definition, exposure risk would prioritize inclusion in the most appropriate tier and phase.

Implement communications campaign targeting key communities and populations

Mistrust of government and lack of accurate, in language, culturally sensitive information are key barriers to equitable vaccine distribution. The workgroup recommends the County immediately implement a targeted communications campaign for communities and populations at high risk for inequity to address these barriers. The County must engage community and faith-based organizations as well as trusted providers that work with these communities and populations to develop and disseminate information to counter persistent inaccuracies. In addition to engaging community-based organizations as trusted messengers, the County should also utilize ethnic media, and localize implementation.[5]

Given the County 's cultural diversity, the communications campaign must be culturally relevant and in multiple languages and education levels. The County should collaborate and leverage supportive agencies' (e.g., State unemployment, disability or social security) expertise in serving disproportionately impacted populations. Doing so would encourage participation for notifications and updates about COVID-19 vaccines aligned to individual preferences. Furthermore, the County should use these agency websites to link to County media and develop accessible materials for residents with disabilities (e.g., homebound, blind, deaf, and those with cognitive or mobility disabilities) already utilizing the aforementioned agencies.

Target vaccine distribution to disproportionately impacted population hotspots

The workgroup has a number of recommendations related to improving vaccine access for vulnerable populations related to data driven distribution. A comprehensive discussion related to data implications is included in the Process and Outcomes for Monitoring & Assessment Section of this report due to the importance of the approach in equitable vaccine distribution. Our workgroup recommends the County identify and prioritize vaccine distribution to COVID-19 disproportionately impacted communities. The County should use a data driven process to identify hotspots. We recommend the use of index data that captures multiple indicators. In addition to utilizing traditional strategies for targeting and prioritizing vaccine distribution in hotspot communities, the County should also engage in outreach efforts to distribute the vaccine to populations at high risk of inequity that are geographically dispersed throughout the county such as Native Americans and Asian Pacific Islanders **(See Appendix F)**.

Heat mapping is also important to identify vulnerable population clusters that may have transportation barriers to access vaccine distribution site. The County should develop mobile vaccine distribution capacity to reach these individuals to address this barrier. In addition, to accommodate individuals with physical disabilities and limited mobility, including older adults, vaccine distribution sites must be ADA compliant or offer alternatives.

Enhance data collection and reporting

The workgroup recommends the County implement additional data collection and reporting practices to support equity in vaccine distribution. Specifically, the workgroup recommends that the County collect and report data in regular intervals such that racial, ethnic and geographic disparities are readily identifiable and can support targeted vaccination planning. In addition, allowing individuals multiple race category options instead of one multi-racial optional, supports more accurate analysis of the most impacted groups. Racial and ethnic data should be disaggregated, for certain Native American and Asian populations. The workgroup also recommends the County implement the data collection and reporting recommendations included in the Los Angeles City/County American Indian Commission Letter to the Board of Supervisors: *Ensuring Collection of Full Racial and Ethnic Data of COVID-19 Patients Throughout Los Angeles County* (**Appendix G**). The County's communications and vaccine distribution strategy should incorporate this data to address identified disparities and gaps. In addition, vulnerable populations require:

- Robust data tracking of individuals that fail to obtain the second vaccine dose. These individuals may require more vigilance and customized solutions if high declination rates increase.
- It is equally important that we protect against any pressures to "claw back" vaccines from high-risk communities for underutilizing vaccine allocation. Considerable trust issues persist that could impede communities' vaccination uptake if this report's recommended engagement strategies aren't well executed. Establishing protocols for the scenario, where vaccines aren't subject to inequitable reclamation/redistribution is key.

II. Process and Outcomes for Monitoring Assessment of Equitable Vaccination for Vulnerable Populations

A. Rapid Response Model

As noted in the previous section, given the significance of data implications, a subcommittee comprised of a cross-functional team of data experts, physicians/health professionals, CBOS, government and faith-based leaders convened for this assessment. The subcommittee identified process and outcomes needs for continuous assessment and monitoring of equitable vaccination of high-risk populations to maximize effectiveness using the "Framework for Action Convening: Building Trust in and Access to a COVID-19 Vaccination"[iv] developed by Trust for America's Health, the National Medical Association, and UnidosUS. The action plan framework includes agency, transparency, accountability, and relevance specified below for a rapid response to inequities inherent in the initial vaccine distribution:

1. Agency

The committee must have representation in the room when and where decisions are made regarding vaccine distribution. In addition, the committee should have access to minutes and other records of relevant committees and workgroups that determine allocation of vaccines. This ensures that the committee can assess the authenticity of responsiveness to community concerns brought forth to decision makers.

As community representatives, we must have the opportunity and resources to ensure full and authentic participation and leadership in all steps of the distribution and monitoring process

2. Accountability

We must have an organizational chart that describes decision making authority for vaccine allocation, to which entities, and to where allocation of additional financial and workforce resources allocation to ensure equity. For example, engaging support to address health care resource disparities with vaccine mobile units, pop-up PODS (Points of Dispensing) in under-resourced neighborhoods, and equitable re-allocation of potential vaccine wastage (excess and unused doses).

Clarity on State level and County level authority, responsibility and resource control is critical so committee can leverage membership for State level matters. In light of the recent announcement that Blue Shield of California (BSC) will serve as the state's third party administrator for vaccine procurement and distribution, it is imperative that BSC's role addresses any confusion regarding allocation through federal partnerships, multi-County entities, and allocations to local public health authorities.

3. Transparency

The Governor indicated in his announcement of BSC's role, there is an end to end data collection process that also reports directly to the federal government. This should be shared with the data systems that are being currently employed by the State of California and Los Angeles County.

II. Process and Outcomes for Monitoring Assessment of Equitable Vaccination for Vulnerable Populations

A. Rapid Response Model (Continued)

We need real time data sharing on:

- Neighborhood/Community level of greatest need for vaccine (See options II.B.5)
- Criteria for selecting PODs and plans for reaching isolated or marginalized populations
- Rates of distribution by neighborhood, race/ethnicity, age group, and gender
- Uptake to demonstrate resources and vaccination opportunities are equitably offered, supported, and to identify lagging areas for appropriate resource distribution. We also need transparency regarding what data LA County DPH has direct access to and what we should seek externally:
    - Federal Systems: V-SAFE, VAERS, VSP, Tiberius
    - State: CAIR2, PrepMod, MyTurn
- The budget allocation and share from CARE Act that DPH has access to for COVID-19 and related services would also provide insights

The community trust-building process is currently in jeopardy due to real and perceived inequities. For example, reports of lower tier persons and ineligible individuals getting vaccinated, while Tier 1a persons in communities of color may not have adequate access. In addition, the perception that funds to support efforts to ensure equity in under-resourced setting are not being shared with the most impacted regions and efforts.

4. Relevancy

Demographic data must be:
(1) disaggregated by local neighborhood or ZIP code, race, ethnicity, including smaller groups within the Asian American, Native Hawaiian and Pacific Islander at the sub-population level and
(2) must be community-informed, consistently and accurately collected, reported and used (with consent) in a timely manner to guide planning and decision-making.

An Equity dashboard should be posted by DPH demonstrating uptake by neighborhood or ZIP code, race, ethnicity to demonstrate allocation of resources and vaccination opportunities are fairly offered and supported. In addition, the Equity dashboard identifies lagging areas for appropriate resource distribution and access improvement

Placement of resources (Gaps in POD maps need to be addressed immediately).

In summary, while the above rapid response model addresses the most immediate need, **Appendix E** provides recommendations for ongoing data and process requirements relative to equity.

II. Process and Outcomes for Monitoring Assessment of Equitable Vaccination for Vulnerable Populations

B. Reporting and Outcomes Tracking

The Committee reviewed priorities and overarching equity committee goals with the following suggestions towards monitoring and assessment of specific processes and outcomes:

1. Development of real-time registry/database for tracking and mapping of real-time vaccine distribution for equity committee review (within appropriate privacy safeguards) for external weekly reporting of vaccination 1st and 2nd doses by:
    a. Vaccine administration site (Points of Distribution- to include tier 1a and 1b and 1c from Aligning Resources for Mass Vaccination Committee (ARMVC)) with numbers of vaccines distributed
    b. Zip-code, age, gender, race, and ethnicity of those vaccinated
    c. With linkages to clinical, administrative, and public health data

2. Data safety, privacy, and monitoring protocol to ensure safeguards against misuse and reuse of data, release of any personal identifiable information, protected health information, and information that will allow individual case identification. This statement acknowledges the conflicting need for data transparency to ensure equitable distribution, administration and follow-up with the need for data privacy.

3. Certificates of confidentiality or other means to ensure protections for undocumented immigrant communities. These measures protect against use of data or identifiers for any purpose outside of vaccine allocation documentation, health outcomes reporting, provision of post vaccination patient information and estimation of health care needs.

4. Collection and weekly reporting for equity committee review of the following process measures and intermediate outcomes by zip-code, age, gender, race, and ethnicity:

    a. Specific venues for vaccine distribution with date ranges and times active.
    b. Cumulative accounting of numbers of vaccinations from those particular pods/locations.
    c. Documentation of educational materials made available and received by those eligible for vaccine with culturally and linguistically appropriate content.
    d. Tracking efforts to ensure 2nd vaccination received via culturally and linguistically appropriate content.
    e. Documentation of educational materials made available and received once individual has received the goals vaccine. Documentation also needs to ensure appropriate education on adverse event reporting such as V-SAFE, both app and telephone number mechanisms in culturally and linguistically appropriate formats.
    f. Reporting of methods and number of attempts to reach those who do not complete second dose rates to accompany reporting percent completion rates by race, ethnicity, and zip code
    g. Document provision of locations listing for access to care and support for potential adverse events available to vaccine recipients that is not dependent on ability to pay or having health insurance coverage, and offered in culturally and linguistically appropriate formats.

II. Process and Outcomes for Monitoring Assessment of Equitable Vaccination for Vulnerable Populations

B. Reporting and Outcomes Tracking (Continued)

5. Mapping of indices to inform allocation with overlay of vaccine series completion rates for comparison includes geographic regions of:

    - *Increased risk for COVID-19 Medical Vulnerability Indicators*
        - https://www.medrxiv.org/content/10.1101/2020.11.02.20215657v1
    - Pre-Existing Health Vulnerability *UCLA*
        - https://britecenter.org/news/2021/01/11/ucla-brite-center-and-ucla-center-for-neighborhood-knowledge-develop-model/
    - *The California Healthy Places Index*
        - https://healthyplacesindex.org/
    - *Real time infection rates for COVID-19*
        - http://publichealth.lacounty.gov/media/coronavirus/data/index.htm#graph-positivity
    - *Real time death rates from COVID-19 data identifying*
        - http://publichealth.lacounty.gov/media/coronavirus/data/index.htm#graph-deaths
    - *Race and COVID mapping by Advancement Project:*
        - https://www.racecounts.org/covid/
        - https://www.advancementprojectca.org/tools-we-use/maps-and-data/statewide-report-how-race-fuels-a-pandemic link

6. Development of a Los Angeles County specific database with age, gender, race, ethnicity, and zip code for equity committee weekly review of those vaccinated with linkages/reference to data sources below:

    a. Vaccine Adverse Event Reporting System (VAERS) with daily reporting by demographics and geography
    b. Vaccine Safety Datalink's (VSD) collaborative project between the United States Centers for Disease Control and Prevention's (CDC's) Immunization Safety Office and health care organizations to actively monitor vaccines safety and conduct studies about rare and serious post-vaccination adverse events in which providers, parents, and patients report adverse events.
    c. V-SAFE, the smartphone-based health checker for people who received a SARS-CoV-2 vaccine that sends text messages and web-based surveys to vaccine recipients to check in regarding health problems following vaccination telephone follow-up to anyone who reports clinically significant adverse events.
    d. National Healthcare Safety Network (NHSN) monitoring system data for health care workers and long-term care facility residents that reports to the VAERS
    e. California Immunization Registry CAIR2 http://cairweb.org/
    f. Linkages of LA County registry with local provider networks and practices for longitudinal assessment of vaccine effectiveness impact.

II. Process and Outcomes for Monitoring Assessment of Equitable Vaccination for Vulnerable Populations

B. Reporting and Outcomes Tracking (Continued)

7. Track pre vaccination education and outreach efforts documenting which communities have been reached. Consider outreach mapping similar to California Community Foundation COVID Grant making and CARES Act-Community Health Worker Outreach Initiative.

8. Provide a data collection platform for those in LA County who are not comfortable receiving vaccine for continuing assessment of any new themes associated with vaccine reluctance and to assess the impact of efforts to reduce specific concerns, fear, or misinformation.

9. Provide data collection platform for feedback from LA County vaccine recipients on information received after receipt of vaccine for quality improvement and any concerns.

10. Engage Los Angeles clinical provider networks to report immediate staffing vaccination needs for those outside of large networks.

11. Document additional resource allocation for vaccination education/awareness efforts, distribution of vaccine operations, and follow-up support by geography and specific organization to ensure equity. Notification and distribution of the second vaccine dose must be treated as seriously as timely distribution and receipt of the initial dose.

12. Social Justice is not just getting the vaccines but includes focus on how to make it happen and documenting that communities receive needed resources to do so.

13. Document specific partnered activities such as: follow-up and outreach for second dose and needs assessment and resources provision, with community-based organizations, non-profit organizations, private sector, academic, and community health workers/promotoras to maximize trust and demonstrate collaborative efforts.

14. Public dissemination dash-boarding, feedback on above services provided and steps taken to ensure equity noted above in relevant languages for Los Angeles County specific communities.

15. Use data to identify hotspot communities that have been hardest hit by the pandemic and target and prioritize vaccine distribution in these communities;

16. Use data to prioritize vaccinating individuals and their families who have been disproportionately impacted by COVID-19 or who are at high infection risk. These individuals include, but are not limited to, Latinx, Black, NHPI, and AIAN individuals, essential workers who must work in-person and live in multi-generational/multi-family households, and individuals living in congregate settings.

III. Community Engagement and Communications

Overall Comments

- Degree of trust needs to be addressed and acknowledged
- Consistent messages need to be happening now- leading up to vaccinations
- Messaging requires inclusion of specifics about side effects
- Leverage community organizations and community health worker models/experience
- Ethnic media for culturally appropriateness and trusted messenger is critical
- Addressing immigrant & multi-household quarantine challenges would help support building community trust
- Community locations are key for walk-ups not just drive-ins
- Efforts need to be community localized not government led
- Beyond ethnicity and "people who look like us", culture is important. Faith, sports and worksites are all about culture. Combining culture with influence and then access can go a long way.

Highest risk populations summarized below are consistent with Equity Committee vulnerable populations listed in **Appendix D**.

Populations at risk	Barriers
 • People living with diabetes or at risk, including gestational diabetes (maternity risk) • People with disabilities, including Downs syndrome (people with whom it's hardest to communicate with and reach with services) • Homebound • Caretakers and caretakers with chronic health conditions • Private caregiver sectors, not registered • Older adults-65 + • People with Alzheimer's, dementia, mental health issues • People experiencing homelessness • Essential workers and people with interactions with the public • Undocumented or immigrants and refugees	• Disabilities, dependent on a caretaker • Uninsured, or no regular health care access • Undocumented • No car and limited initial walk-in vaccine sites in vulnerable communities • No computer or smart phone for individuals and seniors who do not access information online • Telephonic access challenges due to call center volume • Legacy of low vaccine confidence • Misinformation travels globally via social media & immigrants obtain misinformation from country of origin • Anticipation of long appointment waits • Post-vaccination 15-30 minutes wait • Side effect concerns & understanding • Negating 2nd dose due to side effect concerns, 1st dose experience or access challenges • Language accessibility & literacy limitations

III. Community Engagement and Communications

Solutions

Solutions require a focused approach to representation with trusted messengers as accurate, culturally appropriate information sources to initiate the following:

Messaging Content & Trusted Messenger

- Unified consistent message and information from a dependable and trusted source.
- Messenger is more important than the message. However, message being used and delivered, needs to be unified, consistent, and communicated from a trusted source.
- Culturally relevant messages in preferred language, delivered in different modes (written, video, oral, etc.).
- Engagement of health ministry section of faith-based organizations.
- Identification and application of best practice such as successful community Census participation.
- Identify government agencies and CBOS skilled in this area- and preferred agencies.
- Use ethnic media including radio and traditional newspapers (for older adults).
- Frame vaccination as a benefit to personal health versus a government led mass effort to enhance uptake. Government led creates reluctance and fear.
- Some communities are more deferential to authority and the idea of the collective good. Align messaging to this deferential preference as well.
- Approach messaging not only as a health priority, but also how the individual is saving his or her family by taking the vaccine.

Collaborations

- Engage faith-based leaders and leverage their media influence. For example, Archbishop Gomez's vaccination photo has a major influence on LatinX vaccine hesitancy.
- Engage political leaders who are trusted in a community. For example, in the API community for the Census Congresspersons Ted Liu, Judy Chu, Jimmy Gomez and others were engaged.
- Engage community-based organizations who are trusted messengers to deliver public health information on vaccination process and sign-ups.
- Use agencies already reaching the target audiences:
  - For example, Department of Aging and Disability food delivery service reaches those unable to leave their house or certain category of age. Leverage existing systems to distribute information about vaccinations.
  - Include postcards or flyers with basic information for mentioning during food delivery.
- City and certain public programs are resource rich:
  - For a specific goal or objectives, distribute information to all department branches to reach the right people.
  - Our joint information systems and perform well in coordinating these types of efforts.
- For caretakers, employer engagement is important:
  - Provide tools and resources-education and information about vaccines and benefits
  - Also provide to centers for broader distribution.
- Ensure people who speak the community language are front and center.
- Address information access- online only is insufficient. Meet the community where they are- the local grocery store, doctor's office, hospital, etc.

IV. Operations to Maximize Vaccine Access & Use for the Most at Risk Populations

Barriers/Challenges & Rationale	Recommendations & Solutions
  (1) Community based vaccinators Need more community vaccinators: • Representative of the community (culturally & linguistically appropriate). • Community vaccinators are well primed to identify and engage hardest to reach who may be missed through traditional strategies. • Community vaccinators are also well positioned to support community outreach and education. Expanding community vaccinators also supports sustainability: • Provides skills that can lead to career opportunities. • Strengthens our healthcare system that currently has workforce shortages limited workforce getting even worse. • Ensures community vaccinators are available on an ongoing basis for potential future pandemics.	**Accelerated Community Vaccine Training and Certification Program** The county should accelerate a vaccine training and certification program for community groups/non-medical professionals to ensure provide and community vaccine readiness. Partner with community collaborators to expedite implementation. Specify the following: **IMMEDIATE RECOMMENDATION** • Timeframe: Critical to implement ASAP • # Goal (may depend on the vaccine #) • Recommendations around logistics and supports (Need to understand the prerequisites) Additional considerations: • Create a vetting program to avoid any potential vaccination misuse. • Collaborate with groups already involved in COVID testing or providing other vaccines such as the HIV mobile testing units.
(2) Vaccine sites in high impacted communities Need to ensure that there are sufficient, accessible, and welcoming locations offering vaccines in the community.	**Data transparency in vaccine site plans** Aligns with similar request from the Process and Outcomes Subcommittee Section II. The committee needs an understanding of the current vaccination site plan. Requires an overlay of the current/anticipated MPODS (Medical Points of Distribution) and heat maps (using data that Dr. Vickie Mays collected) to understand the gaps and provide more strategic recommendations.

IV. Operations to Maximize Vaccine Access & Use for the Most at Risk Populations

Barriers/Challenges & Rationale	Recommendations & Solutions
(2) Vaccine sites in high impacted communities *(Continued)*	However, without the above information, following are possible recommendations: • Identify vaccination sites in low-income/diverse communities and hard to reach places throughout the county. • Determine sites ASAP, to support Phase 1b and 1c not just for the final phase.
(3) Vaccine site flexibility in areas for hard to reach populations and essential worksites	The vaccine site plan should leverage existing processes/plans such as the MPODS (which is why we need the data referenced above) and other programs such as: • Redirect or expand mobile units currently being used for testing, also provide support and testing (i.e., HIV) for other health needs to vulnerable populations such as homeless. • Evaluate funding recommendations to support mobile unit deployment at a variety of sites disproportionately impacted (i.e., grocery stores). • Leverage American Red Cross blood drive infrastructure.
(4) Vaccine site accessibility for the disabled, transit dependent, language limited and other vulnerable populations	Vaccine sites should be strategically near transportation hubs, parking access, language access, disability access. Potential trusted sites include but are not limited to: • Syringe location sites- MPODs • Education sites- LAUSD, community colleges, etc. • Boys and Girls Clubs, YMCAs • Churches
(5) Vaccine site transportation	A transportation plan that includes free passes to and from vaccination sites: • This should include working with Metro, LADOT, app-based services, access services and other public/private transportation services
(6) Provider vaccination readiness	Plan must include financial and nonfinancial support to assist organizations with readiness, creating collaborations, trainings, etc. Provide support and education on how to become a certified provider vaccination site; need to get this moving in the next month so there is time. Refer to the sites below for additional information: http://publichealth.lacounty.gov/acd/ncorona2019/vaccine/ http://cairweb.org/enroll-now/ http://cairweb.org/lcrs/

IV. Operations to Maximize Vaccine Access & Use for the Most at Risk Populations

Barriers/Challenges & Rationale	Recommendations & Solutions
(7) Vaccine facility/site readiness 	A site requirements/preferences checklist from another state was submitted from a committee member for consideration: ☐ 5-6k square ft in one large space or multiple divided spaces ☐ Proximity to public transportation ☐ Parking is a preference, but not required ☐ Located in hardest hit areas and/or underserved neighborhoods ☐ Space for storage and staff break room ☐ ADA compliant (if site meets other requirements, the city can provide needed equipment for compliance, ramps, etc.) ☐ Ability to connect to power (standard electrical) ☐ Operational HVAC system (no additional filtration requirements) ☐ 24/7 access is a preference, but not required ☐ The city provides tables, chairs, room dividers, IT equipment, and other necessities for a basic vaccine clinic set-up
(8) Tier clarification Significant confusion about tiers, especially with constant changes and state and national variances Need to ensure people understand the sub-phases and tiers will limit the number of people who will need to be vaccinated in Phase 2.	**IMMEDIATE RECOMMENDATION** As a group, we need better definition of who qualifies within the initial tiers. This will help provide better overall recommendations for how to encourage more individuals in the first Phase and then address who remains in Phase 2. Below are several initial recommendations; Provide broad education and clarification about the tiers, who qualifies within each, and how the process works: • Explain dissemination by tier and when the move to the next tier occurs. • Create a very succinct document that can be understood by multiple communities. • Be clear about social service agencies that could be seen as essential work and whether the staff are eligible for the initial Phase 1 tiers or not. • An innovative approach provides a way for consumers to verify health conditions- engaging pharmacies, and community health workers to conduct diabetes or cardiovascular verifications and simultaneously enroll residents. This accounts for the fact that many high-risk and medically vulnerable individuals with chronic conditions do not have a medical home or health insurance.

IV. Operations to Maximize Vaccine Access & Use for the Most at Risk Populations

Barriers/Challenges & Rationale	Recommendations & Solutions
(9) Formally address hospital distribution of excess vaccine The public's information about who is served in the initial phase and information about vaccine re-directed out of sequence, potentially creates mixed messages and misinformation that could cause further vaccine hesitancy. 	Formalize rapid response protocol for hospital and facility use of excess vaccine as part of conditions of participation (pre-registration, wait lists, etc.): • Need better protocols/structure for the initial phase to minimize any later division and confusion with better explanation of what happens with excess. • Should consider going to the next tier so we are moving in the prioritized fashion. • Report any challenges or changes through DHS so that decisions to address can be made in an orderly fashion. • Create a scheduling system to reduce waiting times. • Include wait list or 'pre-registration' standards for facilities to prep in advance.

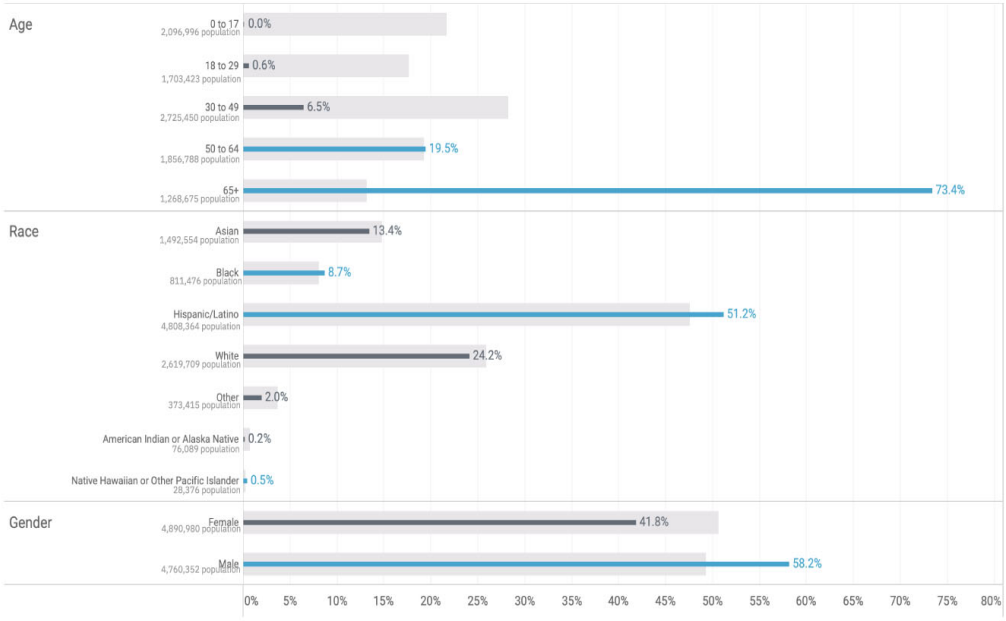
Appendix A: Los Angeles County Cumulative COVID-19 Deaths

LA County Cumulative COVID-19 Deaths by Demographics

All metrics last updated at 1 PM, January 21, 2021

0%	1%	6%	19%	73%
0 to 17 yrs	18 to 29 yrs	30 to 49 yrs	50 to 64 yrs	65+

PERCENT OF TOTAL DEATHS COMPARED TO POPULATION



KEY TAKEAWAYS

- Data is incomplete with **1.3% of Deaths still under investigation**
- As of December 19, 2020, 8,192 out of 8,875 deaths (92.3%) had comorbidities (underlying conditions)

MOST IMPACTED GROUPS

- 65+
- Males
- Hispanic/Latino Americans
- Black Americans
- Native Hawaiian or Other Pacific Islander

Legend
Percent of LA County Population
Percent of Total Deaths

Source: Los Angeles Department of Public Health.

Prepared by Mayor's Innovation Team

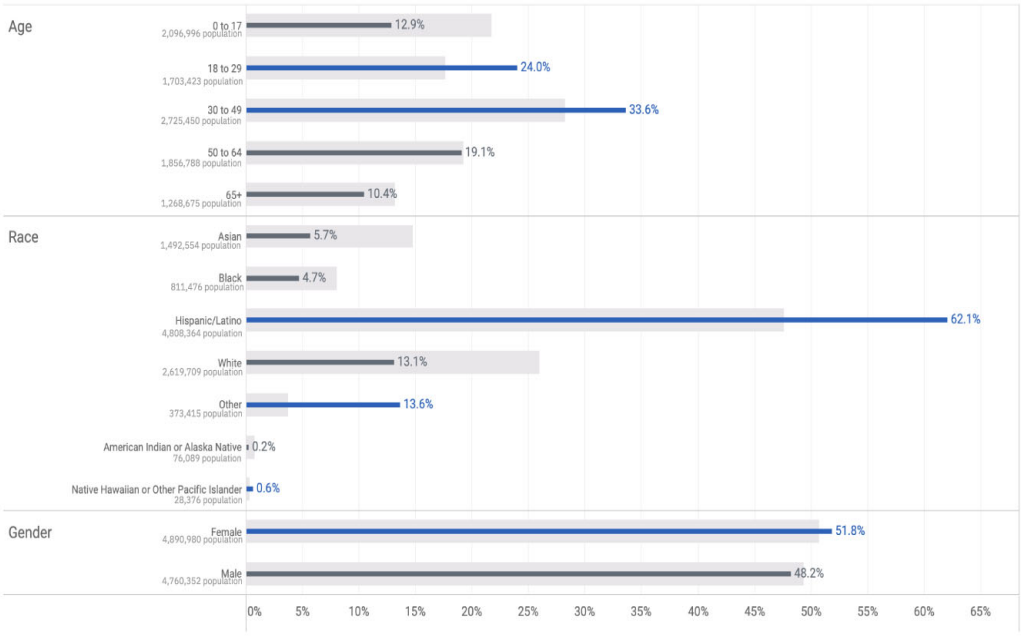
Appendix B: Los Angeles County Cumulative COVID-19 Case Demographics

LA County Cumulative COVID-19 Cases by Demographics

All metrics last updated at 1 PM, January 21, 2021

13%	24%	34%	19%	10%
0 to 17 yrs	18 to 29 yrs	30 to 49 yrs	50 to 64 yrs	65+

PERCENT OF TOTAL CASES COMPARED TO POPULATION



KEY TAKEAWAYS

- Data is incomplete with **25.4% of Cases still under investigation**

MOST IMPACTED GROUPS

- Hispanic/Latino Americans
- Females
- 30-59 year olds
- 18-29 year olds
- Native Hawaiian or Other Pacific Islander

Legend:

Percent of LA County Population

Percent of Total Cases

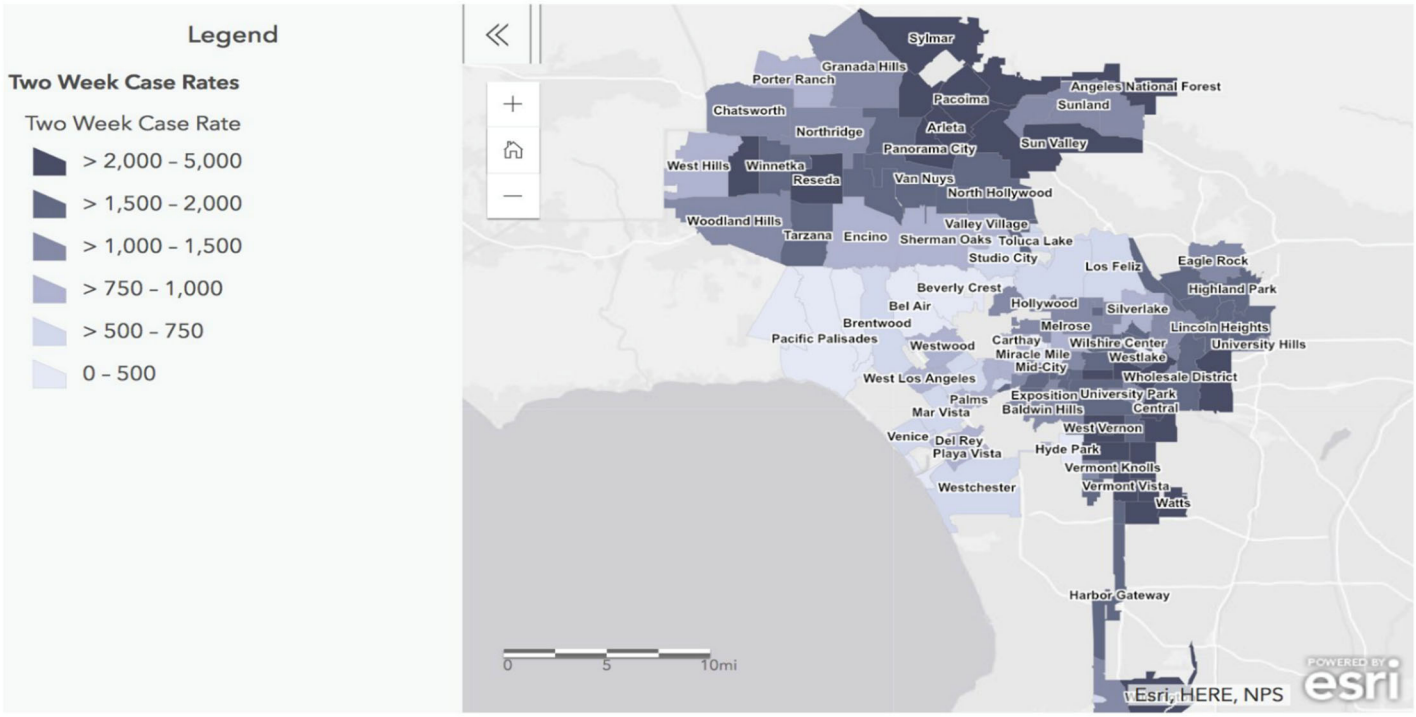
Source: Los Angeles Department of Public Health.

Prepared by Mayor's Innovation Team

Appendix C: COVID Case Rates Neighborhood Comparisons

Case Rate: As of January 22, 2021

New Cases per 100,000 residents: Case rates offer a way to compare neighborhoods with different population sizes. In general, the higher the case rate, the more widespread COVID-19 is in that area.



Prepared by Mayor's Innovation Team

Source: City of Los Angeles COVID-19 Neighborhood Map
https://corona-virus.la/Map

Appendix D: Populations at Risk of Inequity

- ☐ Low-income residents
- ☐ Black, Latinx, Asian, Pacific Islander, Native American (including immigrant indigenous populations) or Alaskan Native residents
- ☐ Immigrants – particularly residents who are non-citizens or undocumented
- ☐ Uninsured
- ☐ Unemployed
- ☐ Employed in the informal economy
- ☐ People with disabilities including, but not limited to, residents who are deaf, hard of hearing, blind residents, and residents with physical disabilities causing limited mobility
- ☐ Elderly
- ☐ Homebound
- ☐ Non-native or Limited English speakers
- ☐ County residents with low-autonomy or agency to protect themselves from virus transmission. For example: Individuals dependent on a caretaker for well-being, hygiene or safekeeping, and incarcerated residents, residents of group halfway or rehabilitative home, and 16+ residents of group foster homes.
- ☐ Unlicensed caregivers and health aides not belonging to an agency and informal economy workers performing essential services or cash pay only workers
- ☐ Residents without any, consistent, or unreliable access to digital technology
- ☐ LGBTQIA+ residents – particularly those who have additional marginalized identities, such as race, ethnicity and disability
- ☐ Residents living in COVID-19 hotspots
- ☐ Incarcerated and recently released individuals
- ☐ Illiterate individuals

Appendix E: Equity Committee Key Recommendations Summary

Section	Recommendation
I. COVID-19 Vaccine Equity: Assessment of Challenges and Solutions *Redefine phase/tier categorizations* *Expand eligibility verification documentation options*	(1) Include exposure risk and mortality for equitable prioritization in vaccine distribution planning to account for disproportionate impact on communities of color (i.e., essential workers) (2) Address transportation vaccine accessibility barriers in vaccine distribution (3) Prioritize public transit workers and residents with low-autonomy or agency to protect themselves from virus transmission for vaccine distribution. These residents include: a) Individuals dependent on a caretaker for well-being, hygiene or safekeeping b) Incarcerated residents c) Residents of group halfway or rehabilitative homes d) 16+ residents of group foster homes (4) Ensure individuals who receive a first vaccination dose while incarcerated, are entitled to a timely second dose regardless of whether they are incarcerated or back in the community at the time of their second dose (5) Include individuals working jobs with close/personal proximity to non-family members, but currently excluded from priority tier categories within the tier and phase commensurate to their work and risk of exposure. This would include: • Identifying unlicensed caregivers, or health aides not belonging to an agency as healthcare workers • Including disabled and caregivers with confirmation letters from service agencies recently • Expanding Phase 1b, Tier 2 under the broader category of individuals in congregate settings with outbreak risk • Gray economy workers performing essential duties: a) Including nannies and tutors in Phase 1B, Tier 1 education and childcare b) Including housekeepers and domestic caregivers in Phase 1B, Tier 2 under the congregate settings with outbreak risk category c) Including gardeners/landscapers, and day laborers in Phase 1B, Tier 2 under the Industrial, commercial, residential, and sheltering facilities and services category d) Including street vendors in the food category in Phase 1B, Tier 2 e) Including rideshare and taxi drivers and delivery workers in Phase 1B, Tier 2 under the transportation and logistics category f) Develop eligibility or verification options that do not exclude unlicensed caregivers, health aides not belonging to an agency, or 'gray' economy workers (i.e., cash pay only) (6) Expand eligibility verification documentation options to account for undocumented and immigrant workers needs

Appendix E: Equity Committee Key Recommendations Summary (Continued)

Section	Recommendation
II. Process and Outcomes Monitoring and Assessment of Equitable Vaccination for Vulnerable Populations *Implement data collection and reporting practices to support equitable distribution*	(7) Ensure transparency in data collection and reporting. Collect and report data such that racial and ethnic disparities, hot spots alignment to vaccine distribution (geographic disparities) can be identified (8) Use data to prioritize vaccinating individuals and their families disproportionately impacted by COVID-19 who are at high infection risk as noted in IIB (9) Implement reporting and outcomes tracking measures for disproportionately impacted communities Section IIB.7-15 (10) Develop a registry/dataset for tracking and mapping vaccine distribution for equity committee weekly review with external reporting of vaccination 1st and second doses by: • Vaccine administration sites with numbers of vaccine distribution • Zip code, age, gender, race and ethnicity of individuals vaccinated • 2nd dose reach rates and attempts to reach documented (11) Map indices listed (Section IIB.5) to inform allocation with overlay of vaccine series completion rates for comparison with geographic regions: • Increased risk for COVID-19 Medical Vulnerability Indicators • Pre-Existing Health Vulnerability UCLA • California Healthy Places Index • Real time infection rates for COVID-19 • Real time death rates from COVID-19 data identifying • Race and COVID mapping by Advancement Project (12) Use data to identify geographic hotspots within the county hardest hit by the pandemic (13) Target vaccine distribution sites to disproportionately impacted population hotspots (14) Racial and ethnic data should be collected and reported such that disaggregation is feasible and Native American data is not limited to only residents who identify as Native American alone (15) Implement data safety and monitoring protocols (Section IIB.1-3) (16) Develop Adverse Event Reporting L.A County specific database • Includes data Sources noted in Section IIB.6 • Documentation of appropriate consumer education on adverse events reporting: options (i.e., V-safe telephone number and app options) in culturally and linguistically appropriate formats)

Appendix E: Equity Committee Key Recommendations Summary (Continued)

Section	Recommendation
III. Communications, Community Engagement, Education and Awareness *Implement vaccine communications targeting key communities and populations*	(17) Implement a COVID-19 vaccine communications campaign targeted to high need communities and populations. e) The campaign should consist of culturally relevant messages and information tailored to specific communities and populations f) Messages and information should be provided in multiple languages and include visuals and other options to account for illiteracy and language limitations g) Community-based organizations and ethnic media should be engaged as trusted messengers and assist in message development, dissemination, and misinformation mitigation. h) The campaign should acknowledge historic injustices and biases practices towards various groups i) The campaign should highlight testimonials of community members receiving the COVID-19 vaccine (18) Address technological accessibility barriers in communications and vaccine distribution. For example, expand to support reminder calls for first and second dose appointments for individuals without online access (19) Collaborate with heavily-requested services and supportive agencies (e.g. State unemployment, disability or social security portals) to encourage sign-ups for notifications/updates about COVID-19 vaccines: a) Use agency websites to link to County media, and develop accessible materials to reach blind and deaf residents who may also use those same agencies b) Collaborate with community-based organizations to address community members' needs to rebuild trust which will gradually influence vaccine uptake c) Implement vaccine distribution and communication strategies to reach populations geographically distributed throughout the county (e.g. Native Americans, Pacific Islanders).

Appendix E: Equity Committee Key Recommendations Summary (Continued)

Section	Recommendation
IV. Operations to Maximize Vaccine Access and Use for the Most Vulnerable At Risk Populations *Target and prioritize vaccine distribution to disproportionately impacted communities*	(17) Immediately Accelerate Vaccine Training and Certification Program for community vaccinators (Section IV.1) (18) Overlay current/anticipated PODS and heat maps using data Dr. Vickie Mays collected as noted in recommendation #11 to identify gaps and interventions (19) Identify vaccine sites based on Section II Recommendations to support Phase 1b and 1c based on (20) Develop and implement mobile vaccination strategy that targets and prioritizes high need communities and populations Section IV.3 (21) Ensure vaccine distribution sites accessibility (ADA compliant or include ADA compliant alternatives) for the disabled, transit dependent, language limited and other vulnerable populations (22) Develop and implement a transportation plan that includes free passes or vouchers to and from vaccination sites (Section IV.5) (23) Provide vaccine readiness for disproportionately impacted providers (Section IV.6-7) (24) Clarify tiers to ensure and provide broad educations (Section IV.8) (25) Formalize protocols for hospital and facility use of excess vaccine as part of the conditions of participation terms (Section IV.9)

Appendix F: A3PCON and AANHPI Letter to the Board of Supervisors

A3PCON
ASIAN PACIFIC POLICY & PLANNING COUNCIL

ASIAN AMERICAN NATIVE HAWAIIAN AND PACIFIC ISLANDER
AANHPI
HEALTH INITIATIVE

January 22, 2021

Dear members of the Los Angeles County Board of Supervisors,

We, the undersigned, are members of the Asian Pacific Policy and Planning Council (A3PCON) and the Los Angeles County Asian American and Native Hawaiian & Pacific Islander COVID-19 Taskforce, which was formed in April 2020, as a response from the community to prevent and abate the spread of COVID-19 in Los Angeles County. (http://publichealth.lacounty.gov/docs/RacialEthnicSocioeconomicDataCOVID19.pdf, See pg. 29). We are supported by the Asian & Pacific Policy and Planning Council (A3PCON) and the Los Angeles County Department of Public Health.

Thank you for your tireless effort in leading LA County's fight against the COVID-19 pandemic. We would like to ensure that the unique needs of our diverse populations are accurately represented in any decision-making efforts of Los Angeles County, and that you will coordinate with our organizations to maximize the effectiveness of the vaccine roll-out, distribution and uptake.

We strongly urge the LA County Board of Supervisors to:

- Clearly recommend that the County send mobile vaccination units out into communities of color ~ especially for older adult populations, and particularly for communities of color with limited-English proficiency (LEP) capacity and barriers to individual transportation, supported by the new State mandate for older adults 65 and older in Phase 1b, to be vaccinated now.
- Request a simplified redesign of the County's vaccine appointment website (http://publichealth.lacounty.gov/acd/ncorona2019/vaccine/hcwsignup/). Presently, the website is challenging to navigate for the community health workers, healthcare workers, and community-based organizations who are making appointments. The online platform also presents a significant technical barrier for the 8.0% of households without any computing devices and the 15.5% of households who do not have Internet subscription (American Community Survey, 2015-2019).
- Recommend streamlined and coordinated in-language vaccine assistance. To be effective, vaccine appointments and information must be easy to access and understand. It is incredibly daunting for monolingual or limited-English speaking older adults to try to sign up on their own, let alone get themselves to vaccine sites.
- Support, including financially, Asian American and Native Hawaiian & Pacific Islander (AANHPI) serving community-based organizations (CBOs) and federally qualified health centers (FQHCs) to identify areas of need for our communities and provide needed outreach and education to effectively reach hard-to-reach populations, including low-income, immigrants, and limited-English proficient (LEP) persons. Funding CBOs, FQHCs, and community clinics can help create and support effective community mobile vaccine sites because we serve the underserved, underinsured, uninsured county residents, and those most disproportionately impacted.

Appendix F: A3PCON and AANHPI Letter to the Board of Supervisors

- This map was created by the Task Force to identify FQHCs that may be recommended as community COVID-19 community vaccine sites for elderly AANHPIs: https://bit.ly/3bCu5IM

- Ensure equitable allocation of COVID-19 vaccinations to these community mobile vaccine sites. While we understand that the five county supersites are/will be overwhelmed with vaccine allocations, we want to underscore our national, state, and local commitment to communities of color, particularly limited-English proficient older adults, in accessing COVID-19 vaccines.

The five Supervisorial Districts below are Los Angeles County's Asian Americans, Native Hawaiian & Pacific Islanders (AANHPIs) who are 65 years old and over (American Community Survey 2015-2019):

- District 1 - 23.2% of the 126,209 AANHPIs are 65 years old and over
- District 2 - 17.7% of the 186,345 AANHPIs are 65 years old and over
- District 3 - 14.7% of the 232,063 AANHPIs are 65 years old and over
- District 4 - 18.1% of the 55,545 AANHPIs are 65 years old and over
- District 5 - 17.8% of the 53,869 AANHPIs are 65 years old and over

As we all know, COVID-19 is causing enormous morbidity and mortality across Los Angeles and is disproportionately affecting racial/ethnic minority populations and elderly persons. As of January 17, 2021, despite comprising only 13.2% of the County's population, residents who are 65 years old and over make up 72.6% of those who have died from COVID-19 and for whom age was known (*Los Angeles County COVID-19 Surveillance Dashboard*, http://dashboard.publichealth.lacounty.gov/covid19_surveillance_dashboard/).

Willingness to be vaccinated for COVID-19 also varies by age, race/ethnicity, education level, and occupation. Preliminary results found that 86.7% of Asian Americans in Los Angeles County would get the COVID-19 vaccine if it were available (2020 California Health Interview *Survey*, https://healthpolicy.ucla.edu/health-profiles/Pages/COVID-19-Preliminary-Estimates.aspx). Among those aged 65 and over of any race/ethnicity in Los Angeles County, 80.4% would get the vaccine if it were available.

It is our understanding that the Los Angeles Department of Public Health's COVID-19 Vaccine Equity Committee will be releasing a report with its recommendations at the end of January 2021. We would recommend using effective tools to ensure the efficient and equitable prioritization and resource allocation to address the COVID-19 pandemic. Currently, one of the tools bring considered is the Healthy Places Index (HPI), which the State uses for its Blueprint for a Safe Economy. Although the Healthy Places Index (HPI) can be a valuable tool to predict life expectancy at birth, it may not be the ideal tool to determine COVID-19 vaccine sites. The Native Hawaiian Pacific Islander (NHPI) COVID-19 Data Policy Lab at the UCLA Center for Health Policy Research conducted an analysis of the HPI and found that for smaller racial/ethnic population groups that are geographically dispersed, the HPI may under-represent their vulnerability for other measures, such as those related to COVID-19. (See attached Dr. Ninez Ponce memo). Therefore, we believe that any tool that is used should include critical factors, such as disaggregated race and ethnicity, language proficiency, immigration status, and multigenerational households.

In this unprecedented time, we are grateful for the leadership demonstrated by the Board of Supervisors and County leaders, such as the LA County Department of Public Health, and look

Appendix F: A3PCON and AANHPI Letter to the Board of Supervisors

forward to further engagement in strengthening targeted outreach to AANHPI communities in LA County.

If you have any questions please follow up with Manju Kulkarni, mkulkarni@a3pcon.org.

Sincerely,
Members of the LA County AANHPI COVID-19 Taskforce and
the Asian Pacific Policy & Planning Council

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Berenice Constant, AltaMed Health Services
Loraine A. Escobedo, PhD, MPH, at the Cancer Research Center for Health Equity, Cedars-Sinai Cancer*
Heng Lam Foong, MS, Asian & Pacific Islander Forward Movement
Lisa Fu, MPH, California Healthy Nail Salon Collaborative
D. Kalani Heinz, PhD(c), Hawai'i's Daugthers Guild
Brian Hui, PhD, at Special Service for Groups, Inc. - Research & Evaluation
Erica Juhn, MA, MPH, at Special Service for Groups, Inc. - Research & Evaluation
Mariko Kahn, Pacific Asian Counseling Center
Marjorie Kagawa Singer, PhD, MA, MN, FAAN at the UCLA Fielding School of Public Health
Manjusha P. Kulkarni, Esq., Asian Pacific Policy & Planning Council
Cevadne Lee, MPH, Southeast Asian Community Alliance & UCI Chao Family Comprehensive Cancer Center*
Albert Lowe, MA, MLIS, United Teachers Los Angeles*
Chanchanit (Chancee) Martorell, Thai Community Development Center
Erich Nakano, Little Tokyo Service Center
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Alexandra Suh, KIWA (Koreatown Immigrant Workers Alliance)
Debra Suh, Center for the Pan Asian Family
Sissy Trinh, Southeast Asian Community Alliance
Jennifer Tsui, PhD, MPH, USC Department of Preventive Medicine*
Kawen T. Young, Native Hawaiian & Pacific Islander Alliance
Doreena Wong, Asian Resources, Inc.

**Inclusion of organization names are for identification purposes only*

cc: Los Angeles Department of Public Health
Los Angeles Department of Public Health's COVID-19 Vaccine Equity Committee

Appendix G: Native American Indian Commission Letter to the Board of Supervisors

LOS ANGELES CITY/COUNTY
NATIVE AMERICAN INDIAN COMMISSION

Chairperson
CHRISSIE CASTRO
Navajo

Vice Chairperson
RUDY ORTEGA JR.
Fernandeño Tataviam

Treasurer
SHAWN IMITATES-DOG
Choctaw/Lakota

Secretary
PAT LOPEZ
Taos Pueblo/Tiwa

ANDREA N. GARCIA, M.D.
Mandan, Hidatsa, Arikara

ALLISON HICKS
Prairie Band of Potawatomi Nation/Choctaw

DAWN JACKSON
Saginaw Chippewa

FRED LEAF
Potawatomi

RANDALL MURPHY
Choctaw/Lakota

TRACY PEREZ
Navajo

JOSEPH A. QUINTANA
Kewa Pueblo

TED TENORIO
Tiguan Nation

CHERI THOMAS
Quinault/Yurok

Executive Director
ALEXANDRA VALDES
Tlingit/Athabascan

April 13, 2020

LA County Board of Supervisors
500 W. Temple
Los Angeles, CA 90012

Dear Honorable Members of the Board of Supervisors,

The Los Angeles City/County Native American Indian Commission (LANAIC) is writing to lend our support for the proposed LA County Board Motion *Ensuring Collection of Full Racial and Ethnic Data of COVID-19 Patients throughout Los Angeles County (April 14, 2020).*

The potential impacts of the COVID-19 crisis could be catastrophic for the American Indian and Alaska Native (AIAN) population residing in Los Angeles County (LAC). AIANs are at increased risk of severe illness and death caused by COVID-19 due to higher rates of underlying medical conditions such as diabetes, heart disease, lung disease, and other conditions that may lead to a compromised immune system. Furthermore, AIAN mortality rates in LAC from coronary heart disease and diabetes are higher than that of all other races (157.8/100,000 population, and 58.2/100,000 population, respectively). AIAN adults are also more uninsured (29.5% of AIAN adults 18-64) than all other races (22.7%) leaving those who are uninsured particularly vulnerable if they fall ill with COVID-19. Given that an astounding 56% of adult AIAN households report incomes of less than 200% of the Federal Poverty Level, AIANs are particularly vulnerable to the economic consequences of this crisis (LAC DPH Office of Women's Health. Health Indicators for Women in Los Angeles County: Highlighting Disparities by Ethnicity and Poverty Level, January 2017.) A prior Board Motion on AIAN homelessness illuminated a critical lack of data for those AIAN experiencing homelessness; thus there is no way of knowing whether these most vulnerable individuals will get housed in emergency shelters, the extent to which they are represented in the Coordinated Entry System, let alone if they meet high risk criteria.

Comprehensive data by race and ethnicity will be key to understanding how COVID-19 is impacting and potentially worsening health and economic disparities across communities. Data by race and ethnicity will also be important for understanding the extent to which there are disparities in access to and receipt of health and economic relief. Together these data can help shape and target response and relief efforts. LA County must collect this critical data in order to understand the burden of this disease on different populations including the urban AIAN population.

3175 West 6th Street, Los Angeles, California 90020
(213) 738-3241 | Fax (213) 637-9655 | www.lanaic.org | contact@lanaic.org
aferguson@wdacs.lacounty.gov

Appendix G: Native American Indian Commission Letter to the Board of Supervisors (Continued)

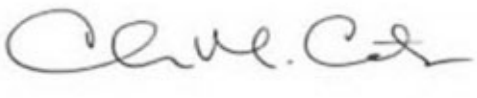
Data describing AIAN is already underreported, omitted, or highly inaccurate and we must ensure that is not the case with COVID-19. Though the AIAN population is small relative to other ethnic and minority populations, Los Angeles County contains the largest number of AIAN compared to all other counties in the United States (roughly 171,000). Previous AIAN researchers and advocates attempted to address this data issue in 2002 with a motion sponsored by Supervisors Burke and Antonovich that directed multiple county entities to improve data collection for AIAN. Nearly two decades later in October 2019 similar directives were made to various County entities to improve AIAN data collection with the passage of the Board Motion, *Identifying, Supporting and Serving American Indians and Alaska Natives who are at Risk of or Experiencing Homelessness*.

Even with the aforementioned efforts we know that data collection of the AIAN community remains a challenge for LA County. In order to ensure it is collected properly during the COVID-19 crisis we recommend the following:

- That racial data be reported for those tested (to assess for testing disparities), those reported positive, and COVID-19-related fatalities
- That racial data be reported for those high-risk individuals who are housed in emergency shelters
- Mandate that racial data be collected upon testing, hospital admission and any other healthcare interaction related to COVID-19. Collection efforts should prioritize self-reported race.
- That the following definitions of AIAN be reported:
    - Those who identify as AIAN alone
    - Those who identify as AIAN alone and in combination with other races
    - Those who AIAN who identify as Hispanic
- That the Departments of Public Health and Health Services work collaboratively with the LANAIC, local AIAN data experts, and AIAN serving organizations when collecting and reporting AIAN health data

We applaud the Board's effort to understand the disparate effects that COVID-19 may have on underserved communities.

Sincerely,



Chrissie Castro
Chairperson
Los Angeles City/County Native American Indian Commission

Appendix H: Equity Committee Members as of 01.27.21

*Co-Chairs Hector Flores, MD and Roberto Vargas, MD, MPH

First Name	Last Name	Affiliation
Jerry P	Abraham, MD	LA County Medical Association (LACMA)
Luckie	Alexander	LA LGBT Center
Fatu	Amara	Intern and Watson Foundation Fellow (IBM)
Amber	Bolanos	Caring Right at Home
William H.	Boyer	LA Community College District
Carolyn	Buenaflor	Cedars-Sinai
Kimberly	Cooper, MPH	LAPH, Senior Analyst
Michael	Cousineau, DrPH	USC Keck School of Medicine
Kara	Crew, MPH	DPH COVID-19 Outbreak Team, (Volunteer Meeting Scribe)
Isaac	Cuevas	Archdiocese of Los Angeles
Brittney	Daniel	California Community Foundation
Jason	Dawson	Center for Health Equity
Omer	Deen, MD	LA County Medical Association (LACMA)
Carmina	De Santiago	LA City Emergency Management Department
Sandra	Diaz	SEIU- Service Employees International, VP Proxy for David Huerta, President SEIU USWW
Alexandra	Ferguson (Valdes)	Los Angeles City-County Native American Indian Commission
Hector	Flores, MD*	White Memorial/Adventist Health; Practices East L.A. & Montebello
Chandra	Ford, PhD, MPH	Center for Health Equity UCLA Sector
Ignacio	Gonzalez	Southern California Resource Services for Independent Living
Stephen	Gutierrez	Los Angeles Fire Department
Andre	Herndon	DCOS, Mayor Eric Garcetti
David	Huerta	SEIU- Service Employees International
Robert	Hoo	OneLA
La Tina	Jackson	Department of Mental Health
Diamond	James	Mayor's Innovation Team, Civic Design Lead
Joanne	Kim	City of LA, Sr. Advisor to Councilmember Marqueece Harris Dawson (high impacted areas South LA)
John	Kim	Advancement Project California
Joyce	Kitchen	Emmanuel-HM Turner AME (African Methodist Episcopal) Church
Jackie	Koci Tamayo	City of LA Emergency Management Department

Appendix G: Equity Committee Members as of 01.27.21

*Co-Chairs Hector Flores, MD and Roberto Vargas, MD, MPH

First Name	Last Name	Affiliation
Manjusha	Kulkarni, Esq	Asian Pacific Policy & Planning Council
Mara	Landay	Mayor's Office of Public Safety, Policy Director, Emergency Mgmt.
Cindy	Levey	Cedars-Sinai
Donna	Lieberman	American Diabetes Association
Wendy	Macy	LA General Manager, Personnel Department
Capri	Maddox	LA Civil & Human Rights Department
Vickie	Mays, PhD	UCLA Brite Center on Research, Education, Training and Strategic Communication on Minority Health Disparities
Aurea	Montes-Rodrigues	South LA Coalition
Heather Jue	Northover	LAPH Center for Equity
Hoang	Nguyen	LA County Supervisorial District 1
Nicholas	Nguyen, MPH	Salvation Army California South Division, Emergency Disaster Svcs.
Joe	Paul	Elder City of Refuge Church
Nora	Preciado	Mayor's Office - Immigrant Affairs
Myron	Quon	National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
Richard	Rideout	Los Angeles Fire Department
Erika	Rogers	Community Clinic Association of Los Angeles County
Walt	Senterfitt	LAPH IRB & Community Advocate
Stephen	Simon	General Manager, Department of Disability
Jean	Tolentino	City of Los Angeles
Matthew	Trujillo	Advancement Project California - alternate
Jennifer	Tsui, PhD	USC Department of Preventive Medicine
'Alisi	Tulua	National Pacific Islander COVID-19 Response Team
Diane	Vanette	OneLA
Roberto	Vargas*, MD, MPH	Charles R. Drew University College of Medicine, Assistant Dean of Health Policy
Sonya	Vasquez	Community Health Councils (CHC)
Tracey	Veal-1	DPH Fellow, Facilitator
Norma	Vega	American Red Cross - LA Region
Aquilina	Versoza	Pilipino Workers Center of Southern California
Richard Allen	Williams, MD	Minority Health Institute
Doreena	Wong	Asian Resources, Inc.

References

[1] National Academies of Sciences, Engineering, and Medicine. 2020. *Framework for equitable allocation of COVID-19 vaccine*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25917

[2]*Ensuring equity in COVID-19 planning, response, and recovery decision making: An equity lens tool for health departments.* Human Impact Partners and Big Cities Health Coalition, December 2020.

[3] Los Angeles County Public Health. January 26, 2021. Listing of Department of Public Health Press Releases (lacounty.gov)

[4] National Academies of Sciences, Engineering, and Medicine. 2020. *Leading health indicators 2030: Advancing health, equity, and well-being*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25682.

[5] Los Angeles County Public Health, December 2020-January 2021. *COVID-19 Vaccine Listening Session Summaries*.

[6] *Native Hawaiian Pacific Islander (NPHI) COVID-19 Data Policy Lab at the UCLA Center for Health Policy Research Data Analysis of HPI by Racial/Ethnic Composition memo to California Surgeon General Dr. Burke Harris, California Surgeon General Dr. Burke Harris, CDPH Director Dr. Aragón, CDPH State Epidemiologist Dr. Pan, and Members of the California Community COVID-19 Vaccination Advisory Committee*. Ninez A. Ponce, MPP, PhD, January 18, 2021.

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[i] Los Angeles County Department of Public Health Daily COVID-19 Data http://publichealth.lacounty.gov/media/Coronavirus/data/index.htm accessed January 25th, 2021

[ii] The California Healthy Places Index https://healthyplacesindex.org/ accessed January 25th, 2021

[iii] Paul M. Ong and Jonathan D. Ong. (2020) "Assessing Vulnerability Indicators and Race/Ethnicity." UCLA Center for Neighborhood Knowledge. January 18th, 2020

[iv] Building Trust in and Access to a COVID-19 Vaccine Among People of Color and Tribal Nations: A Framework for Action Convening https://www.tfah.org/wp-content/uploads/2020/12/VaccineConveningPolicyBriefFnl.pdf accessed January 25th, 2021

Note: In delineating objective measures of need to inform the decision-making process, presenting data on vaccine allocation in a format that will help inform DPH, the committee, and the public is critical. Inclusion of demographic descriptive data on ii above, in addition to the former, supports trust and objective assessments of achieving equity.

COVID-19 Vaccine Equity Committee
December 23, 2020

- Goals
- Deliverables
- Subcommittees
- Delphi Technique
- Next Steps

COVID-19 Vaccine Equity Committee
Goals & Deliverables

ACTION ORIENTATION

Provide a voice for disproportionately impacted groups for equitable vaccine distribution with specific actions

OPERATIONAL ALIGNMENT

Monitor operational efforts for vaccine distribution from an equity perspective and provide recommendations to LACPH Leadership/Board of Supervisors for program approval/inclusion

COMMITTEE ALIGNMENT

Collaborate with other workgroups (Aligning Resources for Mass Vaccination & Communication) to confirm equity alignment via shared meeting notes, resources forums, listening sessions, and operational coordination

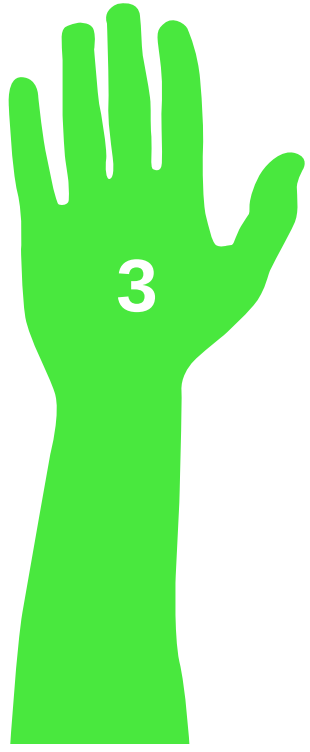
1st REPORT DUE JAN 27

COVID-19 Vaccine Equity Subcommittee Discussion

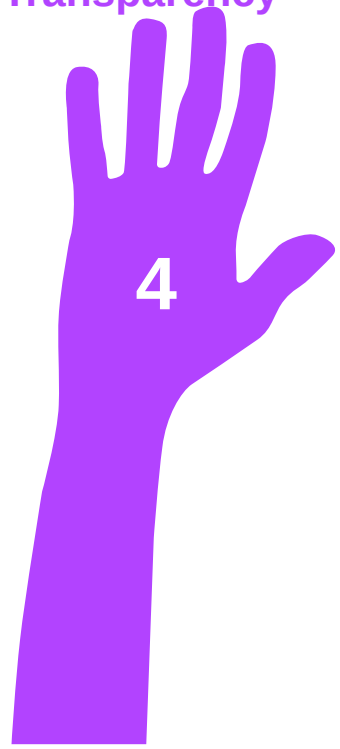
Assessment of Challenges to Achieve Vaccine Equity
(1) Qualitative
(2) Quantitative

Communication Education & Awareness (Aligns with Communication Committee)

Operations & Prioritization to Maximize Vaccine Access & Use for Most at Risk Populations (incl. activities & resources)



Process & Outcomes (e.g., Vaccination Rates) For Continuous Assessment & Monitoring of Equitable Vaccination of High Risk Populations for Effectiveness & Transparency



COVID-19 Vaccine Equity Subcommittee Example

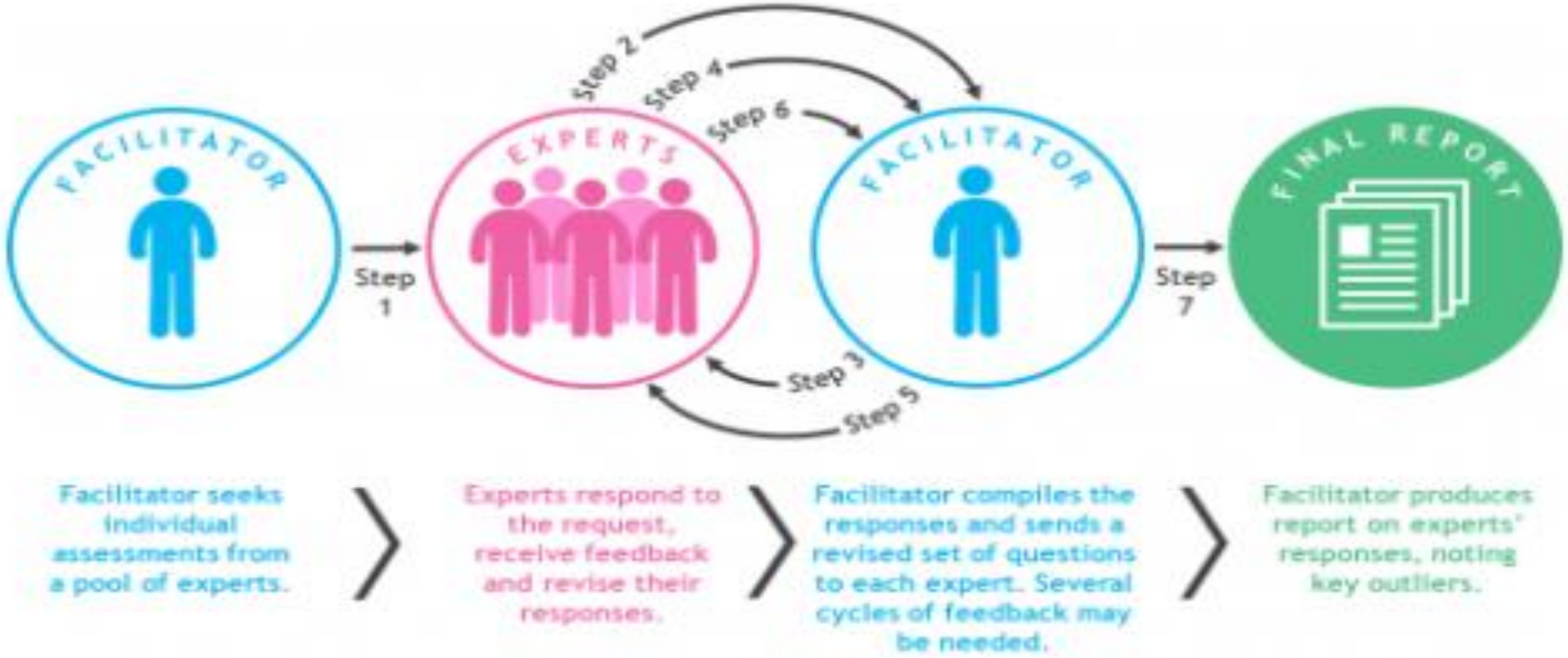
Assessment of Challenges: Breakouts to develop
Advantage: All voices are heard

Population	Barriers to Access to or Use of Vaccine	Resources/Solutions (Available for or Evidence)
Native American	Geographically dispersed, including care access	

COVID-19 Vaccine Equity Subcommittees: Delphi Technique

Delphi Technique

- **Definition: A research design (usually considered a qualitative method) to develop the best workable solutions to problems where data is missing or incomplete**
- **Goal: to obtain the most reliable opinion consensus from a group of experts**
- **Process: Series of reviews**



Source: https://research.phoenix.edu/content/research-methodology-group/delphi-method

COVID-19 Vaccine Equity Subcommittees: Delphi Technique

Step 1

Breakouts to Develop Lists

a. Assessment of Challenges

b. Communication, Awareness & Education

c. Operations & Prioritization

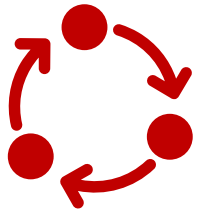
d. Process & Outcomes

Step 2

Lists submitted to full Committee for Review.

Suggestions, Additions,

Rankings- iterations



Step 3

Report drafted, developed & submitted.

<u>Accountability Grid</u>

Feedback from Leadership: which recommendations accepted & rationale for decisions for transparency.

Ongoing review

COVID-19 Vaccine Equity Subcommittee Discussion

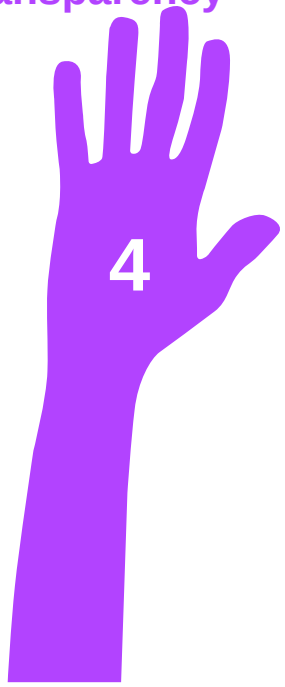
(1) Choose/assign to subcommittee (info will be sent prior to next Wed.)
(2) Meetings- first 30 minutes together, 60 minutes subcommittees

Assessment of Challenges to Achieve Vaccine Equity
(1) Qualitative
(2) Quantitative

Communication Education & Awareness (Aligns with Communication Committee)

Operations & Prioritization to Maximize Vaccine Access & Use for Most at Risk Populations (incl. activities & resources)

Process & Outcomes (e.g., Vaccination Rates) For Continuous Assessment & Monitoring of Equitable Vaccination of High-Risk Populations for Effectiveness & Transparency



List of Priority Zip Codes

90044	90005	90032	90027	91803
90201	90043	90061	90301	93591
90011	90221	90222	90303	90013
90001	90706	90270	90716	90040
90006	90723	90304	91303	90242
90255	90744	91205	91340	90302
90280	91352	91406	91342	90605
91402	91706	91744	91411	90606
90023	90029	90012	90021	90650
90037	90059	90015	90024	90670
90063	90262	90026	90034	91010
90813	91733	90062	90038	91103
90002	91766	90640	90042	91204
90007	93534	90802	90058	91304
90018	90016	90806	90247	91306
90057	90047	91768	90501	91324
90022	90220	93552	90602	91356
90033	90250	90008	90660	91401
90805	91343	90020	90710	91502
91331	91405	90065	90810	91767
91732	91731	90731	91201	91776
93535	91770	90804	91203	91801
90003	90017	91335	91601	93536
90004	90019	91606	91745	93551
91605	90028	91702	91748	
93550	90031	91754	91755	

February 26, 2021

Dear California Vaccination Provider:

Thank you for your work administering COVID-19 vaccinations to vulnerable Californians. We know this effort has meant a significant investment of time and resources in the earliest weeks of COVID-19 vaccinations, and we appreciate your dedication to helping end the pandemic in our State.

Since mid-December, we have learned important lessons. Our early vaccination plan laid the groundwork for COVID-19 vaccinations at the local level, but we must build a more robust statewide network to accelerate the administration of vaccines and ensure more equitable access.

On January 26, Gov. Gavin Newsom announced a series of improvements to the State's vaccination plan aimed at making it easier for people to know when they are eligible for vaccination and how to make an appointment. He also directed State officials to enhance California's vaccine network to make it capable of administering COVID-19 vaccines more rapidly to more Californians equitably, efficiently, and safely.

In accordance with the Governor's direction, the state has asked Blue Shield of California to be the State's Third Party Administrator to build an enhanced state vaccine network. Under this plan, the State will allocate vaccines directly to providers to maximize distribution efficiency and equity.

At the state's direction, Blue Shield of California continues to consult with leaders of each local health jurisdiction, healthcare providers and others in our combined efforts to address gaps and help tackle this pandemic together. We are also contracting with existing and new providers to build an enhanced state vaccine network capable of delivering vaccinations at the scale needed in our state.

The following are key guiding principles as we transition to this new model:

- Deliver capacity to ensure California can meet the goal of vaccinating 25 million people by the summer of 2021;
- Build on the current system's existing capacity and vaccination processes that are working well while enhancing state oversight of the vaccine supply and accountability for all doses;
- Promote equity in vaccine delivery by supporting vulnerable communities with resources to ensure access and reduce barriers to vaccinations;
- Simplify access to vaccines with a single vaccination portal for all Californians to make appointments and support unified statewide approach to ensure consistency in prioritizations for vaccines by the State;
- Ensure appropriate allocations across the state to maximize efficiency in the delivery of vaccines to all Californians.

Blue Shield of California is an independent member of the Blue Shield Association L52000-W (1/20)

Beginning on March 1, 2021 and over the next few weeks, we will be transitioning to the new State-led approach in three phases.

- The first phase of the transition involves a three-week process where the TPA will begin implementing State-approved vaccine allocation to counties and providers. Providers and local health jurisdictions may choose to continue in their roles as vaccine providers by contracting with the TPA. The agreement includes using the state's MyTurn portal for scheduling vaccination appointments and reporting data to the TPA and the state to provide daily visibility about the vaccine network's operation. Providers interested in becoming part of the network may email CovidVaccineNetwork@BlueShieldca.com.

- During the second phase, the allocation will begin to follow the State's equity and priority directives, and all providers and local health jurisdictions will be required to follow state prioritization guidance (i.e., age, sectors, health condition, etc.). We will continue our outreach and onboarding local health jurisdictions and providers to the state vaccine network.

- In the third phase of the transition, beginning March 15, the TPA will manage all providers in the network and assume responsibility for implementing the State-approved allocation of all vaccine doses provided to California.

It's important to note that local health jurisdictions will continue to be key partners with the state and the TPA, helping us understand which providers are vaccinating equitably, efficiently, and effectively.

We recognize this transition is happening quickly and that it represents a change for providers. However, as the federal government prepares to ramp up the availability of vaccines in coming weeks and months, we are aiming to build a provider network here in California that is only constrained by the number of vaccines we receive.

Thank you for your patience as we all work together to ensure that Californians receive vaccinations as efficiently, equitably, and as quickly as possible. Your work administering the COVID-19 vaccine is saving lives. We are grateful for your efforts and look forward to working with you in the weeks and months ahead.

For more information, please call the CDPH COVID Provider Call Center at (833) 502-1245 or send an email to covidcallcenter@cdph.ca.gov.

Yours Sincerely,

Aliza Arjoyan
Senior Vice President, Provider Partnerships & Network Management
Blue Shield of California – State of California's Third Party Administrator

Memorandum of Understanding
Between
County of Los Angeles Department of Public Health
and
Kedren Community Health Center, Inc.

1. Declaration

This Memorandum of Understanding (MOU) is entered into between Los Angeles County (County) Department of Public Health (DPH) and Kedren Community Health Center, Inc dba KEDREN HEALTH.

2. Purpose

The purpose of this MOU is a voluntary agreement between DPH and KEDREN HEALTH to work cooperatively and coordinate dispensing of Medical Countermeasures ("MCM"), as directed by DPH, in response to a major public health emergency in Los Angeles County in order to protect the health and welfare of the public's health.

Pursuant to this MOU, KEDREN HEALTH would be considered by DPH to be a MCM Dispensing Site meaning that, KEDREN HEALTH would dispense life-saving MCM to its predetermined population (i.e. patients, personnel, family members, vendors, and visitors), as outlined in the DPH – KEDREN HEALTH MCM Dispensing Plan and in accordance with the terms of this Memorandum.

It is understood that the parties anticipate that this MOU would be activated by DPH only in the event of a major public health emergency that is accompanied by a declaration of a local, State, and/or federal disaster or emergency. However, at the discretion of DPH, KEDREN HEALTH MCM Dispensing Site(s) may not be utilized at the time of the incident. In the event DPH activates this MOU, DPH Responsible Person will notify the KEDREN HEALTH Responsible Person, as identified in Paragraph 14 of this MOU and request activation of their MCM Dispensing Site(s) as outlined in the DPH – KEDREN HEALTH MCM Dispensing Plan. This Plan is public safety sensitive and, as such, is confidential and not attached to this MOU. In the event KEDREN HEALTH elects not to activate as an MCM Dispensing Site, DPH will be notified immediately.

This MOU recognizes that KEDREN HEALTH is a critical partner with the capability and interest in protecting the public's health during a major public health emergency by dispensing MCM supplied by, and in accordance with procedures promulgated and/or required by DPH. This effort will assist DPH in efforts to provide life-saving medications throughout the County.

This MOU defines the policies and procedures that would be followed in the event that a major, county-wide public health emergency is declared and DPH elects to activate KEDREN HEALTH as MCM Dispensing Site(s) owned and operated by KEDREN HEALTH for the purposes of dispensing MCM. KEDREN HEALTH will utilize its own licensed medical and other personnel and resources needed to dispense the MCM as outlined in the LACDPH – KEDREN HEALTH MCM Dispensing Plan.

It is understood that KEDREN HEALTH and DPH will extend their best efforts to implement the purposes of this MOU, consistent with their respective missions and resource availability.

3. Definitions

As used in this MOU, the following terms are defined:

- Medical Countermeasure (MCM): FDA-regulated products that may be used in the event of a potential public health emergency, stemming from a terrorist attack with a biological, chemical, or radiological/nuclear material; a naturally occurring emerging disease; or a natural disaster.

- MCM Dispensing: Provision of MCM in support of prophylaxis or treatment to the identified population in accordance with public health guidelines and/or recommendations.

- Mass Dispensing: Provision of antibiotic drugs or vaccine by public health agencies and partners, which likely cannot solely be provided by community clinics and hospitals, as such dispensing would likely overwhelm their clinical and/or patient care operations.

- Public Health Emergency: Any situation where, in the judgment of the County DPH's Public Health Officer ("PHO") an emergency condition exists from the introduction of any contagious, infectious, or communicable disease, chemical agent, non-communicable biologic agent, toxin, or radioactive agent, which threatens the health of the general public, and which requires extraordinary actions to protect the public's health.

- The Public Readiness and Emergency Preparedness Act of 2005 (PREP Act): Authorizes the Secretary of the US Department of Health and Human Services (HHS) to issue a PREP Act declaration that provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of medical countermeasures to disease, threats and conditions determined by the Secretary to constitute a present, or credible risk of a future public health emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such medical countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from liability, and is different from, and not dependent on, other emergency declarations.

4. Assumptions

- It is anticipated that any public health emergency in which DPH PHO seeks implementation of the procedures encompassed in this MOU would be preceded by the declaration of a local, State, and/or federal emergency or health emergency by either the DPH PHO or appropriate governmental entity.

- The DPH PHO, based upon his/her discretion, request activation of this MOU and MCM Dispensing Sites, in order to contain and treat the emergency conditions existing from the introduction of any contagious, infectious, or

communicable disease, chemical agent, non-communicable biologic agent, toxin, or radioactive agent, which threatens the health of the public, and requires extraordinary actions to protect the public's health.

- KEDREN HEALTH, may, at its sole discretion, elect either to accept or decline a request to activate their MCM Dispensing Site(s) and dispense MCM to their population.

- In the event KEDREN HEALTH elects to activate their MCM Dispensing Site(s), all KEDREN HEALTH personnel involved in dispensing MCM, pursuant to a declared public health emergency and an issued PREP Act declaration, may be provided the same liability immunity as all County personnel as outlined in the PREP Act. KEDREN HEALTH is responsible to confirm that its actions under this MOU would be covered by the PREP Act.

- MCM to be dispensed at activated MCM Dispensing Site(s) will be provided to KEDREN HEALTH by DPH at no cost.

5. Creation of Obligation

This MOU is not intended to create additional obligations on the part of KEDREN HEALTH or DPH, except as explicitly detailed herein.

6. MOU Activation

In the event the DPH PHO determines that it is in the public interest to activate KEDREN HEALTH MCM Dispensing Site(s) for dispensing MCM, the DPH PHO or designated representatives will contact one of the KEDREN HEALTH Responsible Persons or their designee, identified herein below in Paragraph 14, Designation of Responsible Persons. The communication will request the activation of MCM Dispensing Site(s) as outlined in the DPH-KEDREN HEALTH MCM Dispensing Plan.

This communication will also specify the medication and approximate number available for dispensing. This determination is made at the sole discretion of the DPH PHO. The allotment of MCM may depend upon certain factors, including but not limited to, the nature of the public health emergency, the availability of MCM, and the anticipated impact of the incident.

If the KEDREN HEALTH Responsible Person agrees to the request, that person will coordinate with DPH personnel and confirm the following:

- The operational period for MCM dispensing
- Location of MCM dispensing operations
- Number of MCM requested
- Arrangements for delivery or pick-up of MCM
- Secured storage and tracking of MCM
- Contact information for person(s) responsible for overall MCM Dispensing operations (i.e., name, title, phone number, email address)

- Communication of regular situational status reports

7. KEDREN HEALTH Responsibilities

In the event that KEDREN HEALTH agrees to activate their MCM Dispensing Site(s), KEDREN HEALTH agrees to perform the following activities:

- Deploy KEDREN HEALTH personnel to operate MCM Dispensing Site(s) as outlined in the DPH-KEDREN HEALTH MCM Dispensing Plan
- Determine the number of MCM needed, if different from estimated numbers in plan
- Coordinate the pick-up or delivery of MCM
- Provide security for the dispensing site, MCM and personnel
- Provide all licensed medical and other personnel required to properly dispense MCM
- Dispense MCM under the supervision of licensed medical personnel
- Dispense MCM in accordance with procedures provided by DPH to KEDREN HEALTH
- Coordinate with DPH throughout the duration of MCM dispensing operations
- Communicate situational status reports to DPH on an hourly basis
- Track MCM inventory, maintain all records necessary, and return reusable or unused MCM

8. DPH Responsibilities Upon Activation

In the event that KEDREN HEALTH agrees to activate their MCM Dispensing Site(s) at the request of the DPH PHO, DPH agrees to perform the following activities:

- Coordinate the pick-up or delivery of MCM and instructions for their use
- Provide procedures and protocols to be followed by the KEDREN HEALTH licensed medical and other personnel when dispensing MCM

9. Reimbursements for Costs Incurred

It is the responsibility of the respective entities to maintain all records necessary to request federal reimbursement of its own costs. Neither party is responsible for the costs incurred by the other in performing the activities as a result of activating this MOU. DPH will extend good faith efforts to assist KEDREN HEALTH in recovering eligible costs from the Federal Emergency Management Agency ("FEMA"), federal, State, or local government funds, or other permissible source of recovery. KEDREN HEALTH agrees to not charge individuals for any MCM that have been provided through this agreement, except as otherwise permitted by the County or HHS.

This MOU does not document nor provide for the exchange of funds or personnel between County and KEDREN HEALTH nor does it make any commitment of funds or resources.

10. MCM Dispensing Plan

In coordination with DPH, KEDREN HEALTH agrees to develop and maintain appropriate plans for activation, maintenance of sustained operations, and MCM dispensing, and to submit such plans to DPH for review and approval annually. DPH agrees to provide technical assistance including, but not limited to access to technical expertise, planning templates, and recommended dispensing procedures. DPH shall be provided a copy of the final DPH - KEDREN HEALTH MCM Dispensing Plan.

11. Training and Exercises

To ensure that MCM Dispensing plans can be effectively carried out, DPH may request that KEDREN HEALTH personnel participate in training and/or exercises to test the capability of KEDREN HEALTH and DPH to jointly implement plans, which are performed in accordance with the California Emergency Services Act. Such training and exercises shall be scheduled in coordination with KEDREN HEALTH. KEDREN HEALTH agrees to make personnel available for such mutually-agreed upon training and/or exercise events, to the extent that time and resources permit.

DPH agrees to assist KEDREN HEALTH in training and exercising KEDREN HEALTH personnel in MCM dispensing operations.

12. Assistance in Locating Special Needs Populations

KEDREN HEALTH will use good faith efforts to work with DPH to develop procedures and protocols to identify the number of people within their target population who may require special assistance during a major public health emergency. It is understood that such procedures and protocols must be consistent with all local, State, and federal laws and protect their privacy.

13. Term of Agreement

Effective upon execution, this MOU shall remain in force until September 30, 2030. Either entity may terminate this MOU by providing sixty (60) calendar days prior written notice to the other.

This MOU may be modified via a written amendment to this MOU upon mutual written consent of DPH and KEDREN HEALTH.

14. Designation of Responsible Persons

The following persons, identified by position title, have been designated as the responsible persons for all communications related to this MOU, including any required notice, related to this MOU, including but not limited to, its future activation or termination. Either entity may change its responsible persons by written notice to the other entity.

LACDPH Responsible Parties:

(1) Jee Kim, MCM Dispensing Manager
600 South Commonwealth Ave, Suite 700
Los Angeles, CA 90005
Office: (213) 637-3636
Cell: (213) 254-7944
Fax: (213) 381-0006
JeeKim@ph.LACounty.gov

(2) Dee Ann Bagwell, Policy and Planning Director
600 South Commonwealth Ave, Suite 700
Los Angeles, CA 90005
Office: (213) 637-3630
Fax: (213) 381-0006
DBagwell@ph.LACounty.gov

(3) Stella Fogleman, Director, Emergency Preparedness and Response Division
600 South Commonwealth Avenue, Suite 700
Los Angeles, California 90005
Office: (213) 637-3600
SFogleman@ph.LACounty.gov

KEDREN HEALTH Responsible Parties:

(1) Dr. Jerry P Abraham, MD MPH CMQ, Family & Community Medicine, Epidemiologist
4211 S Avalon Blvd
Los Angeles, California 90011
Office: (832) 687-3242
Email: abraham.jerry@gmail.com

(2) Dr. Kelly Jones, MD, Primary Care CMO, Family Physician
4211 S Avalon Blvd
Los Angeles, California 90011
Office: (310) 621-0771
Email: kjones@kedrenhealth.org

(3) Mr. Sonny Tran, MBA, Primary Care Chief Operating Officer
4211 S Avalon Blvd
Los Angeles, California 90011
Office: (310) 833-8324
Email: sonnyde@gmail.com

/

/

/

15. Signatures

The undersigned hereby represent and acknowledge that they are duly authorized to execute this MOU on behalf of the entity for which they sign.

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

1/5/21
Date

KEDREN HEALTH

Rahn Kennedy Bailey, MD, DFAPA, ACP

Dr. Rahn K Bailey, MD
Chief Medical Officer, Forensic Psychiatrist

12/29/2020
Date

Closed Medical Point of Dispensing Planning Guide for Healthcare Partners

May 2020

Los Angeles County Department of Public Health
Emergency Preparedness and Response Division
Policy and Planning Unit – Medical Countermeasures Team

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Introduction

Los Angeles County Department of Public Health (LACDPH) is the principal agency responsible for dispensing life-saving preventive medications (i.e., vaccines or antibiotics) to the entire county population during public health emergencies. One strategy to rapidly dispense such medications, and thereby reduce disease morbidity and mortality, involves collaborating with partners on the development of Closed Medical Points of Dispensing (Closed MPODs).

A Closed MPOD is a facility that is used temporarily during public health emergencies to dispense preventive medication to a pre-identified group of people. These sites reduce demand at Public MPODs, support business continuity for critical infrastructure, and provide an alternative method for dispensing to those with disabilities or access and functional needs.

Closed MPOD Partners work with LACDPH to develop site-specific plans for mass dispensing preventive medications to a pre-identified group. Closed MPOD Partners also enter into a voluntary agreement with LACDPH (i.e., a memorandum of understanding/MOU) which outlines responsibilities for each organization.

Closed MPOD Partners have the authority to accept or decline a request to activate their site at the time of request from LACDPH. If activated, Closed MPOD Partners are responsible for staffing their Closed MPOD and transporting, tracking, securing, and dispensing preventive medication to the identified population at no cost and in accordance with their MOU/public health guidelines.

Scope

LACDPH may only request Closed MPOD activation in the event of a major public health emergency when accompanied by a declaration of a local, state, or federal disaster. Closed MPODs may only be activated for public health emergencies in which preventive medication is available (e.g., in response to a bioterrorist attack, pandemic influenza, or other emerging infectious disease).

Purpose

The Closed MPOD Planning Guide for Healthcare Partners outlines the steps to become a Closed MPOD Partner with LACDPH. The information collected in the worksheet will assist LACDPH Staff and potential Closed MPOD Partners in developing a Memorandum of Understanding (MOU) and Closed MPOD Plan.

Closed MPOD Planning Process

There are 6 steps to becoming a Closed MPOD Partner with LACDPH:

1. **Attend a LACDPH Closed MPOD Briefing** that provides an overview of Closed MPODs, partner responsibilities, and the planning process. You may wish to invite leadership and other key decision-makers from your organization to facilitate a robust discussion regarding Closed MPOD details.
2. **Complete the Closed MPOD Planning Worksheet and submit to LACDPH.** LACDPH will draft a Closed MPOD Plan and Memorandum of Understanding (MOU) for your site using information from the Closed MPOD Planning Worksheet.
3. **Participate in planning meetings with LACDPH** to review, discuss, and approve your Closed MPOD Plan.
4. **Sign a Memorandum of Understanding** (MOU) using your organization's processes for reviewing and approving MOUs.
5. **Develop a training and exercise plan.** LACDPH will provide training templates and technical assistance with Closed MPOD exercises.
6. **Exercise and revise your plans.** Participate in periodic exercises with LACDPH and revise plans as needed.

Closed MPOD Planning Worksheet

This worksheet collects the information needed to develop your Closed MPOD Plan and Memorandum of Understanding (MOU) between your organization and the Los Angeles County Department of Public Health. If you have any questions about this worksheet or the planning process, contact Kirby Johnson at KJohnson@ph.LACounty.gov or (213) 637-3611.

Email completed documents to KJohnson@ph.LACounty.gov. Once we receive your Closed MPOD Planning Worksheet, we will set-up a meeting with you to review the information and discuss the Closed MPOD Plan for your organization.

Section 1: Information for MOU

Organization	**Name**	Kedren Community Health Center, Inc dba **KEDREN HEALTH**
	Address	4211 S Avalon Blvd; Los Angeles, California 90011
	Type	☒ Hospital ☒ Clinic ☐ Skilled Nursing Facility ☒ Other: Behavioural Health Center
Individual Authorized to Approve MOU	**Name**	**Dr. John H Griffith, PhD**
	Title	President & CEO, Clinical Psychologist
	Phone	213.309.0590
	Email	johngriffith0425@gmail.com
	Address	4211 S Avalon Blvd; Los Angeles, California 90011
Individual Authorized to Execute MOU	**Name**	**Dr. Rahn K Bailey, MD**
	Title	Chief Medical Officer CMO, Forensic Psychiatrist
	Phone	832.623.2052
	Email	rahnkbaileymd@comcast.net
	Address	4211 S Avalon Blvd; Los Angeles, California 90011
Responsible Party (Primary)	**Name**	**Dr. Jerry P Abraham, MD MPH CMQ**
	Title	Family & Community Medicine, Epidemiologist
	Phone	832.687.3242
	Email	abraham.jerry@gmail.com
	Address	4211 S Avalon Blvd; Los Angeles, California 90011
Responsible Party (Secondary)	**Name**	**Dr. Kelly Jones, MD**
	Title	Primary Care CMO, Family Physician
	Phone	310.621.0771
	Email	kjones@kedrenhealth.org
	Address	4211 S Avalon Blvd; Los Angeles, California 90011
Responsible Party (Tertiary)	**Name**	**Mr. Sonny Tran, MBA**
	Title	Primary Care Chief Operating Officer COO
	Phone	310.833.8324
	Email	sonnyde@gmail.com

Section 2: Location(s)

Primary Location for Closed MPOD

Facility Name	**KEDREN HEALTH**
Address	4211 S Avalon Blvd
Room Name / Number	Primary Care Pavilion
Room Dimensions	20’ x 20’
Type of Security	Hospital security
Facility Map Attached?	☐ Yes ☒ No
Room Map Attached?	☐ Yes ☒ No

Contacts for Primary Location

MPOD Operations Point of Contact (Primary)	**Name**	**Amabel Santalices, MSN, RN**
	Title	Director of Nursing DON
	Phone	626.491.2025
	Email	a_santelices@kedren.org
MPOD Operations Point of Contact (Secondary)	**Name**	**Dr. Jerry P Abraham, MD MPH CMQ**
	Title	Family & Community Medicine, Epidemiologist
	Phone	832.687.3242
	Email	abraham.jerry@gmail.com
Facilities Contact for MPOD Location	**Name**	**Ms. Amelia Huckabee, M.Ed.**
	Title	Director of Human Resources HR
	Phone	951.768.1962
	Email	a_huckabee@kedren.org

Alternate Location for Closed MPOD (Optional)

Facility Name	n/a
Address	
Room Name / Number	
Room Dimensions	
Type of Security	
Facility Map Attached?	☐ Yes ☐ No
Room Map Attached?	☐ Yes ☐ No

Contacts for Alternate Location

MPOD Operations Point of Contact (Primary)	**Name**	n/a
	Title	
	Phone	
	Email	
MPOD Operations Point of Contact (Secondary)	**Name**	
	Title	
	Phone	
	Email	
Facilities Contact for MPOD Location	**Name**	
	Title	
	Phone	
	Email	

Section 3: Target Population

Population Type Check the box for groups to include in your Closed MPOD population.	**Estimated Number** Provide estimates for each population that your organization will serve at your Closed MPOD(s).
☒ Employees	400
☒ Students	50
☐ Patients	500+
☒ Physician Residents	100
☐ Guests	100
☐ Other: _	
Total Population	600+ (excluding patients)

Section 4: Staffing

Licensed Medical Personnel Check the box for personnel that will be available to staff your Closed MPOD(s).	**Estimated Number** Provide estimates for each type of personnel that will work in your Closed MPOD(s).
☒ RN	5
☒ MD	2
☐ DO	
☐ PA	2
☐ LVN	
☒ Other: Vaccine Medical Assistants	5
Non-Licensed Personnel	**Estimated Number**
☐ Type: _	
☐ Type: _	
☐ Type: _	
☐ Type: _	
Total Personnel Available	

Section 5: Logistics

Type of Tracking / Inventory System	PREP-MOD, IIS
Type of Security for MPOD Supplies	hospital security
Closed MPOD Supply Kit Location	Primary Care Building A
How will you receive MPOD supplies?	○ Will pick-up ◉ Need delivered
Type of Closed MPOD	○ Antibiotics ◉ Vaccines ○ Dual

Section 6: Activation

Who will contact your Closed MPOD Staff?	**DR. JERRY P ABRAHAM, MD MPH CMQ**
How will Closed MPOD staff be contacted?	MOBILE
Who is responsible for maintaining the Closed MPOD staff contact list?	DR. JERRY P ABRAHAM, MD MPH CMQ
Where will the Closed MPOD staff contact list be kept?	DR. JERRY P ABRAHAM, MD MPH CMQ
Where should Closed MPOD staff report?	KEDREN HEALTH, Primary Care Bldg A
What should Closed MPOD staff bring when they report for their shift?	ROUTINE
Who will contact your Closed MPOD target population?	PRIMARY CARE CLINIC APPOINTMENTS
How will your Closed MPOD target population be contacted?	TELEPHONE

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

February 18, 2021

Bechara Choucair, MD
Vaccinations Coordinator
White House COVID-19 Response Team
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Dr. Choucair:

On behalf of the physician and medical student members of the American Medical Association (AMA), we thank the Biden Administration for their immediate focus on improving and accelerating distribution of COVID-19 vaccines nationwide. Thank you for including the AMA's President, Susan Bailey, MD, in discussions about vaccinations this week. I understand that Dr. Bailey shared with you that, while we are encouraged to see rapid improvement in the number of individuals vaccinated each day, we are concerned that the Administration is not utilizing all potential avenues to get these life-saving vaccinations into the arms of patients. Specifically, physician offices have not been included as part of the national vaccination distribution strategy and have likewise been excluded from distribution plans in many states. **As vaccine supply increases over the coming weeks and months, we strongly urge the Administration to reconsider its current distribution strategy to ensure physician offices can participate in vaccine administration and to encourage states to include these sites of care in their distribution plans**.

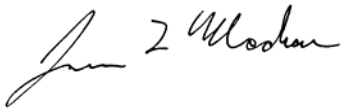
When searching for information regarding vaccinations or when looking to receive a vaccine, the most common place for a patient to turn is to their physician, making physicians uniquely situated to assist in promoting COVID-19 vaccination. However, the current structure for COVID-19 vaccine distribution has left physicians with little to offer patients other than to check with their state or local health department or pharmacies, which can be a challenging process for many patients to navigate. Complicated internet-based appointment scheduling systems have been difficult for even the savviest of patients. For less technology-savvy elderly patients or those without access to broadband internet or smartphones with cellular data access, they have been nearly impossible. Including physician offices in the distribution strategy for COVID-19 would alleviate a significant number of the challenges certain populations are facing with accessing COVID-19 vaccines, as calling a physician office to secure a vaccine appointment may be a much easier option for populations struggling to secure appointments on internet-based systems. Further, due to existing relationships physicians can quickly and easily identify patients with co-morbidities that pose the highest risk for severe COVID-19. Physician offices are also able to offer ease of scheduling, and can provide vulnerable patients, even those that may not regularly see a physician, an environment that may be easier to access and in which they feel more comfortable and safer receiving the vaccine.

Additionally, the exclusion of physician offices from COVID-19 vaccine distribution plans represents a significant missed opportunity to increase the vaccination rate among the nation's traditionally underserved populations. For many Americans, care sites such as hospitals and community health centers may be some distance from where they live. Rural areas are particularly impacted by this issue and are likewise not targets for mass vaccination events. In these instances, physician offices may be more easily accessible and the best available option for COVID-19 vaccine administration.

Physicians will also serve a key role in addressing vaccine hesitancy among many Americans. While current demand for the COVID-19 vaccine is overwhelmingly high, we expect that at some point it will wane and what remains will be a significant portion of the population unvaccinated and with varying levels of vaccine confidence. For those nervous about receiving the vaccine, it is unlikely that they will be persuaded to go to the pharmacy, hospital, or vaccination event by federal, state, and local messaging alone. However, physicians have a tremendous opportunity to discuss the risks and benefits of vaccination with these same patients during in-office visits. Should physicians not be able to offer these patients the vaccine at the time of this discussion, it may result in those patients continuing to go unvaccinated.

As you continue to engage in this unprecedented national vaccination effort, **the AMA strongly urges you to include physician offices in your distribution strategies, while encouraging states to do the same**. As we rapidly approach half a million American lives lost from COVID-19, we cannot afford to miss any opportunity to provide a potentially life-saving vaccination to any patient and we must ensure we make getting vaccinated as accessible as possible for our most vulnerable patients. We must also do everything we can to help those hesitant about receiving this vaccine feel comfortable in making the choice to get vaccinated. In those instances, physicians are absolutely the best situated to build confidence and ensure that we not miss critical opportunities to ensure patients are vaccinated. We look forward to working with you on how to best include physician offices in vaccine distribution and administration strategies. Please do not hesitate to reach out to Shannon Curtis, Assistant Director of Federal Affairs at shannon.curtis@ama-assn.org to further discuss how physicians may best assist you in these critical, life-saving efforts.

Sincerely,



James L. Madara, MD

Feb. 26, 2021: National Advocacy Update

AMA urges Biden administration to include physician offices in COVID-19 vaccine distribution and administration plans

On Feb. 18, the AMA wrote to the White House COVID-19 Response Team urging them to include physician offices in plans to distribute and administer COVID-19 vaccines.

The AMA has raised this issue in multiple conversations with both the Biden Transition team as well as the White House COVID Response Team. While vaccine roll out continues to ramp up in many states, physician offices have not been included as administration sites in many states, despite physician interest in participating in vaccine administration plans.

While the supply of COVID-19 vaccines cannot meet the current demand, the AMA urged the White House to work with states to include physician offices in vaccine strategies once the supply of available vaccine allows for broader distribution. The letter notes that physician offices can play an important role in reaching many vulnerable patients, particularly in underserved areas such as rural areas. It also highlights the key role physicians will play in addressing vaccine hesitancy as demand for the vaccine by those enthusiastic about being vaccinated begins to wane.

Also read an AMA Viewpoints on this issue, by Susan R. Bailey, MD, AMA president, “Physicians provide key voice in building vaccine confidence.”

New telehealth bill modernizes telemedicine laws

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On Feb. 24, Senators Scott, Schatz and Shaheen introduced the Telehealth Modernization Act, which would ensure continued coverage of telehealth services for all CMS beneficiaries by eliminating the 1834(m) statutory restrictions on originating site and geographic location, thereby ensuring Medicare coverage of telehealth services regardless of where the patient is located. Telehealth services have been a crucial component of caring for patients during the COVID-19 pandemic but without a fix by Congress, most Medicare beneficiaries will lose access to these services at the end of the current public health emergency.

It is critically important that we build on the coverage gains made during the pandemic with the telehealth waivers so that Medicare beneficiaries can continue to access telehealth services from their physicians without restrictions. The Telehealth Modernization Act would allow beneficiaries to access these essential services throughout the COVID-19 public health emergency and beyond, and bring telehealth coverage laws into the twenty-first century.

New legislation would reduce America's maternal and infant mortality rate

On Feb. 24, Senators Durbin (D-IL) and Duckworth (D-IL) introduced the bicameral Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act. The legislation seeks to reduce America's rising maternal and infant mortality rate, especially for moms and babies of color who are significantly more likely to die during or shortly after pregnancy. In the United States Black women are three times more likely than white women to die as a result of their pregnancy. In the U.S., maternal mortality claims the lives of 700 American women each year with 70,000 having near-fatal health complications and 60% being preventable.

We are also losing babies in the U.S. with the average death rate of over 23,000 babies per year, with many deaths also being preventable. Babies of color are particularly at risk with Black babies being twice as likely to die as white babies during the first year of birth. The MOMMA's Act seeks to change the unacceptably high death rate for mothers and babies of color and the dynamic that leads to this egregious health disparity with a six-pronged approach that would reduce maternal deaths by:

- Establishing national obstetric emergency protocols through a federal expert committee
- Ensuring dissemination of best shared practices and coordination amongst maternal mortality review committees
- Standardizing data collection and reporting
- Improving access to culturally competent care throughout the care continuum
- Providing guidance and options for states to adopt and pay for doula support services
- Expanding Medicaid coverage to new mom's entire post-partum period (one year)

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The AMA has strong policy in support of expanding Medicaid coverage to one year for a new mom's entire post-partum period; and in conjunction with the AMA Center for Health Equity, has as one of its chief aims the goal of eliminating health disparities and furthering health equity in federal legislation. Consequently, the AMA proudly endorsed the MOMMA's Act along with a host of other federal and state leaders on maternal and child health, with AMA President Susan R. Bailey, MD, quoted as saying,

> By expanding access to health care coverage and social services for postpartum women, this bill would help change the dynamic causing the tragically high maternal mortality that disproportionately harms Black and Brown communities in the United States. The American Medical Association supports this legislation and is committed to working with Congress to tackle the issues surrounding maternal mortality and morbidity.

Rep. Robin Kelly (D-IL-2) plans to introduce the companion bill in the House and the AMA looks forward to working with bill sponsors to see this important legislation enacted so we can start to make meaningful change in the unacceptably high rate of maternal mortality and morbidity for racial and ethnic minorities in this country.

AMA urges passage of the Equality Act

On Feb. 24, the AMA signed its support (PDF) of H.R. 5, the Equality Act, alongside 49 other organizations; it passed the House on Feb. 25. H.R. 5 would amend several provisions of the Civil Rights Act of 1964 to provide affirmative, statutory non-discrimination protections for LGBTQ Americans both in the workplace and in the community. In 2019, the Equality Act was introduced on a bipartisan basis in both the House and Senate, and it passed the House with a bipartisan majority. The AMA signed onto a similar letter in support of the 2019 legislation with this same coalition. These organizations, "representing and employing tens of millions of Americans…have been at the forefront of efforts to combat discrimination based on sexual orientation and gender identity in the workplace," and again urge passage of H.R. 5.

CMS holds physicians harmless from MIPS penalties amid COVID-19 PHE

On Feb. 25, CMS announced it will hold physicians harmless from up to 9% MIPS penalties due to the significant disruptions of the COVID-19 public health emergency on physician practices'

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performance in 2020. The AMA strongly advocated for this automatic relief from MIPS penalties and sincerely thanks CMS for ensuring physicians will not be unduly penalized during the pandemic.

The Extreme and Uncontrollable Circumstances Hardship Exception policy will be automatically applied to ALL MIPS eligible clinicians who do not submit any MIPS data for the 2020 performance period and avoid a 2022 payment penalty. CMS is also reopening the hardship exception application for group practices, virtual groups, and alternative payment model entities who missed the previous 2020 deadline. The reopened application deadline is March 31, 2021. Note, groups and eligible clinicians who submit data in at least two MIPS categories will override the hardship exception and be eligible to earn a bonus from the exceptional performance bonus pool or potentially be subject to a penalty.

Federal government proposes changes to HIPAA

The AMA continues to track proposed changes to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, published in the Federal Register on Jan. 21, 2021, with the intent of supporting value-based health care and reducing regulatory burden, while preserving the privacy and security of each patient's protected health information (PHI). Proposed changes (PDF), including but not limited to the following, focus on the rights of individuals to access their PHI and modifications to requirements that may impede care coordination and case management:

- Creating new regulatory definitions of electronic health record (EHR) and personal health application (PHA)
- Clarifying the scope of covered entities' abilities to disclose PHI to social services agencies, community-based organizations or home- and community-based service providers
- Modifying the definition of "health care operations" to include care coordination and case management for individuals
- Shortening a covered entity's required response time to an individual's request to access their own health records from 30 days to no later than 15 calendar days (with a one-time opportunity to extend the deadline)
- Adjusting to the scope of an individual's right to direct the transmission of PHI to third parties following the *Ciox v. Azar* decision
- Codifying an individual's right to direct electronic copies of PHI stored in an EHR to a third party, such as a health plan or another health care provider
- Creating an exception to the minimum necessary standard for individual-level care coordination and case management disclosures
- Eliminating the requirement that a covered entity obtain an individual's written acknowledgement of receipt of a treatment provider's Notice of Privacy Practices, and the associated requirement to retain copies of such documentation for six years

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If included in the final rule, several of the proposed changes will impact how physicians comply with regulations linked to HIPAA, including the Office of the National Coordinator for Health Information Technology's Information Blocking Rule. The AMA will be developing substantive comments in response to the NPRM, which are due to OCR by March 22.

More articles in this issue

- Feb. 26, 2021: Advocacy Update spotlight on the top issues from the AMA National Advocacy Conference
- Feb. 26, 2021: State Advocacy Update
- Feb. 26, 2021: Advocacy Update other news

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United States Senate
WASHINGTON, DC 20510

March 4, 2021

Jerry P. Abraham, MD MPH CMQ
Director, Kedren Vaccine
4211 S Avalon Blvd
Los Angeles, CA 90011

Dear Dr. Abraham:

We write to invite you to testify on March 9, 2021, before the Senate Committee on Health, Education, Labor and Pensions. The hearing will begin at 10:00 a.m. EST in Room 106 of the Dirksen Senate Office Building and is entitled "Examining our COVID-19 Response: An Update from the Frontlines." The hearing will also be conducted over WebEx to allow for remote participation.

We are interested in hearing your perspective working on the frontlines of the response to COVID-19, particularly your experience and any challenges you have faced in supporting the public health and medical responses to mitigate the spread of COVID-19, providing care for patients, and distributing and administering medical countermeasures, including COVID-19 therapeutics and vaccines. We would also like to hear about steps being taken to bolster the response to COVID-19, as well as your perspective on lessons learned from this pandemic that will better prepare us for challenges ahead related to COVID-19 and other public health threats. We value your service to patients and communities over the last year, and it would be helpful to know what is needed to enable you to continue your work in responding to the pandemic.

Please submit a written statement of any length prior to the hearing for inclusion in the hearing record. At the hearing, you will be given five minutes to summarize your written testimony. Each Senator will then have five minutes to ask questions of witnesses.

In order to accommodate Committee members and the press, please arrange to submit a one paragraph biographical profile, your written testimony, and a one-page summary by electronic mail to Garrett Devenney (Garrett_Devenney@help.senate.gov) and Rachel Portman (Rachel_Portman@help.senate.gov) at least 48 hours prior to the hearing.

We look forward to seeing you on March 9. Your assistance is greatly appreciated.

Sincerely,

Patty Murray
Chair
Senate HELP Committee

Richard Burr
Ranking Member
Senate HELP Committee

Gmail Jerry P Abraham, MD MPH <abraham.jerry@gmail.com>

🥇RECORD TURNOUT! | Tues 3/2 Mtg Follow-Up

1 message

#ThisIsOurShot <contact@thisisourshot.info> Wed, Mar 3, 2021 at 3:28 PM
Reply-To: #ThisIsOurShot <contact@thisisourshot.info>
To: Jerry Abraham <abraham.jerry@gmail.com>

View this email in your browser

Thanks to those of you who joined us at last night's meeting with all-time record participation! A special thank you to Dr. Richard Pan for sharing your "why" with us.

Summary:

1. **Weekly Action Item: **Complete Call-to-Action by Friday, March 5****
2. **Special Announcement: Public Launch next Wednesday, March 10**
3. **Next Meeting: Tuesday, March 9 @ 8:30 pm ET | 5:30 pm PT (**REGISTER HERE**)**

1. **Weekly Action Item: **Complete Call-to-Action by Friday, March 5****

- Sign up three friends for the movement
- Bring a friend with you to next week's meeting (They can register here.)
- Direct message 3 influencers to get them involved.

2. **Special Announcement: Public Launch next Wednesday, March 10**

- Allies and partner organizations will receive communications materials early next week.
- Advocates will be emailed a social media toolkit next Wednesday.

3. **Next Meeting: Tuesday, March 9 @ 8:30 pm ET | 5:30 pm PT**

- Guest Speakers: Dr. Lisa Fitzpatrick, an infectious diseases physician, CDC-trained medical epidemiologist and founder of Grapevine Health, an organization focused on improving health literacy and patient engagement. She has been an advocate of the vaccine, striving to help create trust in Black communities and was enrolled in the COVID-19 vaccine trials.
- REGISTER HERE.

Remember to share your stories on social media, tagging our accounts and using the #ThisIsOurShot hashtag so we can amplify! Thank you for your energy, your expertise, your time and reading to the bottom of this email :)

-Asha, Vicki, Alex, Atul, Hussain, Anna, Nicole, Jay, Sunny, & The Entire #ThisIsOurShot Team

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BRIEFING ROOM

FACT SHEET: President Biden Announces Community Health Centers Vaccination Program to Launch Next Week and Another Increase in States, Tribes, & Territories' Vaccine Supply

FEBRUARY 09, 2021 • STATEMENTS AND RELEASES

Community Health Center Vaccination Program Will Provide Easier Access to Vaccinations for Under-Served Communities

As the U.S. surpasses 26 million COVID-19 infections, President Biden is taking additional steps today to speed up vaccinations across the country. The President announced the launch of the Federally Qualified Health Center program that will provide more vaccines for Community Health Centers that are reaching our underserved and most vulnerable communities. And, the administration will increase the vaccine supply to states, Tribes, and territories by 5% over last week, for a total of a 28% increase since President Biden came into office three weeks ago.

These new steps will help meet the President's goal of administering 100 million shots in 100 days and ensure that vaccines are administered equitably.

The President is taking the following actions today:

Launching First Phase of the Federally Qualified Health Center Program for COVID-19 Vaccination: As part of the Biden-Harris Administration's efforts to ensure that the nation's hardest hit populations are receiving the vaccine, starting the week of February 15, Federally Qualified Community Health Centers (FQHCs) will begin directly receiving vaccine supply. Many people know these as Community Health Centers. Community Health Centers provide primary care services in underserved communities across the country. There are more than 1,300 Community Health Centers serving almost 30 million people across the country. Two-thirds of the population that these centers serve are living at or below the federal poverty line and 60% are racial and/or ethnic minorities. The program will be phased in, with the first centers able to start ordering vaccines as early as the week of February 15. The initial phase

will include at least one Community Health Center in each state, expanding to 250 centers in the coming weeks.

This program is part of a broader effort to ensure all communities are being reached in the national push to get people vaccinated. Community Vaccination Centers in underserved areas, the retail pharmacy program, mobile clinics, and efforts to increase vaccine confidence are also key tools to help states and communities vaccinate their most vulnerable populations. More information on this program is available at www.hrsa.gov/coronavirus/health-center-program.

Expanding Vaccine Supply: Building on last week's announcement, the Biden-Harris Administration will increase overall, weekly vaccine supply to states, Tribes, and territories to 11 million doses nationwide beginning this week. This is a 28% increase since taking office on January 20. The Administration is committing to maintaining this as the minimum supply level for the next three weeks, and we will continue to work with manufacturers in their efforts to ramp up supply.

###

PERSPECTIVES FROM FQHCs:

- Intro & Kedren stats:
  - Located in the heart of South LA, the epicenter of the COVID-19 crisis.
  - Committed to serving our community, who have been disproportionately hurt by both the pandemic and the economic downturn.
  - Kedren responded to the crisis, offering testing, and now vaccines, at a large scale.
  - Number of vaccines administered to date, ongoing monthly (or weekly) vaccine capacity.
  - We and all of the community health centers across the U.S. are in this for the long haul.
  - In addition to providing quality, comprehensive health care, we provide jobs and career ladders for members of our communities.
  - We are rooted in the communities we serve and we have trusted relationships with our patients.
- Responding to the crisis has not been easy:
  - Last year we didn't have enough PPE, then tests. Now we don't have enough vaccines.
  - Recruiting workforce was hard before COVID – now it's even harder. Our workforce is stretched thin, and many of our workers have been hit by COVID themselves.
  - Much of this work has been uncompensated, and we've struggled to cobble together the resources to keep ourselves afloat.
- American Rescue Plan:
  - With the passage of the American Rescue Plan we know that relief is on the way.
  - The Bill's $7.6 billion for health centers will help us continue to respond to the crisis, and to better support our communities. The bill also has funding for workforce programs that will improve the pipeline of workers coming to work with us.
  - Thank you to the Committee for this bill, and for the previous relief we've received. It has been a lifeline that has allowed us to continue to care for the most .
- Federal Vaccine Initiative:
  - The American Rescue Plan, paired with the new federal vaccine initiative, are a game changer for those of us in the trenches.
  - The program has just launched and is being phased in.
  - We are anxiously awaiting our chance to access vaccines through the new initiative. Having access to a predictable and steady flow of vaccines will be a game changer for us, and for the communities we serve.
- Key Takeaways:
  - Health centers are committed to eliminating the disparities that have been illuminated by the pandemic.
  - We are your partner in responding to the crisis, and in working to rebuild our communities post-pandemic.

PERSPECTIVES FROM FQHCs:

They have to continue to include local, trusted, on the ground community clinic for vaccine distribution. We know our community bests and how to reach hard to reach patients, as well, patients trust us (I,e, their providers, community clinics) and are more likely access care through their own clinics.

Also, decreasing any barriers, unnecessary rules, contracts, etc to speed up our ability to administer. The more restrictions/barriers the less access we have.

Active surveillance of outbreaks in vulnerable communities – vaccines is one way to combat and we need to continue surveillance.

Funding for FQHC to be able to increase distribution and not just rely on volunteers or decreasing our patient care to give vaccines. We are already stretched.

Reimbursements to FQHCs when nurses are providing the vaccine administration should have parity like all other vaccine administrations. This would free up physicians in FQHCs to resume their other patientcare duties, specifically providing complex primary care to patients in the safety net.

Senior Resident Elective Rotation
KEDREN HEALTH -- VACCINE FELLOW

Objective: The Vaccine Fellow elective rotation at Kedren will play an important role in the continued and expanding roll-out of COVID-19 vaccination with particular emphasis on hard-to-reach communities. The resident will serve as a leader and work as part of a team of clinical staff and volunteers with the shared mission of protecting the vulnerable and finally ending the COVID-19 pandemic. This elective will help the resident develop enhanced clinical and leadership skills in public health, epidemiology, and a deep dive into ending the COVID-19 pandemic through working with individuals and communities, public health stakeholders, and always through a lens of health equity.

By the end of the rotation, the resident should feel comfortable leading a vaccination operation.

Supervisor: Jerry Abraham, MD, MPH, CMQ, Family & Community Medicine, Global Injury Epidemiologist, Director, KEDREN Vaccines
Location: Kedren Community Health Center (FQHC) and Acute Psychiatric Hospital, 4211 S Avalon Blvd, Los Angeles, CA 90011
Duration: 4 weeks ideal
Hours: ~8am to ~6pm Monday through Friday

Duties: The clinical vaccine fellow will have increasing responsibilities and independence as the rotation progresses, in the domains of clinical, administrative, and community outreach operations.

1. Clinical operations:
    a. Become familiar with all aspects of the Moderna COVID-19 vaccine Emergency Use Authorization and how to approach common clinical scenarios.
    b. Vaccinate clients.
    c. Assist in drawing up vaccines.
    d. Monitor post-vaccination waiting area for allergic reactions.
    e. Help triage client concerns and medical questions.
    f. Manage and coordinate efforts of clinical staff and volunteers
2. Administrative Operations
    a. Help ensure proper vaccine handling, storage and transportation conditions.
    b. Keep track of the amount of vaccine stock
    c. Monitor the pace of vaccination throughout the day, week and month to make appropriate adjustments to the clinical operations
    d. Understand and manage the ancillary supply chain
    e. Attend meetings of the state and local public health departments as well as national updates from the CDC.
3. Health Equity and Outreach
    a. Work in conjunction with volunteers to outreach with local communities
    b. Creatively problem solve to address barriers to vaccination.
    c. Create protocols to fairly distribute a scarce resource as the vaccination tiers and the amount of available vaccine supply continue to be in flux.
    d. There may be opportunities to work on public service announcements or otherwise interface with the public health community and various media outlets.

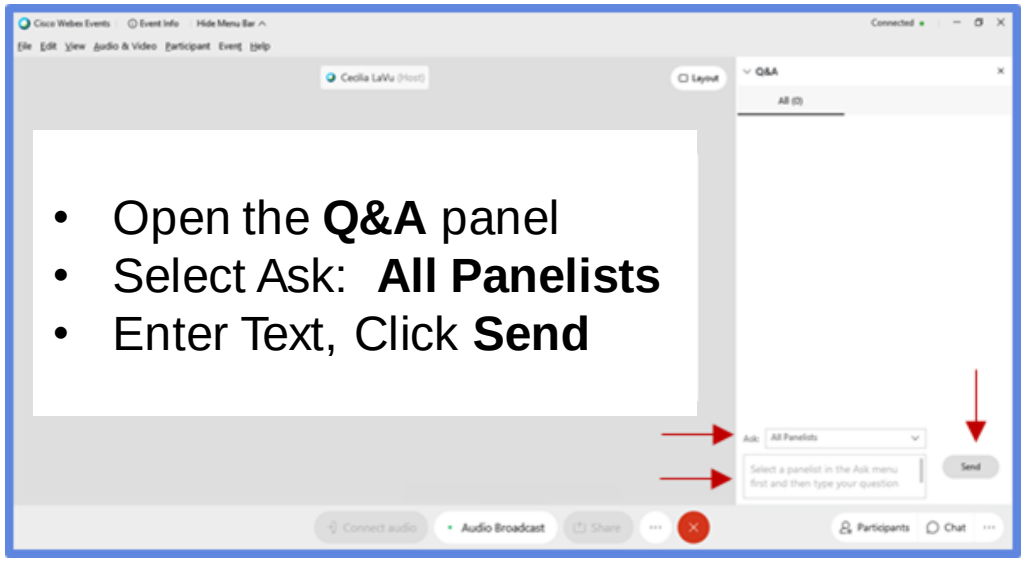
On site parking, lunches, and snacks provided.

Kedren's vision is to eliminate health disparities for children, youth, adults, and families in South Los Angeles by creating access to care irrespective of one's ability to pay. Kedren is committed to promoting well-being by enhancing the quality of life through best practices in healthcare delivery. For more information about Kedren Health, visit www.kedren.org

Welcome to Provider Office Hours

During the session, please use the Q&A panel to comment or ask a question:

Q&A Panel



Housekeeping

Reminder to Panelists:

Please mute yourself when not speaking.

Please monitor the Q&A panel for questions you may be able to answer.

Reminder to Participants:

Please access today's slides and archived presentations at: https://eziz.org/covid/

Agenda

Special Guests

- **My Turn** – Eric Norton, My Turn Project Manager & Ron Thompson, Vice President of IT Shared Services
- **TPA Allocations** – Seth Glickman, MD, Senior Vice President and Chief Health Officer

Q&A

Announcements & Updates

- Clinical – Louise McNitt
- Storage & Handling – Al Hendrickson
- Allocations – Amy Pine
- myCAvax – Claudia Aguiluz

Q&A

Please Participate in Today's Poll

Poll:
Have you registered with My Turn?

A. Yes!
B. No
C. Not yet
D. I tried, but was unsuccessful

Eric Norton

Project Manager, My Turn

&

Ron Thompson

Vice President of IT Shared Services,
Blue Shield of California

My Turn

myCAvax

My Turn Volunteer

Vaccine Management

Provider Office Hours 3/5/2021

CDPH | accenture

My Turn

myCAvax

My Turn Volunteer

MY TURN

CDPH | accenture

Vaccinate ALL 58
Together we can end the pandemic.

My Turn is Now the *Main Way* for Californians to Schedule an Appointment for COVID-19 Vaccination

1

Go to Myturn.ca.gov to register to be notified when it's your turn to get vaccinated.
If you do not have a smart phone or internet access, you may call 1-833-422-4255 for assistance in determining your eligibility for a vaccine. Multilingual support is available.

2

Once it is your turn to be vaccinated, make an appointment using the MyTurn scheduling tool.

Online
Go to Myturn.ca.gov, enter required information to reconfirm your eligibility, see a list of all vaccination clinics, and directly book your appointment online.

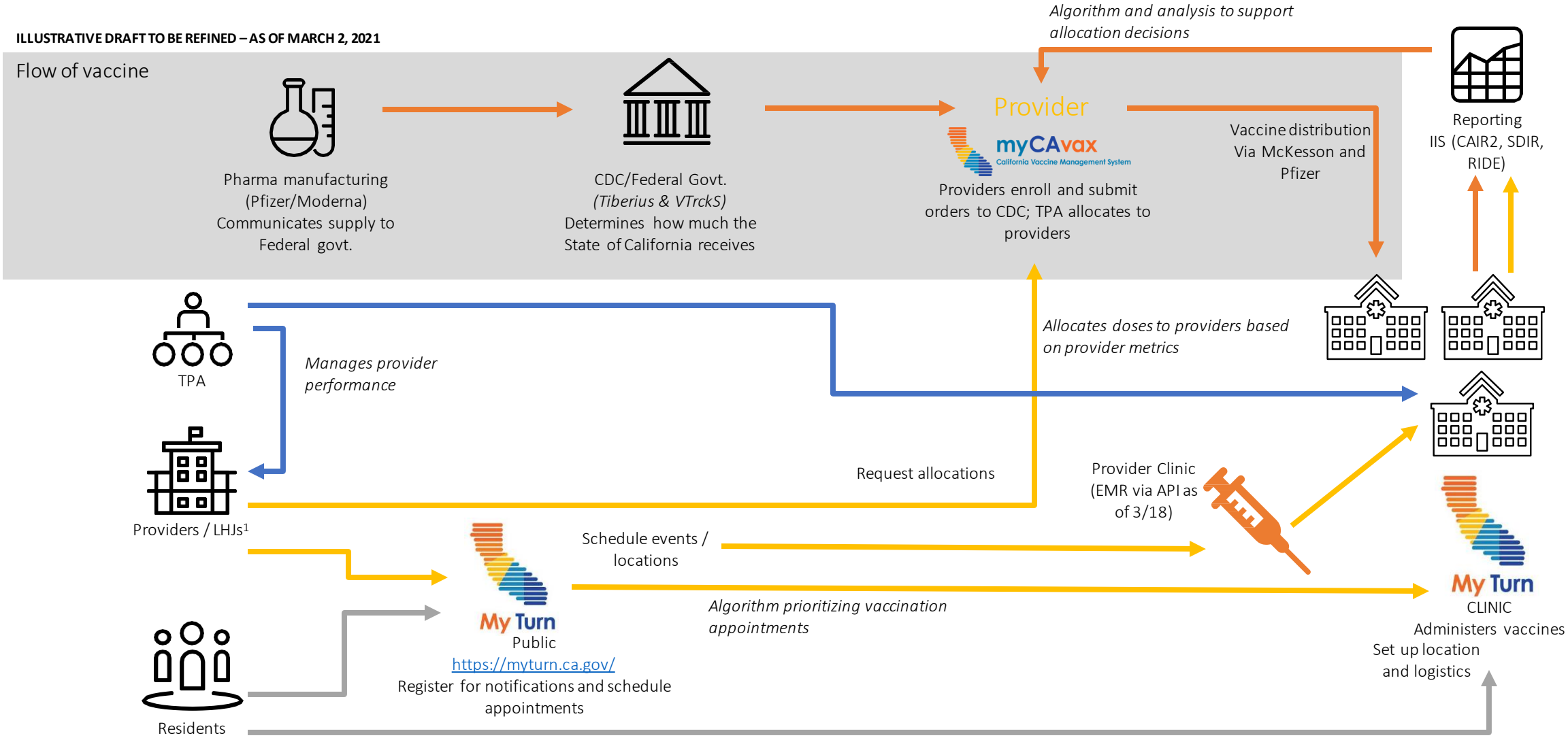
or

By Phone
If you do not have a smartphone or internet access, call 1-833-422-4255 for help to confirm your eligibility and make an appointment. Multilingual speakers are available.

To learn more contact the COVID-19 Hotline at **(833) 422-4255** or visit **VaccinateALL58.com.**

Tech platforms powering vaccine delivery

ILLUSTRATIVE DRAFT TO BE REFINED – AS OF MARCH 2, 2021



1. Pharmacies will have a different relationship with the TPA and state due to direct CDC allocations. The next phase of the federal retail program will be announced next week. Details on this program still pending.

Source: Accenture MyTurn Overview, BSC vaccination work and data flow, and CDPH / CIO input

Vaccine management systems core functionality

myCAvax as of 03/4/21

- Registration (Invitation & Open Enrollment)
- Section A & B Application (Provider Organization & Location)
- DocuSign integration to capture e-signature
- License Verification
- Enrollment Review & Approval Allocations & Ordering
- Migration of Interim calvax data to myCAvax and decommission interim system
- TPA Account Setup (Flag)
- TPA Bulk Allocation Capabilities
- In Network Provider Conversion Process
- In Network Ordering Restrictions
- In Network Provider Capacity Management
- Transfers/Redistribution
- Waste
- Temperature Excursion
- Shipment Incident

myCAvax

My Turn – Public as 03/1/21

- Landing page with introductory content to outline the vaccination process to residents
- Questions to capture and determine a resident's eligibility to get vaccinated
- Questions to capture an eligible resident's personal information in order to get vaccinated
- 11 CDC questions a resident is required to answer in order to get vaccinated
- Optional questions regarding a resident's health insurance coverage
- Questions that capture an ineligible resident's information in order to determine future eligibility
- Functionality to let a resident select a vaccination location and available time slot for first and second dose
- Functionality to let a resident cancel their first and second dose vaccination appointments
- SMS and email notifications regarding a resident's appointments
- SMS & email confirmation upon residents successfully registering to receive vaccine updates
- **.X as of 3/8** - Ability to use a single use code to access targeted clinics and clinics of choice

My Turn – Clinic as of 03/1/21

- Functionality to allow clinic managers to input location, name, and other clinic details
- Availability, hours, and capacity information that clinic managers can input for each clinic
- Clinic Managers can enter the current supply of Moderna or Pfizer vaccine that the clinic has in stock
- Functionality to add vaccine administrators and clinic managers for each location
- Capability for clinic managers to add additional vaccine administrators

My Turn

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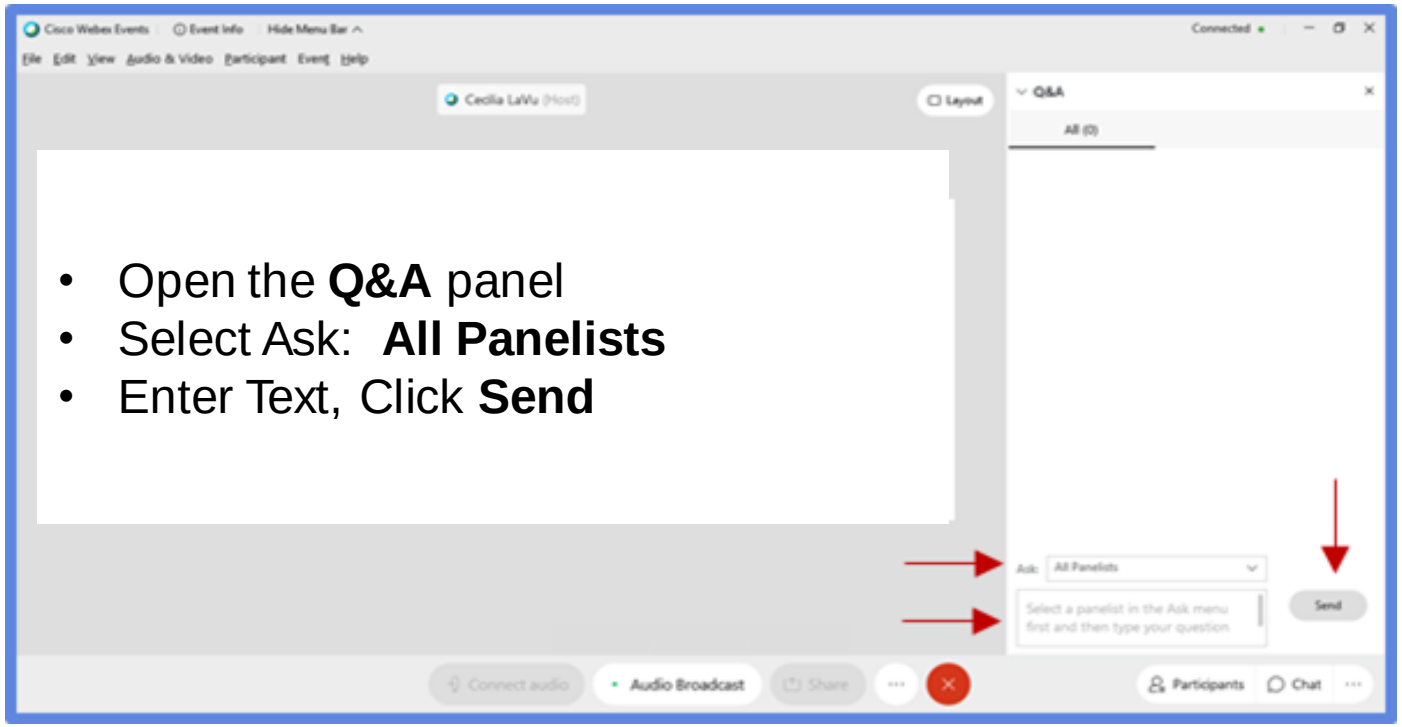
Provider Q&A

How to Ask a Question

During the webinar, please use the Q&A panel to ask a question or make a comment.



- Open the **Q&A** panel
- Select Ask: **All Panelists**
- Enter Text, Click **Send**

TPA Allocations

Seth Glickman, MD
Senior Vice President and Chief Health Officer
Blue Shield of California

Ensuring equitable vaccine allocation for Californians

March 4, 2021

Context

California will build a **statewide vaccine network** to ensure the **equitable delivery of current and anticipated supply** to Californians. The state will allocate vaccines directly to providers to **maximize distribution efficiency, have real-time transparency** into where the vaccines are and to whom they've been administered, and ensure they are **distributed to communities disproportionately impacted** by COVID-19.

The state has entered into a **cost-basis contract with Blue Shield of California to serve as the third party administrator (TPA)** for the statewide vaccine network. This network will include providers who meet program requirements, such as data integration, equity, and volume capacity. The provider types will include health systems, hospitals, clinics, pharmacies, mass vaccination sites and mobile clinics.

This document describes how the TPA will evolve the allocation process to ensure an equitable approach for Californians

Source: TPA

What we are trying to deliver as we build and expand the network

California's Statewide Vaccine Network is designed to save more lives.

Delivering an improved and connected experience

MyTurn.ca.gov

More options to vaccinate Californians faster	• Statewide network of providers • Geographically diverse mega sites • Home visits • Mobile providers • Pharmacies
More resources to reach diverse communities	• Network designed to reach the most vulnerable and those disproportionately affected by COVID-19 infection and death • Support to providers and local health jurisdictions for FEMA-eligible costs associated with supporting the transition to a new system and workflow • Patient navigators • Support services, including extended hours, language capacity, accommodations for physical accessibility and mobile clinics
More user data and reporting for transparency	• A more consistent and reliable user experience for all Californians • Timely data sharing • Daily allocation reports to ensure equity, efficiency, and speed of network • Ongoing community and stakeholder engagement

Source: CA COVID-19 Vaccine Task Force

Information contained in this file is confidential, preliminary, and pre-decisional

Disparities exist in California's COVID-19 burden and vaccine administration

Disparities in COVID's impact on California's diverse communities are severe…

Death rate for Latino people is **21% higher** than statewide
Deaths per 100K people:
151 Latino
125 all ethnicities

Case rate for Pacific Islanders is 31% higher than statewide
Cases per 100K people:
11,206 NHPI
8,533 all ethnicities

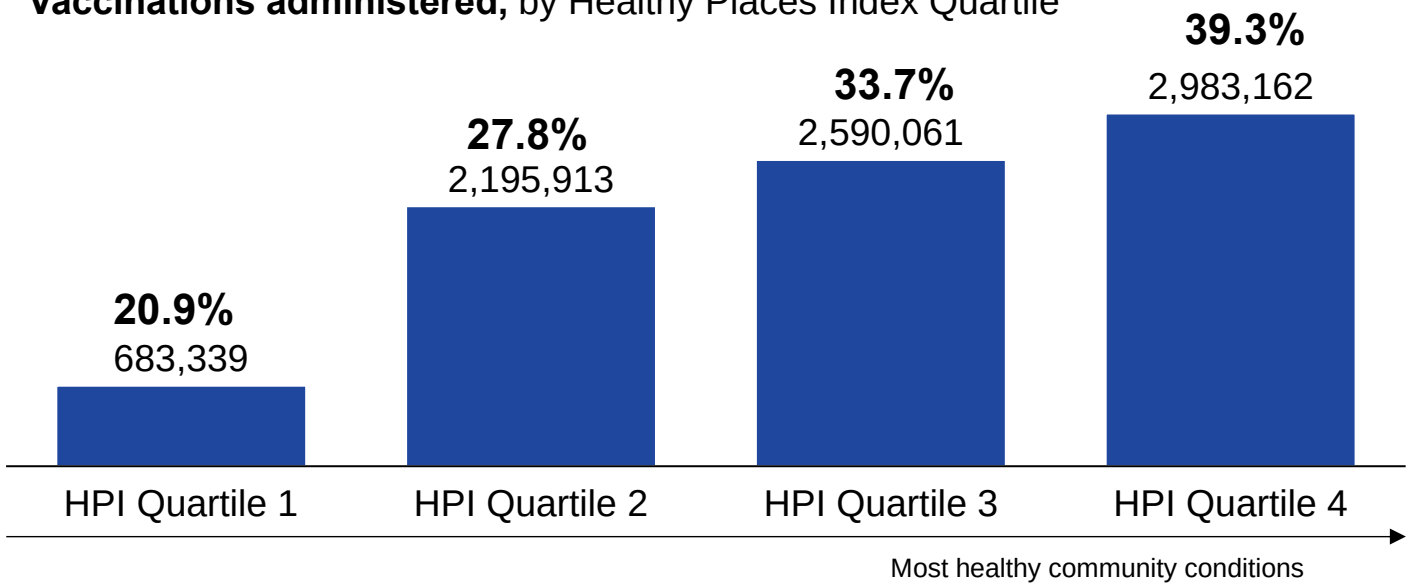
Death rate for Black people is 7% higher than statewide
Deaths per 100K people:
133 NHPI
125 all ethnicities

Case rate for communities with median income <$40K is 38% higher than statewide
Deaths per 100K people:
11,717 income <$40K
8,533 all income brackets

Source: covid19.ca.gov/equity

…and these disparities also exist in COVID vaccine administration

Vaccinations administered, by Healthy Places Index Quartile



The Healthy Places Index (HPI) measures overall well-being in a zip code by evaluating 25 different factors that can impact health, including income, education, and access to health care

Areas are given a score, ranging from least healthy community conditions (Quartile 1) to most healthy community conditions (Quartile 4), with disproportionately higher rates of people of color in lower quartile HPIs

Role and goals of the allocation process

Role of the allocation process

- California is building an enhanced Statewide Vaccine Network to ensure equitable delivery to all Californians

- The TPA will make recommendations to the State to allocate vaccines directly to providers in order to:
  - Ensure vaccines are equitably distributed to communities disproportionately impacted by COVID-19
  - Optimize distribution efficiency
  - Give real-time transparency into where the vaccines are and to whom they have been administered

- Final allocation decision rights remain with the State

Goals for the allocation process

- ✓ Transparent, consistent and predictable for providers
- ✓ Provides flexibility to address urgent public health needs
- ✓ Incorporates input from LHJs and MCEs
- ✓ Supports equitable and timely vaccination for all Californians
- ✓ Allows for an appropriate pace of transition to the new allocation model

Information contained in this file is confidential, preliminary, and pre-decisional

Planned approach for first dose allocation recommendations

1 **Assess the total doses available for allocation**	• Begin with the total first doses allocated by the Federal government to CA • Adjust for allocations reserved to State bodies (e.g., DSH, CDCR) and other urgent issues (e.g., unmet second dose needs)
2 **Apply a geographical weighting**	• For 80% of the remaining vaccine, calculate the share of vaccine each zip code should receive based on eligible population in the zip code – Currently, eligible population is weighted 70/30 by age (65+) and sector (first responders, food/agriculture sector, education & childcare) respectively
3 **Perform an equity weighting to reflect the State's equity priorities**	• To double weight to those areas of highest need, allocation remaining 20% of vaccine to lowest quartile HPI zips only, based on share of eligible population
4 **Allocate vaccine to network sites based on their geographical service and their performance**	• TPA considers input from LHJs and MCEs plus other factors such as zip codes served, performance including success in vaccinating target populations, inventory-on hand, compliance to network requirements to determine final allocation by provider

Allocation formula will be in effect for week of March 1 and March 8 allocations. Formula will be adjusted after 2 weeks to account for Janssen (J&J) vaccine, new eligibility policy on March 15, and TPA onboarding implementation waves

How the allocation process will support California's 5-point plan for equity

As of MAR 1, 2021

	State's five-point plan on equity	How the allocation process will support
Allocation	Provide ultimate determination and approval of all vaccine allocation with a **focus on equity**	**Allocation approach** which will additionally weight areas with the lowest quartile of HPI scores, to reflect the disproportionate burden of COVID-19 in these areas
Network	Promote **equity in vaccine delivery** by supporting vulnerable communities with accessible vaccination sites, patient navigators, extended hours, language capacity, accommodations for physical accessibility	**Adapt to the developing network** to reflect increased capacity and the ability to reach all Californians, especially in communities disproportionately impacted by COVID-19 Provide allocation recommendations **at site level** to reflect both performance and proximity to communities requiring vaccine
Community Partners	Invest in special programs to **support community-based organizations** that are critical to reaching target communities	Support effective allocation recommendations across the statewide provider network including through pop-up **clinics** and **mobile sites**
Data analytics	Use **real-time data analytics** to adjust and intensify targeted efforts and resource allocation to meet equity goals	Based on **timely data analytics** to adjust allocation recommendations as needed to reflect recent performance and the State's emerging vaccine priorities
Public Education	Provide **consistent messaging** and meet Californians where they are in order to reach California's diverse populations	Improve **predictability and clarity** for providers to make it easier for them to support communications in line with the State's messaging to all populations

Source: CA COVID-19 Vaccine Task Force

Information contained in this file is confidential, preliminary, and pre-decisional

You should expect high standards from us – and we appreciate your understanding

We will be:

- Good (not perfect)
- Fast
- Transparent
- Collaborative (as much as possible given the urgency of our collective situation)

We ask for your understanding that:

- Vaccine supply remains limited, and we need to manage for the needs of the whole system
- Federal allocations are subject to change at short notice, either up or down
- We will be doing our best to support the State's goals to support vaccinating all Californians in an equitable way and ensuring transparency and consistency for providers

We deeply value the efforts of local providers to vaccinate Californians.
The changes outlined here are meant to provide planning predictability in support of these efforts.

Any questions?

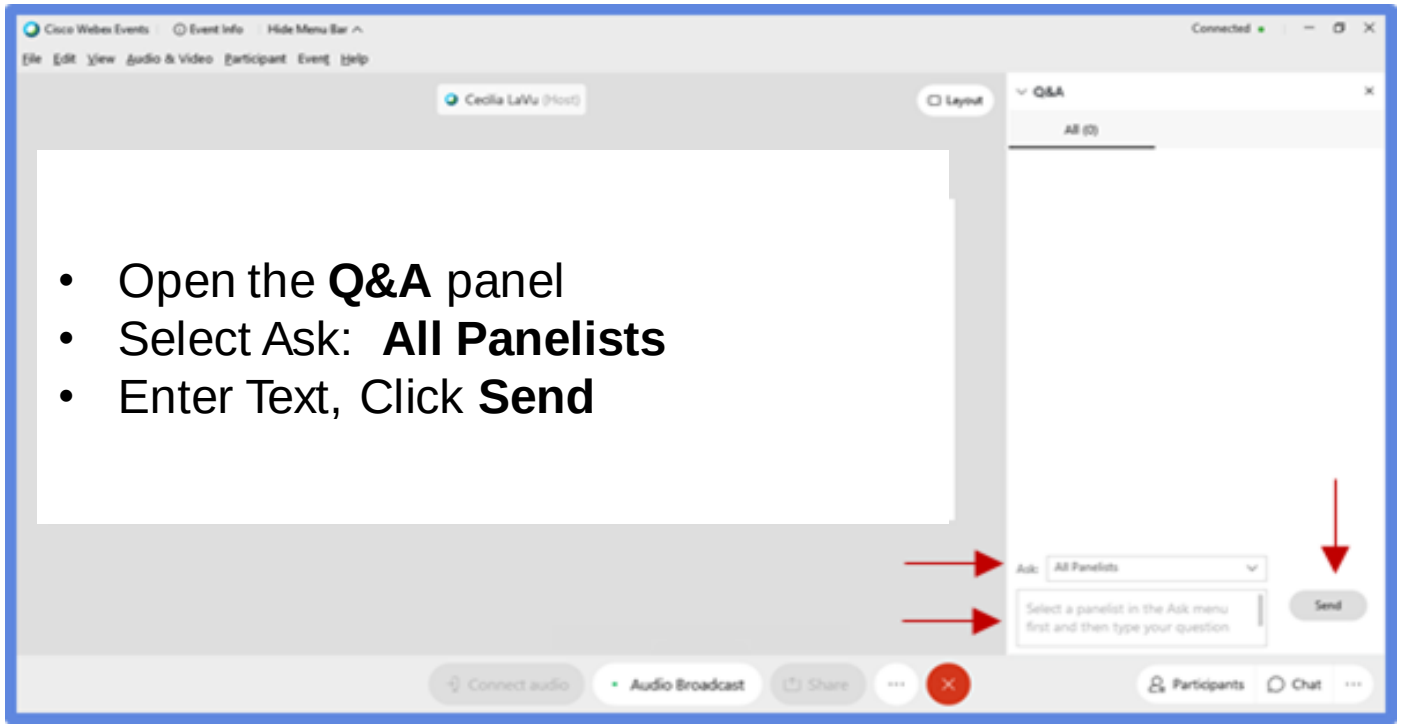
LHJs: please contact your Blue Shield of California account manager

Providers: please contact CovidVaccineNetwork@blueshieldca.com

Provider Q&A

How to Ask a Question

During the webinar, please use the Q&A panel to ask a question or make a comment.



- Open the **Q&A** panel
- Select Ask: **All Panelists**
- Enter Text, Click **Send**

Announcements & Updates

Janssen COVID-19 Vaccine from Johnson & Johnson

Louise McNitt, MD

Janssen COVID-19 Vaccine

- Single dose adenovirus vector vaccine that can be shipped and stored at refrigerator temperatures
  - Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC
- FDA Emergency Use Authorization on 2/27/21 for persons ≥ 18y/o
  - https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine
- ACIP voted to recommend 2/28/21
  - https://www.cdc.gov/vaccines/acip/meetings/slides-2021-02-28-03-01.html
- Western States Scientific Review workgroup unanimously recommends use of Janssen COVID-19 vaccine
- COCA call archived here: https://emergency.cdc.gov/coca/calls/2021/callinfo_030221.asp

Evidence from Clinical Trial – Efficacy

- Demonstrated efficacy against symptomatic, laboratory-confirmed COVID-19
  - Overall efficacy was **66.3%**
  - **83.5%** for severe disease
- COVID-associated hospitalizations:
  - 29 in the placebo group, 2 in the vaccine group
  - VE against hospitalization was **93%** (95% CI: 71%, 98%) at 14 days post vaccination and **100%** at 28 days post vaccination
- **100%** effective against COVID-related death at 28 days post vaccination
- Efficacy against severe disease remained high across world regions (**73-82%**) suggesting protection against severe illness with variant strains

Evidence from Clinical Trial – Safety

- Local reactions within 7 days occurred in ~50% vaccine recipients
  - Pain at the injection site most common
- Systemic reactions within 7 days occurred in ~55% vaccine recipients
  - Headache, fatigue, and myalgia most common
- Most symptoms resolved after 1-2 days

https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-02/28-03-01/04-COVID-Oliver.pdf

Interchangeability of COVID-19 Vaccine Products

- Any COVID-19 vaccine can be used when indicated; no product preference
- COVID-19 vaccines are **not** interchangeable
  - Safety and efficacy of a mixed series has not been evaluated
- If first doses of mRNA COVID-19 vaccine was received but patient unable to compete series with same or different mRNA vaccine (e.g, contraindication)
  - Single dose of Janssen COVID-19 vaccine may be administered at minimum interval of 28 days from mRNA dose*
  - Considered to have received valid, single-dose Janssen vaccination, not mixed vaccination series (mRNA/viral vector)

*Persons with a contraindication to mRNA COVID-19 vaccines have a precaution to Janssen COVID-19 vaccine. In these patients, vaccination should be undertaken in an appropriate setting under the supervision of a health care provider experienced in the management of severe allergic reactions. Consider referral to allergist-immunologist.

Contraindications & Precautions

CONTRAINDICATION TO VACCINATION	PRECAUTION TO VACCINATION	MAY PROCEED WITH VACCINATION
History of the following: • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to component of the vaccine† • Immediate allergic reaction* of any severity after a previous dose or known (diagnosed) allergy to a component of the vaccine†	**Among people without a contraindication, a history of:** • Any immediate allergic reaction* to other vaccines or injectable therapies‡ Note: people with a contraindication to mRNA COVID-19 vaccines have a precaution to Janssen COVID-19 vaccine, and vice versa. See footnote for additional information on additional measures to take in these people.#	**Among people without a contraindication or precaution, a history of:** • Allergy to oral medications (including the oral equivalent of an injectable medication) • History of food, pet, insect, venom, environmental, latex, etc., allergies • Family history of allergies
Actions: • Do not vaccinate. • Consider referral to allergist-immunologist. • Consider other vaccine alternative.†	**Actions:** • Risk assessment • Consider referral to allergist-immunologist • 30-minute observation period if vaccinated	**Actions:** • 30-minute observation period: people with history of anaphylaxis (due to any cause) • 15-minute observation period: all other people

Janssen COVID-19 Vaccine Summary

- ACIP states no preference for any of the 3 authorized COVID-19 vaccines
- Results of Janssen Phase III trials not comparable with mRNA vaccines
  - Different calendar time
  - Different geography

Different circulating variants
Higher background incidence

- Strong protection against severe COVID-19
  - 93% VE against hospitalizations (2 cases in vaccinated vs. 29 in placebo) at 14 days; 100% 28 days post vaccination
  - No COVID-associated deaths in vaccinated group vs. 7 in placebo group

https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-02/28-03-01/02-COVID-Dooling.pdf

CDC Safety Summary

- 75 million COVID-19 vaccine doses have been administered in US through February 28
- Reactogenicity profiles of mRNA vaccines in **v-safe** monitoring are consistent with what was observed in clinical trials
- Anaphylaxis following both vaccines has been reported to VAERS (4.5 cases per million)
- No other safety signals for serious adverse events have been detected in VAERS
- No safety concerns have been identified among VSD Rapid Cycle Analysis prespecified outcomes as of February 13
- No unexpected pregnancy or infant outcomes have been observed related to COVID-19 vaccination during pregnancy
- Safety monitoring in pregnant women is ongoing and planned in **v-safe**, VAERS, VSD and CISA

Take a look at the excellent pregnancy safety monitoring slides in this ACIP presentation (slides 26-38) https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-02/28-03-01/05-covid-Shimabukuro.pdf

Janssen COVID-19 Vaccine Storage & Handling – Al Hendrickson

- 100 dose minimum orders
  - 5 doses per vial
  - 10 vials (50 doses) per carton
  - 2 cartons per order
- 0.5mL dosage
- No diluent/reconstitution required
- Ancillary kits will be provided by the federal government
  - Same kits as Moderna
- Shipped by McKesson

Janssen COVID-19 Vaccine Storage & Handling – Al Hendrickson

- Store between 2°C and 8°C. Protect from light.
- Vaccine is shipped at refrigerated temperatures, but is packed while frozen
  - If still frozen when it arrives, thaw at 2°C to 8°C. If needed immediately, thaw at room temperature (will take approximately two hours to thaw a carton, one to thaw an individual vial).
- Do not store the vaccine at frozen temperatures.
- Can be stored between 9°C and 25°C (48ºF to 77ºF) for up to 12 hours
- After first puncture, the vial can be stored for up to six hours between 2°C to 8°C and at room temperature (maximum of 25°C/77°F) for 2 hours

Janssen Vaccine Temperature Excursion &Expiry Resources – Al Hendrickson

- J&J has released guidance on temperature excursions:
  - Janssen COVID-19 Vaccine Product Quality Checker (vaxcheck.jnj)
  - Temperature Excursion Sheet: https://imedicalknowledge.veevavault.com/ui/approved_viewer?token=7994-e1cad332-7f1d-42d7-9297-e17291c17b11
  - Temperature Excursion Tool: Stability Information (janssenmd.com)
- Expiry dates can also be found on Janssen COVID-19 Vaccine Product Quality Checker (vaxcheck.jnj)
  - You can also scan the QR code or call 1-800-565-4008
  - Keep checking as expiration nears to see if expiry date has been extended

Allocations – Amy Pine

This week's Allocations (3/3/21)

	Doses	Boxes
Pfizer	479,700	410
Moderna	380,300	3,803
J&J*	320,100	3,201
Totals	1,180,100	7,414

*CA will not receive another Janssen allocation until March 23

9,673,787 administered doses!!

Rebranding Update – Claudia Aguiluz

myCAvax

California Vaccine Management System

MyCAvax – Claudia Aguiluz

Allocation Functionality is Still in Progress

- For LHDs:
  - Allocation functionality in myCAvax was ON HOLD while Accenture resolved virtual inventory issues
  - **First and second dose allocations were done in interim CalVax this week**
  - **System will be ready for allocations this weekend**
- For providers:
  - MyCAvax provider portal is active

MyCAvax – Claudia Aguiluz

You replied to this message on 2/27/2021 2:46 PM.

Sent: Saturday, February 27, 2021 6:59:06 AM
To: Maria Davila <mdavila@ph.lacounty.gov>
Subject: COVID-19 Vaccine Order Processed

CAUTION: External Email. Proceed Responsibly.

myCAvax
California Vaccine Management System

IMPORTANT NOTICE: Your COVID-19 Vaccine and Corresponding Ancillary Kits are shipping soon!

Your COVID-19 Vaccine Order Confirmation

Practice	Los Angeles County Vaccine Preventable Disease Control Program
COVID ID	CA138B1005
VFC PIN	070345
Date Order Processed	02/27/2021

Your COVID-19 vaccine order has been processed and submitted to CDC for fulfillment. Ancillary supply kits and diluent (if required) will ship separately from the vaccine due to different cold chain requirements, and timed to arrive before your vaccine shipment. Be aware that the Pfizer vaccine will be shipped by Pfizer and the Moderna vaccine will be shipped by McKesson.

Please share anticipated delivery information listed below with key staff in at your site.

Ancillary Kits
Please expect delivery of the ancillary kits within a 24 hour window of vaccine receipt.

Vaccines
Pfizer: Expect to receive your vaccine request within 3 business days. Sites with ULT units were opted out of dry-ice shipments automatically, unless specifically requested. If your site requested dry-ice, this shipment is timed to arrive the same day as vaccines. Please expect a number of communications from Pfizer alerting you to the delivery of this product.
Moderna: Expect to receive your vaccine request within 2 business days. NOTE: Most orders will be delivered within the next business days. However some may take up to 2 business days.

The following vaccine(s) will be shipped to your practice within 48 hours of order approval.

Vaccine/NDC Code	Doses Requested	Doses Approved
59267-1000-02	104325	104325

- Shipments with Dry-Ice: Place shipment in a well-ventilated area to safely handle the thermal shipping container and dry ice
- Follow instructions provided in each shipment for checking the shipper's temperature monitor.

Did you receive an order confirmation e-mail FROM myCAvax over the weekend?

Please disregard. Some test emails were generated as part of the import of historic orders from Interim CalVax to myCAvax

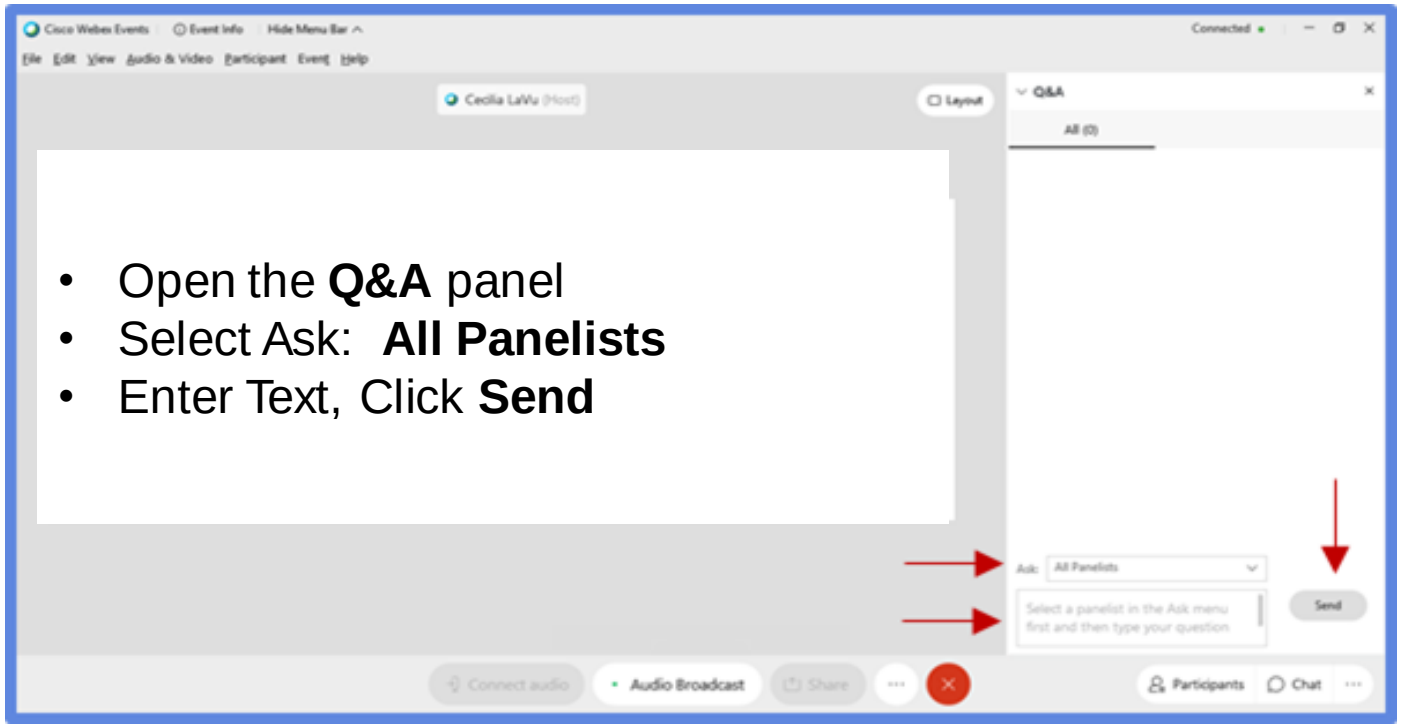
Additional changes

- J & J Janssen's vaccine was added for ordering
- Product added to the vaccine management reports
- Working on the system for readiness to transition ordering through the TPA

Provider Q&A

How to Ask a Question

During the webinar, please use the Q&A panel to ask a question or make a comment.



- Open the **Q&A** panel
- Select Ask: **All Panelists**
- Enter Text, Click **Send**

My Turn Program Enrollment on EZIZ!

Select "My Turn Onboarding" tab

Education & Support

Thank You

for our next weekly

Provider Office Hours

Friday, March 12th

9:00 – 10:00 AM

Provider Resources

COVID-19 Provider Call Center – for questions related to the COVID-19 Vaccine Program

- Email: covidcallcenter@cdph.ca.gov
- Phone: (833) 502-1245
  Monday through Friday from 8 AM – 8 PM

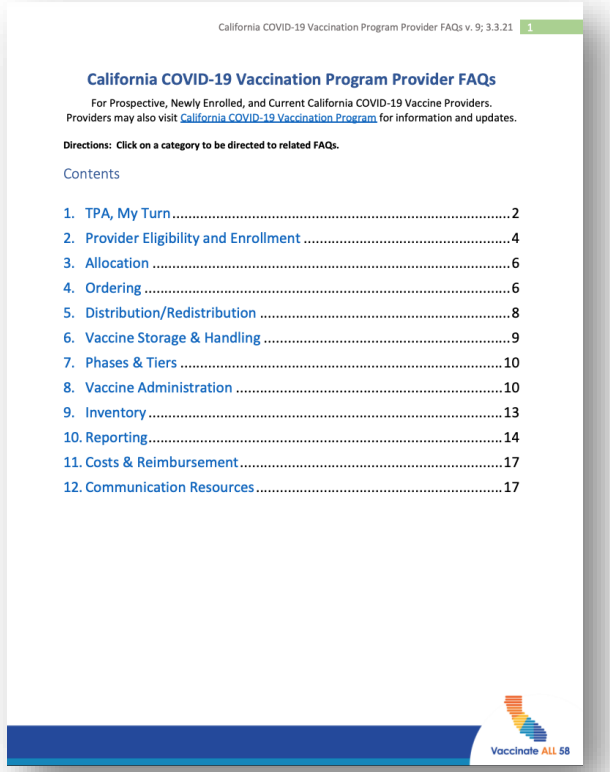
myCAvax Technical Help – for technical questions relating to CalVax

- Email: myCAvax.HD@accenture.com

My Turn – for questions regarding My Turn application

- Email about onboarding: myturnonboarding@cdph.ca.gov
- Email about general questions: myturninfo@cdph.ca.gov

Provider FAQs



https://eziz.org/assets/docs/COVID19/Vax58ProviderFAQs.pdf

What to Expect after Getting a COVID-19 Vaccine

Accessible version: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/expect/after.html

COVID-19 vaccination will help protect you from getting COVID-19. You may have some side effects, which are normal signs that your body is building protection. These side effects **may feel like flu** and **may even affect your ability** to do daily activities, but they should go away in a few days.

Common side effects

On the arm where you got the shot:

- Pain
- Swelling

Throughout the rest of your body:

- Fever
- Chills
- Tiredness
- Headache

Helpful tips

If you have pain or discomfort, talk to your doctor about taking an over-the-counter medicine, such as ibuprofen or acetaminophen.

To reduce pain and discomfort where you got the shot:

- Apply a clean, cool, wet washcloth over the area.
- Use or exercise your arm.

To reduce discomfort from fever:

- Drink plenty of fluids.
- Dress lightly.

When to call the doctor

In most cases, discomfort from fever or pain is normal. Contact your doctor or healthcare provider:

- If the redness or tenderness where you got the shot increases after 24 hours
- If your side effects are worrying you or do not seem to be going away after a few days

Ask your healthcare provider about getting started with v-safe

Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second dose

Learn more about **v-safe**.
www.cdc.gov/vsafe

Remember

- Side effects may feel like flu and even affect your ability to do daily activities, but they should go away in a few days.
- With most COVID-19 vaccines, you will need 2 shots in order for them to work. Get the second shot even if you have side effects after the first one, unless a vaccination provider or your doctor tells you not to get a second shot.
- It takes time for your body to build protection after any vaccination. COVID-19 vaccines that require 2 shots may not protect you until a week or two after your second shot.
- It's important for everyone to continue using all the tools available to help stop this pandemic as we learn more about how COVID-19 vaccines work in real-world conditions. Cover your mouth and nose with a mask when around others, stay at least 6 feet away from others, avoid crowds, and wash your hands often.

HEALTHCARE PROVIDER, PLEASE FILL IN THE INFORMATION BELOW:

If your temperature is ____°F or ____°C or higher or if you have questions, call your healthcare provider.

Tell your healthcare provider about: _____

Healthcare provider phone number: _____

Medication (if needed):

Take _____ every ____ hours as needed.
(type and dose or amount)

cdc.gov/coronavirus

CS 321466-A 12/13/2020

Vaccine Product Comparison Guide

California COVID-19 Vaccination Program

Product Information	Pfizer	Moderna	Janssen
Vaccine Type	mRNA	mRNA	viral vector
NDC	59267-1000-02	80777-0273-99	59676-0580-15
Storage	**ULT Freezer** (-80 to -60°C) till expiration **ULT thermal shipper** (-80 to -60°C) up to 30 days if recharge dry ice upon receipt & every 5 days and limit openings (2/day for 3 mins/opening) **Freezer** (-25 to -15°C) for up to two weeks (may need to adjust thermostat for narrow range) **Refrigerator** (2-8°C) up to 120 hrs./5 days (must carefully track)	**Freezer** –20°C (-25 to -15°C) up to 6 mos. (may need to adjust thermostat for narrow range) **Refrigerator** (2-8°C) up to 30 days if vial is not punctured	**Refrigerator** (2-8°C) up to 3 months if vial is not punctured
Shipper	Pfizer	McKesson	McKesson
Min Order Quantities	1,170 (starting 2/16/21)	100 doses	100 doses
Outer Packaging	ULT thermal shipper	Frozen shipment	Refrigerated shipment
Dimensions	Outer dimensions approx. 16 x 16 x 22” (L x W x H) Vial trays are approx. 9 x 9 x 1.5”	Approx. 2in x 2in x 5 3/8in	Approx. 3.66”x3.66”x2.13”
Package Weight	About 80 lbs. with dry ice	Standard ancillary adult kit	Standard ancillary adult kit
Presentation	6-dose multidose vial, preservative free	10-dose multidose vial, preservative free	5-dose multidose vial, preservative free
Vials/Box	195 MDV per vial tray	10 per carton	10 MDVs per carton
Boxes/Case	Up to 5 trays per thermal shipper	120 boxes per case	2 cartons (50 doses per carton)

Product Information	Pfizer	Moderna	Janssen
Doses/Pallet	N/A	Up to 230,400 doses	TBD
Admin. Route	IM	IM	IM
Vol. per Dose	(2) doses in 0.3 mL -dose injections	(2) doses in 0.5 mL-dose injections	(1) dose 0.5 mL-dose injection
Intervals	At least 21 days apart	At least 28 days apart	N/A
Age Groups	ages ≥16 years	ages ≥18 years	ages ≥18 years
ACIP Recommendations	ACIP Interim Recommendations	ACIP Interim Recommendations	ACIP Interim Recommendations
Thaw Times	Entire tray takes 3 hrs. in refrigerator Vials take 30 mins. at room temp Up to 2 hrs. at room temp prior to dilution	2 hrs. in fridge then 15 mins. at room temp 1 hr. at room temp	Vaccine is initially stored frozen by the manufacturer, then shipped at 2°C to 8°C (36°F to 46°F). If vaccine is still frozen upon receipt, thaw at 2°C to 8°C (36°F to 46°F); if needed immediately, thaw at room temperature (maximally 25°C/77°F).
Reconstitution	Normal saline	No dilution	No dilution
Expiration Dates	This vaccine product has an expiration date located on the vaccine vial. (3/3/21)	Scan the QR code located on the outer carton, or go to www.modernatx.com/covid19vaccine-eua/. As the expiration approaches, check again to determine if the expiry date has been extended. (3/3/21)	Scan the QR code, visit www.vaxcheck.jnj and enter lot #, or call US Toll Free: 1-800-565-4008. As the expiration approaches, check again to determine if the expiry date has been extended. (3/3/21)
Use	Room temp hold time up to 2 hrs. Use or discard after 6 hrs. post-dilution	Room temperature up to 12 hrs. (non-punctured); use or discard within 6 hrs. after first puncture	After first puncture, store vaccine in the refrigerator (between 2°C and 8°C; 36°F and 46°F) for up to 6 hours or at room temperature (up to 25°C/77°F) for 2 hrs.
Ancillary Kits	Kitted for 1,170 adult vaccines (auto-ordered) ships separately from vaccines; diluent/mixing kit included for reconstituted vaccines (see Guide to Ancillary Supplies & Kits)	Kitted for 100 adult vaccines plus overage (auto-ordered); standard syringe; ships separately from vaccines (see Guide to Ancillary Supplies & Kits)	Kitted for 100 adult vaccines plus overage (auto-ordered); standard syringe; ships separately from vaccines (see Guide to Ancillary Supplies & Kits)

Product Information	Pfizer	Moderna	Janssen
Kit Description	Kit box may be one of the following sizes: • 24 in x 18 in x 20 in/45 – 46 lbs. • 24 in x 20 in x 18 in / 45 – 46 lbs. • 24 in x 20 in x 20 in / 45 – 46 lbs. • 24 in x 20 in x 22 in / 45 – 46 lbs.	14 in x 13 in x 9 in 3.5lbs.	14 in x 13 in x 9 in 3.5lbs.
Kit PPE	25 face shields, 50 surgical masks	2 face shields, 4 surgical masks	2 face shields, 4 surgical masks
Other Kits	Dry Ice Kit for initial recharge (can opt out) ships within 24 hours of vaccine delivery; includes PPE (gloves, face shield, ice scoop) & safety instructions	N/A	N/A
Provider Out of Pocket	Pelleted dry ice for up to (2) subsequent recharges if storing vaccines in thermal shippers. ½" to ¾" pellets, about 22 lbs. per recharge	N/A	N/A
Transport Guidance	Move thermal shipper; vials may be stored or transported at ultra-low, frozen, or refrigerated temperatures; Beyond Use Dates vary (see Vaccine Storage & Handling Toolkit COVID-19 Addendum)	Vials may be stored or transported at frozen or refrigerated temperatures; Beyond Use Dates vary; refrigerated transport/delivery limited to 12 hours (see Vaccine Storage & Handling Toolkit COVID-19 Addendum)	Vials may be stored or transported at refrigerated temperatures (see Vaccine Storage & Handling Toolkit COVID-19 Addendum or Transporting Janssen Vaccine)
Fact Sheets	FDA Website	FDA Website	FDA Website

EZIZ

A one-stop shop for immunization training and resources.

- COVID-19 Vaccination
- Program Enrollment
- My Turn Onboarding
- Vaccine Management
- Vaccine Administration
- Reporting Requirements
- Archived Communications
- Patient Resources

Provider Support

COVID Call Center
Email:
covidcallcenter@cdph.ca.gov
Phone: (833) 502-1245
Hours: Mon–Fri, 8AM–8PM

Technical Support for myCAvax
Email:
myCAvax.HD@accenture.com
Phone: (833) 502-1245, option 2

Vaccines
Manufacturer Contacts

Vaccine Management

Vaccinate ALL 58

Resources listed on this page are for providers enrolled in the California COVID-19 Vaccination Program. If you need assistance with viewing documents on this page, either email covidcallcenter@cdph.ca.gov or call (833) 502-1245. Call center hours are 8 am–8 pm.

Vaccines

- Product Information: Pfizer | Moderna | Janssen
- Vaccine Product Comparison Guide
- Guide to Ancillary Supplies & Kits
- Pfizer Vaccine Contents and Quantities for Mega Kits (McKesson–12/11/20)

Storage and Handling

- CDC's Vaccine Storage & Handling Toolkit (COVID-19 Addendum)
- CDC Resource Library
- CDC's COVID-19 Vaccine Expiration Date Tracking Tool

Pfizer-BioNTech COVID-19 Vaccine

- CDC Resources
- Vaccine Delivery Checklist
- Vaccine Storage and Handling Summary
- Beyond Use Date (BUD) Tracking Label (Refrigerator)
- Vaccine Storage and Handling Label
- Dry Ice Handling Instructions
- Shipping, Handling, & Shipper Return Guidelines

Moderna

- CDC Resources
- Storage and Handling Summary
- Beyond Use Date (BUD) Tracking Label (Refrigerator)
- Vaccine Storage and Handling Labels
- McKesson Vaccine Shipper Return Instructions

Janssen (Johnson & Johnson)

- CDC Resources
- Storage, Dosing & Administration (Janssen)
- Storage and Handling Summary (CDC)
- Storage and Handling Labels
- Janssen COVID-19 Vaccine website (Janssen)

Temperature Monitoring

- How to Record Temperatures job aid
- COVID-19 Temperature Log
- Hourly Temperature Log
- Data Logger Setup & Use job aid
- Reporting Temperature Excursions: Job Aid | Worksheet

Vaccine Management

- Vaccine Management at a Glance
- Receiving & Storing Pfizer-BioNTech Vaccine job aid
- Receiving & Storing Moderna Vaccine job aid
- Receiving & Storing Janssen (J&J) Vaccine job aid
- Reporting Doses Spoiled, Expired, or Wasted job aid (includes returns)
- Transporting Vaccine: Janssen (Refer to CDC's Toolkit for Pfizer and Moderna)

- Vaccine Transport Log
- CDC's COVID-19 Vaccine Expiration Date Tracking Tool

Redistribution, Repositioning & Transfers

- Guide to Redistribution, Repositioning and Transfers
- Redistribution Agreement – Before You Apply
- CDC Vaccine Redistribution Agreement
- Redistribution Vaccine Management Plan
- Redistributing Vaccines job aid
- Transferring Vaccines job aid
- Repositioning Vaccines: Guidance for Satellite, Temporary, and Off-Site Clinics

Satellite, Temporary, and Off-Site Clinics

- CDC's Guidance for Planning Vaccination Clinics at Off-Site Locations
- Checklist of Best Practices for Satellite, Temporary, or Off-Site Locations
- COVID-19 Infection Control Guidance
- Interim Guidance for Immunization Services During the COVID-19 Pandemic

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Gmail Jerry P Abraham, MD MPH <abraham.jerry@gmail.com>

MyTurn Onboarding Process

1 message

Melanie Barr <mbarr@ph.lacounty.gov> Wed, Mar 3, 2021 at 5:40 PM
To: "Jerry P Abraham, MD MPH" <abraham.jerry@gmail.com>
Cc: Lucille Rayford <lrayford@ph.lacounty.gov>

Hi Jerry,

Thank you for speaking with me this afternoon to discuss transitioning from PrepMOD to MyTurn. As promised, I have included the latest communication from the State and the forms that must be completed to transition to MyTurn.

Typically, onboarding requires 7-10 days before the first planned clinic on MyTurn. If you have been using PrepMOD to administer vaccines, the State recommends that, if possible, providers make a clean break between systems:

- Finish the first dose and second dose for clients registered in PrepMod
- Set up first and second doses for ***new*** clients in MyTurn

To begin with, per the attached letter from Blue Shield, all providers must be registered with Blue Shield California. If you are not already registered with Blue Shield, email CovidVaccineNetwork@BlueShieldca.com to become a part of their network.

Then to register with the MyTurn system, you will need to send two emails: an Account Creation/New User List and a Clinic Scheduling form.

Account Creation/New User List Form

1. **Send to:** (1) MyTurnClinicLAC@ph.lacounty.gov, and (2 mbarr@ph.lacounty.gov, **and (3)** MyTurn.Clinic.HD@accenture.com

2. **Subject Line:** LA County - Kedren Community Health Center Primary Care Scheduling Form Onboarding: MyTurn Onboarding

3. **Body of email should include:** "The attached users are part of an organization in Los Angeles County. The provider location account is indicated in the spreadsheet. The users will need access to MyTurn-Clinic only under the provider account listed."

4. If you have multiple provider locations, please indicate in the Account column the same provider location and CAIR ID for each clinic's vaccine inventory

5. For the column 'Request Role/Profile', please indicate whether any system users should have clinic manager access to see dashboard reports. Please note these individuals have a high level of access in the system so you only want to give this role to users with approved authority. Clinic Manager access includes clinic creation/modification and vaccine inventory addition/modification.

Clinic Scheduling Form

1. **Send to:** (1) MyTurnClinicLAC@ph.lacounty.gov, and (2 mbarr@ph.lacounty.gov

2. **Subject Line:** LA County - Kedren Community Health Center Primary Care Scheduling Form Onboarding (attention: Melanie Barr)

3. **Body of email should include:** "Please review the scheduling form for *Name of your Organization"* and include any questions about scheduling your clinics that you have.

This document is designed to help you start planning your clinics (location, days and times you will be administering the vaccine). DPH will work closely with Accenture (developers of MyTurn) to ensure that provider appointments for public and targeted/private clinics are released carefully and monitored to ensure they are not overbooked. Complete all the fields including:

1. COVIDReadi/CalVax ID (Part A- COVIDreadi/CalVax)
    a. All Provider Locations
2. How is your provider name and provider locations listed in COVIDReadi/CalVax?
3. CAIR ID(s)
    a. If you have more than one CAIR ID based upon different provider locations, we will need to know under which CAIR ID and provider location you want each clinic to be under so data can be transmitted to CAIR cleanly
4. Clinic Schedule
    a. For your first few clinics, we will need to work closely with Accenture (developers of MyTurn) to ensure that your appointments are released carefully so please complete the attached spreadsheet with details about all public/private clinics you want to hold on MyTurn.
    b. When would you like your first clinic to be in MyTurn (must be at least 7 days in the future from the time of submission of this information)?
    c. Will they be targeted/private or public clinics?
    d. When do you want appointments released for each clinic?

As we discussed, we can have a follow up call next week when you're ready with all this information.

In the meantime, here are some demo videos about the system:

https://www.youtube.com/playlist?list=PLZqpl41f-8c9nIjyV-cElYT_1hyeHH1ft

If you have any questions or need assistance please call 1-213-288-8089 (Monday-Saturday **7:00 a.m.- 5:00 p.m.**) or call me directly at 323- 914-0424

To ensure and promote timely services, please submit forms by no later than **March 8, 2021.**

Thanks Jerry!
Melanie

Melanie Barr, RN, MSN, CNS

Director of Nursing, Vaccine Prevenable Disease Control Program

(213) 351 – 7800 Office

(213) 351 – 7427 Desk

(323) 914 – 0424 Cell (Preferred)

"There's no vaccine for racism." Madame Vice President Kamala Harris

3 attachments

Letter from BlueShield CA.pdf
46K

MyTurn-AccountCreation_New User List.xlsx
21K

MyTurn-Provider Clinic Scheduling Form (3).xlsx
193K

Janssen Vaccine Product Profile (Centrally Distributed) *

California COVID-19 Vaccination Program

* CDC will use its centralized distribution contract with McKesson Corporation to fulfill orders for most vaccine products and associated ancillary supplies.

Topics	Vaccine Specifics
Manufacturer	**Janssen (Johnson & Johnson)**
NDC # in VTrckS	59676-0580-15
Carton dimensions	93 mm x 38 mm x 54 mm (approximately 3.66 in x 3.66 in x 2.13 in)
Minimum order size and increment	100 doses
Presentation	5-dose multidose vial/10 MDVs per carton/ two cartons of 50 doses
Items automatically added to order when you select this product	Ancillary supply administration kit: standard syringe (see Guide to Ancillary Supplies & Kits)
Administration	0.5 ml
Vaccination schedule	1-dose series
Age indications	18 years of age and older
On-site vaccine storage	• Store unpunctured multi-dose vials at 2°C to 8°C (36°F to 46°F) and protect from light. Do not store frozen. • Unpunctured vials may be stored between 9°C to 25°C (47°F to 77°F) for up to 12 hours. • The expiration date is NOT printed on the vaccine vial or carton. To determine the expiration date, scan the QR code located on the outer carton, go to www.vaxcheck.jnj or call 1-800-565-4008.
Handling	• If vaccine is still frozen upon receipt, thaw at 2°C to 8°C (36°F to 46°F); if needed immediately, thaw at room temperature (maximally 25°C/77°F). • At room temperature (maximally 25°C/77°F), a carton of 10 vials will take approximately 2 hours to thaw, and an individual vial will take approximately 1 hour to thaw. Do not refreeze once thawed. • After the first dose has been withdrawn, hold the vial between 2° to 8°C (36° to 46°F) for up to 6 hours or at room temperature (maximally

Topics	Vaccine Specifics
	25°C/77°F) for up to 2 hours. Discard the vial if vaccine is not used within these times.
Transport	• Transport at refrigerated temperatures (2° to 8°C; 36° to 46°F) • CDC recommends transport of vials; if transport of pre-drawn syringes is required, transport at **refrigerator** temperatures between 2°C and 8°C (35°F to 46°F) following guidance in USP COVID-19 Vaccine Handling Toolkit • For more guidance, refer to Transporting Janssen Vaccine.
Expiration Dates	• The expiration date is NOT printed on the vaccine vial or carton. To determine the expiration date: Scan the QR code located on the outer carton, call 1-800-565-4008, or go to www.vaxcheck.jnj/.

FACT SHEET FOR HEALTHCARE PROVIDERS ADMINISTERING VACCINE (VACCINATION PROVIDERS)

EMERGENCY USE AUTHORIZATION (EUA) OF THE JANSSEN COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19)

The U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) to permit the emergency use of the unapproved product, Janssen COVID-19 Vaccine, for active immunization to prevent COVID-19 in individuals 18 years of age and older.

SUMMARY OF INSTRUCTIONS FOR COVID-19 VACCINATION PROVIDERS

Vaccination providers enrolled in the federal COVID-19 Vaccination Program must report all vaccine administration errors, all serious adverse events, cases of Multisystem Inflammatory Syndrome (MIS) in adults, and cases of COVID-19 that result in hospitalization or death following administration of the Janssen COVID-19 Vaccine. See "MANDATORY REQUIREMENTS FOR THE JANSSEN COVID-19 VACCINE ADMINISTRATION UNDER EMERGENCY USE AUTHORIZATION" for reporting requirements.

The Janssen COVID-19 Vaccine is a suspension for intramuscular injection administered as a **single dose** (0.5 mL).

See this Fact Sheet for instructions for preparation and administration. This Fact Sheet may have been updated. For the most recent Fact Sheet, please see www.janssencovid19vaccine.com.

For information on clinical trials that are testing the use of the Janssen COVID-19 Vaccine for active immunization against COVID-19, please see www.clinicaltrials.gov.

DESCRIPTION OF COVID-19

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the novel coronavirus, SARS-CoV-2, that appeared in late 2019. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have reported a wide range of symptoms, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

DOSAGE AND ADMINISTRATION

The storage and handling information in this Fact Sheet supersedes the storage and handling information on the carton and vial labels.

Storage and Handling

Storage Prior to First Puncture of the Vaccine Vial

Store unpunctured multi-dose vials of the Janssen COVID-19 Vaccine at 2°C to 8°C (36°F to 46°F) and protect from light. Do not store frozen.

Unpunctured vials of Janssen COVID-19 Vaccine may be stored between 9°C to 25°C (47°F to 77°F) for up to 12 hours.

The Janssen COVID-19 Vaccine is initially stored frozen by the manufacturer, then shipped at 2°C to 8°C (36°F to 46°F). If vaccine is still frozen upon receipt, thaw at 2°C to 8°C (36°F to 46°F). If needed immediately, thaw at room temperature (maximally 25°C/77°F). At room temperature (maximally 25°C/77°F), a carton of 10 vials will take approximately 2 hours to thaw, and an individual vial will take approximately 1 hour to thaw. Do not refreeze once thawed.

Storage After First Puncture of the Vaccine Vial

After the first dose has been withdrawn, hold the vial between 2° to 8°C (36° to 46°F) for up to 6 hours or at room temperature (maximally 25°C/77°F) for up to 2 hours. Discard the vial if vaccine is not used within these times.

Dosing and Schedule

The Janssen COVID-19 Vaccine is administered intramuscularly as a **single dose** (0.5 mL).

There are no data available on the use of the Janssen COVID-19 Vaccine to complete a vaccination series initiated with another COVID-19 Vaccine.

Dose Preparation

- The Janssen COVID-19 Vaccine is a colorless to slightly yellow, clear to very opalescent suspension. Visually inspect the Janssen COVID-19 Vaccine vials for particulate matter and discoloration prior to administration. If either of these conditions exists, do not administer the vaccine.
- Before withdrawing each dose of vaccine, carefully mix the contents of the multi-dose vial by swirling gently in an upright position for 10 seconds. **Do not shake**.
- Each dose is 0.5 mL. Each vial contains five doses. Do not pool excess vaccine from multiple vials.
- The Janssen COVID-19 Vaccine does not contain a preservative. Record the date and time of first use on the Janssen COVID-19 Vaccine vial label. After the first dose has been withdrawn, hold the vial between 2° to 8°C (36° to 46°F) for up to 6 hours or at room temperature (maximally 25°C/77°F) for up to 2 hours. Discard if vaccine is not used within these times.

Administration

Visually inspect each dose in the dosing syringe prior to administration. The Janssen COVID-19 Vaccine is a colorless to slightly yellow, clear to very opalescent suspension. During the visual inspection,

- verify the final dosing volume of 0.5 mL.
- confirm there are no particulates and that no discoloration is observed.
- do not administer if vaccine is discolored or contains particulate matter.

Revised: Feb/27/2021

Administer the Janssen COVID-19 Vaccine intramuscularly.

CONTRAINDICATION

Do not administer the Janssen COVID-19 Vaccine to individuals with a known history of a severe allergic reaction (e.g., anaphylaxis) to any component of the Janssen COVID-19 Vaccine *(see Full EUA Prescribing Information).*

WARNINGS

Appropriate medical treatment to manage immediate allergic reactions must be immediately available in the event an acute anaphylactic reaction occurs following administration of the Janssen COVID-19 Vaccine.

Monitor Janssen COVID-19 Vaccine recipients for the occurrence of immediate adverse reactions according to the Centers for Disease Control and Prevention guidelines (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/managing-anaphylaxis.html).

Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the Janssen COVID-19 Vaccine.

The Janssen COVID-19 Vaccine may not protect all vaccinated individuals.

ADVERSE REACTIONS

Adverse reactions reported in a clinical trial following administration of the Janssen COVID-19 Vaccine include injection site pain, headache, fatigue, myalgia, nausea, fever, injection site erythema and injection site swelling. In clinical studies, severe allergic reactions, including anaphylaxis, have been reported following the administration of the Janssen COVID-19 Vaccine *(see Full EUA Prescribing Information).*

Additional adverse reactions, some of which may be serious, may become apparent with more widespread use of the Janssen COVID-19 Vaccine.

USE WITH OTHER VACCINES

There is no information on the co-administration of the Janssen COVID-19 Vaccine with other vaccines.

INFORMATION TO PROVIDE TO VACCINE RECIPIENTS/CAREGIVERS

As the vaccination provider, you must communicate to the recipient or their caregiver, information consistent with the "Fact Sheet for Recipients and Caregivers" (and provide a copy or direct the individual to the website www.janssencovid19vaccine.com to obtain the Fact Sheet) prior to the individual receiving the Janssen COVID-19 Vaccine, including:

- FDA has authorized the emergency use of the Janssen COVID-19 Vaccine, which is not an FDA approved vaccine.
- The recipient or their caregiver has the option to accept or refuse the Janssen COVID-19 Vaccine.

- The significant known and potential risks and benefits of the Janssen COVID-19 Vaccine, and the extent to which such risks and benefits are unknown.
- Information about available alternative vaccines and the risks and benefits of those alternatives.

For information on clinical trials that are testing the use of the Janssen COVID-19 Vaccine to prevent COVID-19, please see www.clinicaltrials.gov.

Provide a vaccination card to the recipient or their caregiver with the name of the vaccine ("Janssen COVID-19 Vaccine") and date of administration to document vaccination.

Provide the v-safe information sheet to vaccine recipients/caregivers and encourage vaccine recipients to participate in v-safe. V-safe is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. V-safe asks questions that help CDC monitor the safety of COVID-19 vaccines. V-safe also provides live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information, visit: www.cdc.gov/vsafe.

MANDATORY REQUIREMENTS FOR JANSSEN COVID-19 VACCINE ADMINISTRATION UNDER EMERGENCY USE AUTHORIZATION

In order to mitigate the risks of using this unapproved product under EUA and to optimize the potential benefit of the Janssen COVID-19 Vaccine, the following items are required. Use of unapproved Janssen COVID-19 Vaccine for active immunization to prevent COVID-19 under this EUA is limited to the following (all requirements must be met):

1. The Janssen COVID-19 Vaccine is authorized for use in individuals 18 years of age and older.

2. The vaccination provider must communicate to the individual receiving the Janssen COVID-19 Vaccine or their caregiver, information consistent with the "Fact Sheet for Recipients and Caregivers" prior to the individual receiving the Janssen COVID-19 Vaccine.

3. The vaccination provider must include vaccination information in the state/local jurisdiction's Immunization Information System (IIS) or other designated system.

4. The vaccination provider is responsible for mandatory reporting of the following to the Vaccine Adverse Event Reporting System (VAERS):

    - vaccine administration errors whether or not associated with an adverse event,
    - serious adverse events* (irrespective of attribution to vaccination),
    - cases of Multisystem Inflammatory Syndrome (MIS) in adults, and
    - cases of COVID-19 that result in hospitalization or death.

Complete and submit reports to VAERS online at https://vaers.hhs.gov/reportevent.html. For further assistance with reporting to VAERS, call 1-800-822-7967. The reports should include the words "Janssen COVID-19 Vaccine EUA" in the description section of the report.

5. The vaccination provider is responsible for responding to FDA requests for information about vaccine administration errors, adverse events, cases of MIS in adults, and cases of COVID-19 that result in hospitalization or death following administration of the Janssen COVID-19 Vaccine to recipients.

* Serious adverse events are defined as:
- Death;
- A life-threatening adverse event;
- Inpatient hospitalization or prolongation of existing hospitalization;
- A persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions;
- A congenital anomaly/birth defect;
- An important medical event that based on appropriate medical judgement may jeopardize the individual and may require medical or surgical intervention to prevent one of the outcomes listed above.

OTHER ADVERSE EVENT REPORTING TO VAERS AND JANSSEN BIOTECH, INC.

Vaccination providers may report to VAERS other adverse events that are not required to be reported using the contact information above.

To the extent feasible, report adverse events to Janssen Biotech, Inc. using the contact information below or by providing a copy of the VAERS form to Janssen Biotech, Inc:

e-mail	Fax number	Telephone numbers
JNJvaccineAE@its.jnj.com	215-293-9955	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

ADDITIONAL INFORMATION

For general questions or to access the most recent Janssen COVID-19 Vaccine Fact Sheets, scan the QR code using your device, visit www.janssencovid19vaccine.com or call the telephone numbers provided below.

QR Code	Fact Sheets Website	Telephone numbers
	www.janssencovid19vaccine.com.	US Toll Free: 1-800-565-4008 US Toll: 1-908-455-9922

Revised: Feb/27/2021

AVAILABLE ALTERNATIVES

There is no approved alternative vaccine to prevent COVID-19. There may be clinical trials or availability under EUA of other COVID-19 vaccines.

AUTHORITY FOR ISSUANCE OF THE EUA

The Secretary of the Department of Health and Human Services (HHS) declared a public health emergency that justifies the emergency use of drugs and biological products during the COVID-19 pandemic. In response, FDA has issued an EUA for the unapproved product, Janssen COVID-19 Vaccine, for active immunization to prevent COVID-19 in individuals 18 years of age and older.

FDA issued this EUA, based on Janssen Biotech, Inc.'s request and submitted data.

Although limited scientific information is available, based on the totality of the scientific evidence available to date, it is reasonable to believe that the Janssen COVID-19 Vaccine may be effective for the prevention of COVID-19 in individuals as specified in the Full EUA Prescribing Information.

This EUA for the Janssen COVID-19 Vaccine will end when the Secretary of HHS determines that the circumstances justifying the EUA no longer exist or when there is a change in the approval status of the product such that an EUA is no longer needed.

For additional information about Emergency Use Authorization visit FDA at: https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.

THE COUNTERMEASURES INJURY COMPENSATION PROGRAM

The Countermeasures Injury Compensation Program (CICP) is a federal program that has been created to help pay for related costs of medical care and other specific expenses to compensate people injured after use of certain medical countermeasures. Medical countermeasures are specific vaccines, medications, devices, or other items used to prevent, diagnose, or treat the public during a public health emergency or a security threat. For more information about CICP, visit www.hrsa.gov/cicp, email cicp@hrsa.gov, or call: 1-855-266-2427.

Manufactured by:
Janssen Biotech, Inc.
a Janssen Pharmaceutical Company of Johnson & Johnson
Horsham, PA 19044, USA

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END SHORT VERSION FACT SHEET
Long Version (Full EUA Prescribing Information) Begins On Next Page

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FULL EMERGENCY USE AUTHORIZATION (EUA) PRESCRIBING INFORMATION

JANSSEN COVID-19 VACCINE

FULL EMERGENCY USE AUTHORIZATION (EUA) PRESCRIBING INFORMATION: CONTENTS*

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3 DOSAGE FORMS AND STRENGTHS
4 CONTRAINDICATIONS
5 WARNINGS AND PRECAUTIONS
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*Sections or subsections omitted from the full prescribing information are not listed.

Revised: Feb/27/2021

FULL EMERGENCY USE AUTHORIZATION (EUA) PRESCRIBING INFORMATION

1 AUTHORIZED USE

Janssen COVID-19 vaccine is authorized for use under an Emergency Use Authorization (EUA) for active immunization to prevent coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in individuals 18 years of age and older.

2 DOSAGE AND ADMINISTRATION

For intramuscular injection only.

2.1 Preparation for Administration

- The Janssen COVID-19 Vaccine is a colorless to slightly yellow, clear to very opalescent suspension. Visually inspect the Janssen COVID-19 Vaccine vials for particulate matter and discoloration prior to administration. If either of these conditions exists, do not administer the vaccine.
- Before withdrawing each dose of vaccine, carefully mix the contents of the multi-dose vial by swirling gently in an upright position for 10 seconds. **Do not shake**.
- Each dose is 0.5 mL. Each vial contains five doses. Do not pool excess vaccine from multiple vials.
- The Janssen COVID-19 Vaccine does not contain a preservative. Record the date and time of first use on the Janssen COVID-19 Vaccine vial label. After the first dose has been withdrawn, hold the vial between 2° to 8°C (36° to 46°F) for up to 6 hours or at room temperature (maximally 25°C/77°F) for up to 2 hours. Discard if vaccine is not used within these times.

2.2 Administration

Visually inspect each dose in the dosing syringe prior to administration. The Janssen COVID-19 Vaccine is a colorless to slightly yellow, clear to very opalescent suspension. During the visual inspection,

- verify the final dosing volume of 0.5 mL.
- confirm there are no particulates and that no discoloration is observed.
- do not administer if vaccine is discolored or contains particulate matter.

Administer the Janssen COVID-19 Vaccine intramuscularly.

2.3 Dosing and Schedule

The Janssen COVID-19 Vaccine is administered intramuscularly as a **single dose** (0.5 mL).

There are no data available on the use of the Janssen COVID-19 Vaccine to complete a vaccination series initiated with another COVID-19 Vaccine.

3 DOSAGE FORMS AND STRENGTHS

Janssen COVID-19 Vaccine is a suspension for intramuscular injection. A single dose is 0.5 mL.

4 CONTRAINDICATIONS

Do not administer the Janssen COVID-19 Vaccine to individuals with a known history of severe allergic reaction (e.g., anaphylaxis) to any component of the Janssen COVID-19 Vaccine *[see Description (13)]*.

5 WARNINGS AND PRECAUTIONS

5.1 Management of Acute Allergic Reactions

Appropriate medical treatment used to manage immediate allergic reactions must be immediately available in the event an acute anaphylactic reaction occurs following administration of the Janssen COVID-19 Vaccine.

Monitor Janssen COVID-19 Vaccine recipients for the occurrence of immediate adverse reactions according to the Centers for Disease Control and Prevention guidelines (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/managing-anaphylaxis.html).

5.2 Altered Immunocompetence

Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the Janssen COVID-19 Vaccine.

5.3 Limitations of Vaccine Effectiveness

The Janssen COVID-19 Vaccine may not protect all vaccinated individuals.

6 OVERALL SAFETY SUMMARY

It is MANDATORY for vaccination providers to report to the Vaccine Adverse Event Reporting System (VAERS) all vaccine administration errors, all serious adverse events, cases of Multisystem Inflammatory Syndrome (MIS) in adults, and hospitalized or fatal cases of COVID-19 following vaccination with the Janssen COVID-19 Vaccine. To the extent feasible, provide a copy of the VAERS form to Janssen Biotech, Inc. Please see the REQUIREMENTS AND INSTRUCTIONS FOR REPORTING ADVERSE EVENTS AND VACCINE ADMINISTRATION ERRORS section for details on reporting to VAERS or Janssen Biotech, Inc.

In study COV3001, the most common local solicited adverse reaction (≥10%) reported was injection site pain (48.6%). The most common systemic adverse reactions (≥10%) were headache (38.9%), fatigue (38.2%), myalgia (33.2%), and nausea (14.2%) (see Tables 1 to 4).

Severe allergic reactions, including one case of anaphylaxis in an ongoing open-label study in South Africa, have been reported following the Janssen COVID-19 vaccine administered in clinical studies.

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The safety of the Janssen COVID-19 Vaccine has been assessed in an ongoing Phase 3 Study (COV3001). A total of 43,783 individuals were enrolled in this study, of whom 21,895 adults aged 18 years and older received the Janssen COVID-19 Vaccine [Full Analysis Set (FAS)]. This study is being conducted in the United States (n=19,302), Brazil (n=7,278), South Africa (n=6,576), Colombia (n=4,248), Argentina (n=2,996), Peru (n=1,771), Chile (n=1,133), Mexico (n=479). In this study, 45.0% were female, 54.9% were male, 58.7% were White, 19.4% were Black or African American, 45.3% were Hispanic or Latino, 3.3% were Asian, 9.5% were American Indian/Alaska Native and 0.2% were Native Hawaiian or other Pacific Islander, 5.6% were from multiple racial groups and 1.4% were unknown races (see Table 5). The median age of individuals was 52.0 years (range: 18-100). There were 4,217 (9.6%) individuals who were SARS-CoV-2 seropositive at baseline and who were included in the study. In the United States, 838 of 19,302 (4.3%) individuals were SARS-CoV-2 seropositive. Demographic characteristics were similar among individuals who received the Janssen COVID-19 Vaccine and those who received saline placebo.

The safety subset includes 6,736 individuals (3,356 from the Janssen COVID-19 Vaccine group, 3,380 from the placebo group). The demographic profile in the safety subset was similar in terms of age and gender compared to the FAS. A larger percentage of individuals in the safety subset were White (83.4%) compared to the FAS (58.7%). Geographically, the safety subset was limited to individuals from the United States (51.4%), Brazil (38.5%) and South Africa (10.2%). Fewer individuals in the safety subset compared to the FAS were SARS-CoV-2 seropositive at baseline, 4.5% vs. 9.6%, and had at least one comorbidity 34.1% vs 40.8%.

Safety monitoring in the clinical study consisted of monitoring for: (1) solicited local and systemic reactions occurring in the 7 days following vaccination in a subset of individuals (safety subset), (2) unsolicited adverse events (AEs) occurring in the 28 days following vaccination in the safety subset, (3) medically-attended AEs (MAAEs) occurring in the 6 months following vaccination in the entire study population (FAS), (4) serious AEs (SAEs) and AEs leading to study discontinuation for the duration of the study in the entire study population.

Solicited adverse reactions

Shown below are the frequencies of solicited local adverse reactions (Tables 1 and 2) and systemic adverse reactions (Tables 3 and 4) reported in adults by age group in the ongoing Phase 3 clinical trial (COV3001) in the 7 days following vaccination.

Table 1: Solicited Local Adverse Reactions Reported in the 7 Days Following Vaccination - Individuals 18 to 59 Years of Age

Adverse Reactions	Janssen COVID-19 Vaccine N=2,036 n(%)	Placebo N=2,049 n(%)
Injection Site Pain		
Any	1,193 (58.6)	357 (17.4)
Grade 3[a]	8 (0.4)	0
Injection Site Erythema		
Any (≥25 mm)	184 (9.0)	89 (4.3)
Grade 3[b]	6 (0.3)	2 (0.1)
Injection Site Swelling		
Any (≥25 mm)	142 (7.0)	32 (1.6)
Grade 3[b]	5 (0.2)	2 (0.1)

[a] Grade 3 injection site pain: Defined as incapacitating symptoms; inability to do work, school, or usual activities; use of narcotic pain reliever.

[b] Grade 3 injection site swelling and erythema: Defined as >100 mm.

Table 2: Solicited Local Adverse Reactions Reported in the 7 Days Following Vaccination - Individuals 60 Years of Age and Older

Adverse Reactions	Janssen COVID-19 Vaccine N=1,320 n(%)	Placebo N=1,331 n(%)
Injection Site Pain		
Any	439 (33.3)	207 (15.6)
Grade 3[a]	3 (0.2)	2 (0.2)
Injection Site Erythema		
Any (≥25 mm)	61 (4.6)	42 (3.2)
Grade 3[b]	1 (0.1)	0
Injection Site Swelling		
Any (≥25 mm)	36 (2.7)	21 (1.6)
Grade 3[b]	2 (0.2)	0

[a] Grade 3 injection site pain: Defined as incapacitating symptoms; inability to do work, school, or usual activities; use of narcotic pain reliever.

[b] Grade 3 injection site swelling and erythema: Defined as >100 mm.

Table 3: Solicited Systemic Adverse Reactions Reported in the 7 Days Following Vaccination - Individuals 18 to 59 Years of Age

Adverse Reactions	Janssen COVID-19 Vaccine N=2,036 n(%)	Placebo N=2,049 n(%)
Headache		
Any	905 (44.4)	508 (24.8)
Grade 3[a]	18 (0.9)	5 (0.2)
Fatigue		
Any	891 (43.8)	451 (22.0)
Grade 3[b]	25 (1.2)	4 (0.2)
Myalgia		
Any	796 (39.1)	248 (12.1)
Grade 3[b]	29 (1.4)	1 (<0.1)
Nausea		
Any	315 (15.5)	183 (8.9)
Grade 3[b]	3 (0.1)	3 (0.1)
Fever[c]		
Any	261 (12.8)	14 (0.7)
Grade 3	7 (0.3)	0
Use of antipyretic or pain medication	538 (26.4)	123 (6.0)

[a] Grade 3 headache: Defined as incapacitating symptoms; requires bed rest and/or results in loss of work, school, or cancellation of social activities; use of narcotic pain reliever.

[b] Grade 3 fatigue, myalgia, nausea: Defined as incapacitating symptoms; requires bed rest and/or results in loss of work, school, or cancellation of social activities; use of narcotic pain reliever.

[c] Fever of any grade: Defined as body temperature ≥38°C/100.4°F. Grade 3 fever: Defined as 39.0°C - 40.0°C (102.1°F - 104.0°F).

Table 4: Solicited Systemic Adverse Reactions Reported in the 7 Days Following Vaccination - Individuals 60 Years of Age and Older

Adverse Reactions	Janssen COVID-19 Vaccine N=1,320 n(%)	Placebo N=1,331 n(%)
Headache		
Any	401 (30.4)	294 (22.1)
Grade 3[a]	5 (0.4)	4 (0.3)
Fatigue		
Any	392 (29.7)	277 (20.8)
Grade 3[b]	10 (0.8)	5 (0.4)
Myalgia		
Any	317 (24.0)	182 (13.7)
Grade 3[b]	3 (0.2)	5 (0.4)
Nausea		
Any	162 (12.3)	144 (10.8)
Grade 3[b]	3 (0.2)	3 (0.2)
Fever[c]		
Any	41 (3.1)	6 (0.5)
Grade 3	1 (0.1)	0
Use of antipyretic or pain medication	130 (9.8)	68 (5.1)

[a] Grade 3 headache: Defined as incapacitating symptoms; requires bed rest and/or results in loss of work, school, or cancellation of social activities; use of narcotic pain reliever

[b] Grade 3 fatigue, myalgia, nausea: Defined as incapacitating symptoms; requires bed rest and/or results in loss of work, school, or cancellation of social activities; use of narcotic pain reliever.

[c] Fever of any grade: Defined as body temperature ≥38°C/100.4°F. Grade 3 fever: Defined as 39.0°C - 40.0°C (102.1°F - 104.0°F).

Solicited local and systemic adverse reactions reported following administration of the Janssen COVID-19 Vaccine had a median duration of 1 to 2 days.

Unsolicited adverse events

Individuals within the safety subset in study COV3001 (N=6,736) were monitored for unsolicited adverse events (AEs) for 28 days following vaccination with 99.9% (N= 6,730) of individuals completing the full 28 days of follow-up. The proportion of individuals who reported one or more unsolicited AEs was similar among those in the Janssen COVID-19 Vaccine group (13.1%) and those in the placebo group (12.0%).

Serious Adverse Events (SAEs) and other events of interest

In study COV3001, up to a cut-off date of January 22, 2021, 54.6% of individuals had follow-up duration of 8 weeks. The median follow-up duration for all individuals was 58 days. SAEs, excluding those related to confirmed COVID-19, were reported by 0.4% (n=83) of individuals who received the Janssen COVID-19 Vaccine (N= 21,895) and 0.4% (n=96) of individuals who received placebo (N= 21,888).

Additional adverse events of interest, including but not limited to allergic, neurologic, inflammatory, vascular, and autoimmune disorders, were analyzed among all adverse events collected through protocol-specified safety monitoring procedures as well as unsolicited reporting.

Urticaria (all non-serious) was reported in five vaccinated individuals and 1 individual who received placebo in the 7 days following vaccination. In addition, an SAE of hypersensitivity, not classified as anaphylaxis, was reported in 1 vaccinated individual with urticaria beginning two days following vaccination and angioedema of the lips with no respiratory distress beginning four days following vaccination. The event was likely related to the vaccine.

An SAE of severe pain in the injected arm, not responsive to analgesics, with immediate onset at time of vaccination, and that was ongoing 74 days following vaccination was reported in an individual who received the Janssen COVID-19 Vaccine. An SAE of severe generalized weakness, fever, and headache, with onset on the day following vaccination and resolution three days following vaccination was reported in an individual who received the Janssen COVID-19 Vaccine. Both SAEs are likely related to the vaccine.

Numerical imbalances, with more events in vaccine than placebo recipients, were observed for the following serious and other adverse events of interest in individuals receiving the vaccine or placebo, respectively:

- Thromboembolic events:
    - Deep vein thrombosis: 6 events (2 serious; 5 within 28 days of vaccination) vs. 2 events (1 serious; 2 within 28 days of vaccination).
    - Pulmonary embolism: 4 events (3 serious; 2 within 28 days of vaccination) vs. 1 event (serious and within 28 days of vaccination).
    - Transverse sinus thrombosis: 1 event (serious and within 28 days of vaccination) vs. 0.
- Seizures: 4 events (1 serious; 4 within 28 days of vaccination) vs. 1 event (0 serious and 0 within 28 days following vaccination).
- Tinnitus: 6 events (0 serious; 6 within 28 days of vaccination, including 3 within 2 days of vaccination) vs. 0.

For these events, a causal relationship with the Janssen COVID-19 vaccine cannot be determined. The assessment of causality was confounded by the presence of underlying medical conditions that may have predisposed individuals to these events.

There were no additional notable patterns or numerical imbalances between treatment groups for specific categories of serious adverse events (including neurologic, neuro-inflammatory, and cardiovascular events) that would suggest a causal relationship to the Janssen COVID-19 Vaccine.

8 REQUIREMENTS AND INSTRUCTIONS FOR REPORTING ADVERSE EVENTS AND VACCINE ADMINISTRATION ERRORS

See Overall Safety Summary (Section 6) for additional information.

The vaccination provider enrolled in the federal COVID-19 Vaccination Program is responsible for MANDATORY reporting of the listed events following Janssen COVID-19 Vaccine administration to the Vaccine Adverse Event Reporting System (VAERS):

- Vaccine administration errors whether or not associated with an adverse event,
- Serious adverse events* (irrespective of attribution to vaccination),
- Cases of Multisystem Inflammatory Syndrome (MIS) in adults,
- Cases of COVID-19 that result in hospitalization or death.

* Serious Adverse Events are defined as:
- Death;
- A life-threatening adverse event;
- Inpatient hospitalization or prolongation of existing hospitalization;
- A persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions;
- A congenital anomaly/birth defect;
- An important medical event that based on appropriate medical judgement may jeopardize the individual and may require medical or surgical intervention to prevent one of the outcomes listed above.

Instructions for Reporting to VAERS

The vaccination provider enrolled in the federal COVID-19 Vaccination Program should complete and submit a VAERS form to FDA using one of the following methods:

- Complete and submit the report online: https://vaers.hhs.gov/reportevent.html, or
- If you are unable to submit this form electronically, you may fax it to VAERS at 1-877-721-0366. If you need additional help submitting a report you may call the VAERS toll-free information line at 1-800-822-7967 or send an email to info@vaers.org.

IMPORTANT: When reporting adverse events or vaccine administration errors to VAERS, please complete the entire form with detailed information. It is important that the information reported to FDA be as detailed and complete as possible. Information to include:

- Patient demographics, (e.g., patient name, date of birth),
- Pertinent medical history,
- Pertinent details regarding admission and course of illness,
- Concomitant medications,
- Timing of adverse event(s) in relationship to administration of Janssen COVID-19 vaccine,
- Pertinent laboratory and virology information,
- Outcome of the event and any additional follow-up information if it is available at the time of the VAERS report. Subsequent reporting of follow-up information should be completed if additional details become available.

The following steps are highlighted to provide the necessary information for safety tracking:

1. In Box 17, provide information on Janssen COVID-19 Vaccine and any other vaccines administered on the same day; and in Box 22, provide information on any other vaccines received within one month prior.

2. In Box 18, description of the event:

    a. Write "Janssen COVID-19 Vaccine EUA" as the first line.

    b. Provide a detailed report of vaccine administration error and/or adverse event. It is important to provide detailed information regarding the patient and adverse event/medication error for ongoing safety evaluation of this unapproved vaccine. Please see information to include listed above.

3. Contact information:

    a. In Box 13, provide the name and contact information of the prescribing healthcare provider or institutional designee who is responsible for the report.

    b. In Box 14, provide the name and contact information of the best doctor/healthcare professional to contact about the adverse event.

    c. In Box 15, provide the address of the facility where vaccine was given (NOT the healthcare provider's office address).

Other Reporting Instructions

Vaccination providers may report to VAERS other adverse events that are not required to be reported using the contact information above.

To the extent feasible, report adverse events to Janssen Biotech, Inc. using the contact information below or by providing a copy of the VAERS form to Janssen Biotech, Inc:

e-mail	Fax number	Telephone numbers
JNJvaccineAE@its.jnj.com	215-293-9955	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

10 DRUG INTERACTIONS

There are no data to assess the concomitant administration of the Janssen COVID-19 Vaccine with other vaccines.

11 USE IN SPECIFIC POPULATIONS

11.1 Pregnancy

Pregnancy Exposure Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to Janssen COVID-19 Vaccine during pregnancy. Women who are vaccinated with Janssen COVID-

19 Vaccine during pregnancy are encouraged to enroll in the registry by visiting https://c-viper.pregistry.com.

Risk Summary

All Pregnancies have a risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Available data on Janssen COVID-19 Vaccine administered to pregnant women are insufficient to inform vaccine-associated risks in pregnancy.

In a reproductive developmental toxicity study female rabbits were administered 1 mL of the Janssen COVID-19 Vaccine (a single human dose is 0.5 mL) by intramuscular injection 7 days prior to mating and on Gestation Days 6 and 20 (i.e., one vaccination during early and late gestation, respectively). No vaccine related adverse effects on female fertility, embryo-fetal or postnatal development up to Postnatal Day 28 were observed.

11.2 Lactation

Risk Summary

Data are not available to assess the effects of Janssen COVID-19 Vaccine on the breastfed infant or on milk production/excretion.

11.3 Pediatric Use

Emergency Use Authorization of the Janssen COVID-19 Vaccine does not include use in individuals younger than 18 years of age.

11.4 Geriatric Use

Clinical studies of Janssen COVID-19 Vaccine included individuals 65 years of age and older and their data contributes to the overall assessment of safety and efficacy *[see Overall Safety Summary (6.1) and Clinical Trial Results and Supporting Data for EUA (18)]*. Of the 21,895 individuals who received a single-dose of the Janssen COVID-19 Vaccine in COV3001, 19.5% (n=4,259) were 65 years of age and older and 3.7% (n=809) were 75 years of age and older. No overall differences in safety or efficacy were observed between individuals 65 years of age and older and younger individuals.

13 DESCRIPTION

The Janssen COVID-19 Vaccine is a colorless to slightly yellow, clear to very opalescent sterile suspension for intramuscular injection. It contains no visible particulates. The vaccine consists of a replication-incompetent recombinant adenovirus type 26 (Ad26) vector expressing the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) spike (S) protein in a stabilized conformation.

The Ad26 vector expressing the SARS-CoV-2 S protein is grown in PER.C6 TetR cells, in media containing amino acids and no animal-derived proteins. After propagation, the vaccine is

processed through several purification steps, formulated with inactive ingredients and filled into vials.

Each 0.5 mL dose of Janssen COVID-19 Vaccine is formulated to contain 5×10^{10} virus particles (VP) and the following inactive ingredients: citric acid monohydrate (0.14 mg), trisodium citrate dihydrate (2.02 mg), ethanol (2.04 mg), 2-hydroxypropyl-β-cyclodextrin (HBCD) (25.50 mg), polysorbate-80 (0.16 mg), sodium chloride (2.19 mg). Each dose may also contain residual amounts of host cell proteins (≤0.15 mcg) and/or host cell DNA (≤3 ng).

Janssen COVID-19 Vaccine does not contain a preservative.

The vial stoppers are not made with natural rubber latex.

14 CLINICAL PHARMACOLOGY

14.1 Mechanism of Action

The Janssen COVID-19 Vaccine is composed of a recombinant, replication-incompetent human adenovirus type 26 vector that, after entering human cells, expresses the SARS-CoV-2 spike (S) antigen without virus propagation. An immune response elicited to the S antigen protects against COVID-19.

18 CLINICAL TRIAL RESULTS AND SUPPORTING DATA FOR EUA

An ongoing, multicenter, randomized, double-blind, placebo-controlled Phase 3 Study (COV3001) (NCT04505722) is being conducted in the United States, South Africa, Brazil, Chile, Argentina, Colombia, Peru and Mexico to assess the efficacy, safety, and immunogenicity of a single-dose of the Janssen COVID-19 Vaccine for the prevention of COVID-19 in adults aged 18 years and older. Randomization was stratified by age (18-59 years, 60 years and older) and presence or absence of comorbidities associated with an increased risk of progression to severe COVID-19. The study allowed for the inclusion of individuals with stable pre-existing medical conditions, defined as disease not requiring significant change in therapy during the 3 months preceding vaccination, as well as individuals with stable human immunodeficiency virus (HIV) infection.

A total of 44,325 individuals were randomized equally to receive Janssen COVID-19 Vaccine or saline placebo. Individuals are planned to be followed for up to 24 months, for assessments of safety and efficacy against COVID-19.

The primary efficacy analysis population of 39,321 individuals (19,630 in the Janssen COVID-19 Vaccine group and 19,691 in the placebo group) included 38,059 SARSCoV-2 seronegative individuals at baseline and 1,262 individuals with an unknown serostatus. Demographic and baseline characteristics were similar among individuals who received the Janssen COVID-19 Vaccine and those who received placebo (see Table 5).

Table 5: Summary of Demographics and Baseline Characteristics - Primary Efficacy Analysis Population

	Janssen COVID-19 Vaccine (N=19,630) n (%)	Placebo (N=19,691) n (%)
Sex		
Male	10,924 (55.6)	10,910 (55.4)
Female	8,702 (44.3)	8,777 (44.6)
Age (years)		
Mean (SD)	51.1 (15.0)	51.2 (15.0)
Median	52.0	53.0
Min, max	(18; 100)	(18; 94)
Age group		
≥18 to 59 years of age	12,830 (65.4)	12,881 (65.4)
≥60 years of age	6,800 (34.6)	6,810 (34.6)
≥65 years of age	3,984 (20.3)	4,018 (20.4)
≥75 years of age	755 (3.8)	693 (3.5)
Race[a]		
White	12,200 (62.1)	12,216 (62.0)
Black or African American	3,374 (17.2)	3,390 (17.2)
Asian	720 (3.7)	663 (3.4)
American Indian/Alaska Native[b]	1,643 (8.4)	1,628 (8.3)
Native Hawaiian or other Pacific Islander	54 (0.3)	45 (0.2)
Multiple	1,036 (5.3)	1,087 (5.5)
Unknown	262 (1.3)	272 (1.4)
Not reported	341 (1.7)	390 (2.0)
Ethnicity		
Hispanic or Latino	8,793 (44.8)	8,936 (45.4)
Not Hispanic or Latino	10,344 (52.7)	10,259 (52.1)
Unknown	173 (0.9)	162 (0.8)
Not reported	319 (1.6)	333 (1.7)
Region		
Northern America (United States)	9,185 (46.8)	9,171 (46.6)
Latin America	7,967 (40.6)	8,014 (40.7)
Southern Africa (South Africa)	2,478 (12.6)	2,506 (12.7)
Comorbidities[c]		
Yes	7,830 (39.9)	7,867 (40.0)
No	11,800 (60.1)	11,824 (60.0)

[a] Some individuals could be classified in more than one category.

[b] Including 175 individuals in the United States, which represents 1% of the population recruited in the United States.

[c] Number of individuals who have 1 or more comorbidities at baseline that increase the risk of progression to severe/critical COVID-19: Obesity defined as BMI ≥30 kg/m^2 (27.5%), hypertension (10.3%), type 2 diabetes (7.2%), stable/well-controlled HIV infection (2.5%), serious heart conditions (2.4%), asthma (1.3%), and in ≤1% of individuals: cancer, cerebrovascular disease, chronic kidney disease, chronic obstructive pulmonary disease, cystic fibrosis, immunocompromised state (weakened immune system) from blood or organ transplant, liver disease, neurologic conditions, pulmonary fibrosis, sickle cell disease, thalassemia and type 1 diabetes, regardless of age.

Efficacy Against COVID-19

The co-primary endpoints evaluated the first occurrence of moderate to severe/critical COVID-19 with onset of symptoms at least 14 days and at least 28 days after vaccination. Moderate to severe/critical COVID-19 was molecularly confirmed by a central laboratory based on a positive SARS-CoV-2 viral RNA result using a polymerase chain reaction (PCR)-based test.

- Moderate COVID-19 was defined based on the following criteria: the individual must have experienced any one of the following new or worsening signs or symptoms: respiratory rate

≥20 breaths/minute, abnormal saturation of oxygen (SpO2) but still >93% on room air at sea level, clinical or radiologic evidence of pneumonia, radiologic evidence of deep vein thrombosis (DVT), shortness of breath or difficulty breathing OR any two of the following new or worsening signs or symptoms: fever (≥38.0°C or ≥100.4°F), heart rate ≥90 beats/minute, shaking chills or rigors, sore throat, cough, malaise, headache, muscle pain (myalgia), gastrointestinal symptoms, new or changing olfactory or taste disorders, red or bruised appearing feet or toes.

- Severe/critical COVID-19 was defined based on the following criteria: the individual must have experienced any one of the following at any time during the course of observation: clinical signs at rest indicative of severe systemic illness (respiratory rate ≥30 breaths/minute, heart rate ≥125 beats/minute, oxygen saturation (SpO2) ≤93% on room air at sea level, or partial pressure of oxygen/fraction of inspired oxygen (PaO2/FiO2) <300 mmHg), respiratory failure (defined as needing high-flow oxygen, non-invasive ventilation, mechanical ventilation, or extracorporeal membrane oxygenation [ECMO]), evidence of shock (defined as systolic blood pressure <90 mmHg, diastolic blood pressure <60 mmHg, or requiring vasopressors), significant acute renal, hepatic, or neurologic dysfunction, admission to intensive care unit (ICU), death.

Final determination of severe/critical COVID-19 cases were made by an independent adjudication committee.

The median length of follow up for efficacy for individuals in the study was 8 weeks post-vaccination. Vaccine efficacy for the co-primary endpoints against moderate to severe/critical COVID-19 in individuals who were seronegative or who had an unknown serostatus at baseline was 66.9% (95% CI: 59.0; 73.4) at least 14 days after vaccination and 66.1% (95% CI: 55.0; 74.8) at least 28 days after vaccination (see Table 6).

Table 6: Analyses of Vaccine Efficacy Against Centrally Confirmed Moderate to Severe/Critical COVID-19 – With Onset at Least 14 Days and at Least 28 Days Post-Vaccination - Primary Efficacy Analysis Population

	Janssen COVID-19 Vaccine N=19,630		Placebo N=19,691		
Subgroup	COVID-19 Cases (n)	Person-Years	COVID-19 Cases (n)	Person-Years	% Vaccine Efficacy (95% CI)
14 days post-vaccination					
All subjects[a]	116	3116.6	348	3096.1	66.9 (59.0; 73.4)
18 to 59 years of age	95	2106.8	260	2095.0	63.7 (53.9; 71.6)
60 years and older	21	1009.8	88	1001.2	76.3 (61.6; 86.0)
28 days post-vaccination					
All subjects[a]	66	3102.0	193	3070.7	66.1 (55.0; 74.8)[b]
18 to 59 years of age	52	2097.6	152	2077.0	66.1 (53.3; 75.8)
60 years and older	14	1004.4	41	993.6	66.2 (36.7; 83.0)

[a] Co-primary endpoint.
[b] The adjusted CI implements type I error control for multiple testing and is presented upon meeting the prespecified testing conditions.

Vaccine efficacy against severe/critical COVID-19 at least 14 days after vaccination was 76.7% (95% CI: 54.6; 89.1) and 85.4% (95% CI: 54.2; 96.9) at least 28 days after vaccination (see Table 7).

Table 7: Analyses of Vaccine Efficacy: Secondary Endpoints of Centrally Confirmed Severe/Critical COVID-19 – in Adults 18 Years of Age and Older With Onset at Least 14 Days and at Least 28 Days Post-Vaccination – Primary Efficacy Analysis Population

	Janssen COVID-19 Vaccine N=19,630		Placebo N=19,691		
Subgroup	COVID-19 Cases (n)	Person-Years	COVID-19 Cases (n)	Person-Years	% Vaccine Efficacy (95% CI)
14 days post-vaccination					
Severe/critical	14	3125.1	60	3122.0	76.7 (54.6; 89.1)[a]
28 days post-vaccination					
Severe/critical	5	3106.2	34	3082.6	85.4 (54.2; 96.9)[a]

[a] The adjusted CI implements type I error control for multiple testing and is presented upon meeting the prespecified testing conditions.

Among all COVID-19 cases with onset at least 14 days post vaccination, including cases diagnosed by a positive PCR from a local laboratory and still awaiting confirmation at the central laboratory, there were 2 COVID-19 related hospitalizations in the vaccine group (with none after 28 days) and 29 in the placebo group (with 16 after 28 days).

As of the primary analysis cut-off date of January 22, 2021, there were no COVID-19-related deaths reported in Janssen COVID-19 Vaccine recipients compared to 5 COVID-19-related deaths reported in placebo recipients, who were SARS-CoV-2 PCR negative at baseline.

Janssen COVID-19 Vaccine Efficacy in Countries With Different Circulating SARS-CoV-2 Variants.

Exploratory subgroup analyses of vaccine efficacy against moderate to severe/critical COVID-19 and severe/critical COVID-19 for Brazil, South Africa, and the United States were conducted (see Table 8). For the subgroup analyses, all COVID-19 cases accrued up to the primary efficacy analysis data cutoff date, including cases confirmed by the central laboratory and cases with documented positive SARS-CoV-2 PCR from a local laboratory which are still awaiting confirmation by the central laboratory, were included. The concordance rate observed up to the data cut-off date between the PCR results from the local laboratory and the central laboratory was 90.3%.

Table 8: Summary of Vaccine Efficacy against Moderate to Severe/Critical and Severe/Critical COVID-19 for Countries With >100 Reported Moderate to Severe/Critical Cases

		Severity	
	Onset	Moderate to Severe/Critical Point estimate (95% CI)	Severe/Critical Point estimate (95% CI)
US	at least **14 days** after vaccination	74.4% (65.0; 81.6)	78.0% (33.1; 94.6)
	at least **28 days** after vaccination	72.0% (58.2;81.7)	85.9% (-9.4; 99.7)
Brazil	at least **14 days** after vaccination	66.2% (51.0; 77.1)	81.9% (17.0; 98.1)
	at least **28 days** after vaccination	68.1% (48.8; 80.7)	87.6% (7.8; 99.7)
South Africa	at least **14 days** after vaccination	52.0% (30.3; 67.4)	73.1% (40.0; 89.4)
	at least **28 days** after vaccination	64.0% (41.2; 78.7)	81.7% (46.2; 95.4)

Strain sequencing was conducted on available samples with sufficient viral load from centrally confirmed COVID-19 cases (one sequence per case). As of February 12, 2021, samples from 71.7% of central laboratory confirmed primary analysis cases had been sequenced [United States (73.5%), South Africa (66.9%) and Brazil (69.3%)]. In the United States, 96.4% of strains were identified as the Wuhan-H1 variant D614G; in South Africa, 94.5% of strains were identified as the 20H/501Y.V2 variant (B.1.351 lineage); in Brazil, 69.4% of strains were identified to be a variant of the P.2 lineage and 30.6% of strains were identified as the Wuhan-H1 variant D614G. As of February 12, 2021, SARS-CoV-2 variants from the B1.1.7 or P.1 lineages were not found in any of the sequenced samples.

19 HOW SUPPLIED/STORAGE AND HANDLING

Janssen COVID-19 Vaccine is supplied in a carton of 10 multi-dose vials (NDC 59676-580-15). A maximum of 5 doses can be withdrawn from the multi-dose vial.

The storage and handling information in this Fact Sheet supersedes the storage and handling information on the carton and vial labels.

Storage Prior to First Puncture of the Vaccine Vial

Store unpunctured multi-dose vials of the Janssen COVID-19 Vaccine at 2°C to 8°C (36°F to 46°F) and protect from light. Do not store frozen.

Unpunctured vials of Janssen COVID-19 Vaccine may be stored between 9°C to 25°C (47°F to 77°F) for up to 12 hours.

The Janssen COVID-19 Vaccine is initially stored frozen by the manufacturer, then shipped at 2°C to 8°C (36°F to 46°F). If vaccine is still frozen upon receipt, thaw at 2°C to 8°C (36°F to 46°F). If needed immediately, thaw at room temperature (maximally 25°C/77°F). At room temperature (maximally 25°C/77°F), a carton of 10 vials will take approximately 2 hours to thaw, and an individual vial will take approximately 1 hour to thaw. Do not refreeze once thawed.

Storage After First Puncture of the Vaccine Vial

After the first dose has been withdrawn, hold the vial between 2° to 8°C (36° to 46°F) for up to 6 hours or at room temperature (maximally 25°C/77°F) for up to 2 hours. Discard the vial if vaccine is not used within these times.

20 PATIENT COUNSELING INFORMATION

Advise the recipient or caregiver to read the Fact Sheet for Recipients and Caregivers.

The vaccination provider must include vaccination information in the state/local jurisdiction's Immunization Information System (IIS) or other designated system. Advise recipient or caregiver that more information about IISs can be found at:
https://www.cdc.gov/vaccines/programs/iis/about.html.

21 CONTACT INFORMATION

For general questions or to access the most recent Janssen COVID-19 Vaccine Fact Sheets, scan the QR code using your device, visit www.janssencovid19vaccine.com or call the telephone numbers provided below.

QR Code	Fact Sheets Website	Telephone numbers
	www.janssencovid19vaccine.com.	US Toll Free: 1-800-565-4008 US Toll: 1-908-455-9922

This Full EUA Prescribing Information may have been updated. For the most recent Full EUA Prescribing Information, please see www.janssencovid19vaccine.com.

Manufactured by:
Janssen Biotech, Inc.

Revised: Feb/27/2021

a Janssen Pharmaceutical Company of Johnson & Johnson
Horsham, PA 19044, USA

Revised: Feb/27/2021
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FACT SHEET FOR RECIPIENTS AND CAREGIVERS

EMERGENCY USE AUTHORIZATION (EUA) OF THE JANSSEN COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER

You are being offered the Janssen COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of receiving the Janssen COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Janssen COVID-19 Vaccine may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Janssen COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Janssen COVID-19 Vaccine.

The Janssen COVID-19 Vaccine is administered as a **single dose**, into the muscle.

The Janssen COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please visit www.janssencovid19vaccine.com.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE

WHAT IS COVID-19?

COVID-19 is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Common symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

WHAT IS THE JANSSEN COVID-19 VACCINE?

The Janssen COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Janssen COVID-19 Vaccine to prevent COVID-19 in individuals 18 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE JANSSEN COVID-19 VACCINE?

Tell the vaccination provider about all of your medical conditions, including if you:

- have any allergies,
- have a fever,
- have a bleeding disorder or are on a blood thinner,
- are immunocompromised or are on a medicine that affects your immune system,
- are pregnant or plan to become pregnant,
- are breastfeeding,
- have received another COVID-19 vaccine,

WHO SHOULD GET THE JANSSEN COVID-19 VACCINE?

FDA has authorized the emergency use of the Janssen COVID-19 Vaccine in individuals 18 years of age and older.

WHO SHOULD NOT GET THE JANSSEN COVID-19 VACCINE?

You should not get the Janssen COVID-19 Vaccine if you:

- had a severe allergic reaction to any ingredient of this vaccine.

WHAT ARE THE INGREDIENTS IN THE JANSSEN COVID-19 VACCINE?

The Janssen COVID-19 Vaccine includes the following ingredients: recombinant, replication-incompetent adenovirus type 26 expressing the SARS-CoV-2 spike protein, citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate-80, sodium chloride.

HOW IS THE JANSSEN COVID -19 VACCINE GIVEN?

The Janssen COVID-19 Vaccine will be given to you as an injection into the muscle.

The Janssen COVID-19 Vaccine vaccination schedule is a **single dose**.

HAS THE JANSSEN COVID-19 VACCINE BEEN USED BEFORE?

The Janssen COVID-19 Vaccine is an unapproved vaccine. In an ongoing clinical trial, 21,895 individuals 18 years of age and older have received the Janssen COVID-19 Vaccine.

WHAT ARE THE BENEFITS OF THE JANSSEN COVID-19 VACCINE?

In an ongoing clinical trial, the Janssen COVID-19 Vaccine has been shown to prevent COVID-19 following a single dose. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE JANSSEN COVID-19 VACCINE?

Side effects that have been reported with the Janssen COVID-19 Vaccine include:

- Injection site reactions: pain, redness of the skin and swelling.
- General side effects: headache, feeling very tired, muscle aches, nausea, and fever.

There is a remote chance that the Janssen COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Janssen COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing,
- Swelling of your face and throat,
- A fast heartbeat,
- A bad rash all over your body,
- Dizziness and weakness.

These may not be all the possible side effects of the Janssen COVID-19 Vaccine. Serious and unexpected effects may occur. The Janssen COVID-19 Vaccine is still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?

If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS)**. The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Janssen COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to Janssen Biotech, Inc. at the contact information provided below.

e-mail	Fax number	Telephone numbers
JNJvaccineAE@its.jnj.com	215-293-9955	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

You may also be given an option to enroll in **v-safe**. **V-safe** is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. **V-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. **V-safe** also provides live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET THE JANSSEN COVID-19 VACCINE?

It is your choice to receive or not receive the Janssen COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES JANSSEN COVID-19 VACCINE?

Currently, there is no FDA approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

CAN I RECEIVE THE JANSSEN COVID-19 VACCINE WITH OTHER VACCINES?

There is no information on the use of the Janssen COVID-19 Vaccine with other vaccines.

WHAT IF I AM PREGNANT OR BREASTFEEDING?

If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THE JANSSEN COVID-19 VACCINE GIVE ME COVID-19?

No. The Janssen COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD

When you receive the Janssen COVID-19 Vaccine, you will get a vaccination card to document the name of the vaccine and date of when you received the vaccine.

ADDITIONAL INFORMATION

If you have questions or to access the most recent Janssen COVID-19 Vaccine Fact Sheets, scan the QR code using your device, visit the website or call the telephone numbers provided below.

QR Code	Fact Sheets Website	Telephone numbers
	www.janssencovid19vaccine.com.	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

HOW CAN I LEARN MORE?

- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.

Contact your local or state public health department.

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

WHAT IS THE COUNTERMEASURE INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses for certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?

The United States FDA has made the Janssen COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Janssen COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used during the COVID-19 pandemic.

The EUA for the Janssen COVID-19 Vaccine is in effect for the duration of the COVID-19 declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

Manufactured by:
Janssen Biotech, Inc.
a Janssen Pharmaceutical Company of Johnson & Johnson
Horsham, PA 19044, USA

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For more information, call US Toll Free: 1-800-565-4008, US Toll: (908) 455-9922 or go to www.janssencovid19vaccine.com

Revised: Feb/27/2021

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 02/2021

February 27, 2021

Janssen Biotech, Inc.
Attention: Ms. Ruta Walawalkar
920 Route 202
Raritan, NJ 08869

Dear Ms. Walawalkar:

This letter is in response to a request from Janssen Biotech, Inc. that the Food and Drug Administration (FDA) issue an Emergency Use Authorization (EUA) for emergency use of the Janssen COVID-19 Vaccine for the prevention of Coronavirus Disease 2019 (COVID-19) for individuals 18 years of age and older, as described in the Scope of Authorization (Section II) of this letter, pursuant to Section 564 of the Federal Food, Drug, and Cosmetic Act (the FD&C Act or the Act) (21 U.S.C. 360bbb-3).

On February 4, 2020, pursuant to Section 564(b)(1)(C) of the Act, the Secretary of the Department of Health and Human Services (HHS) determined that there is a public health emergency that has a significant potential to affect national security or the health and security of United States citizens living abroad, and that involves the virus that causes COVID-19.[1] On the basis of such determination, the Secretary of HHS on March 27, 2020, declared that circumstances exist justifying the authorization of emergency use of drugs and biological products during the COVID-19 pandemic, pursuant to Section 564 of the Act, subject to terms of any authorization issued under that section.[2]

The Janssen COVID-19 Vaccine is for active immunization to prevent COVID-19 caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in individuals 18 years of age and older. The vaccine contains a recombinant, replication-incompetent human adenovirus serotype 26 (Ad26) vector, encoding the SARS-CoV-2 viral spike (S) glycoprotein, stabilized in its pre-fusion form. It is an investigational vaccine not licensed for any indication.

FDA reviewed safety and efficacy data from an ongoing phase 3 trial which has enrolled 43,783 participants randomized 1:1 to receive Janssen COVID-19 Vaccine or saline control. The trial has enrolled participants 18 years of age and older. FDA's review has considered the safety and effectiveness data as they relate to the request for emergency use authorization. FDA's review of the available safety data from 43,783 participants 18 years of age and older, who were followed

[1] U.S. Department of Health and Human Services, *Determination of a Public Health Emergency and Declaration that Circumstances Exist Justifying Authorizations Pursuant to Section 564(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 360bbb-3.* February 4, 2020.

[2] U.S. Department of Health and Human Services, *Declaration that Circumstances Exist Justifying Authorizations Pursuant to Section 564(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 360bbb-3*, 85 FR 18250 (April 1, 2020).

for a median duration of eight weeks after receiving the vaccine or placebo, did not identify specific safety concerns that would preclude issuance of an EUA. FDA's analysis of the efficacy data from 39,321 participants 18 years of age and older who were SARS-CoV-2 seronegative or who had an unknown serostatus at baseline show that the vaccine was 66.9% effective (95% confidence interval (CI): 59.0, 73.4) and 66.1% effective (95% CI: 55.0, 74.8) in preventing moderate to severe/critical COVID-19 occurring at least 14 days and at least 28 days after vaccination, respectively. Based on these data, and review of manufacturing information regarding product quality and consistency, it is reasonable to believe that the Janssen COVID-19 Vaccine may be effective. Additionally, it is reasonable to conclude, based on the totality of the scientific evidence available, that the known and potential benefits of the Janssen COVID-19 Vaccine outweigh its known and potential risks, for the prevention of COVID-19 in individuals 18 years of age and older. Finally, on February 26, 2021, the Vaccines and Related Biological Products Advisory Committee voted in agreement with this conclusion.

Having concluded that the criteria for issuance of this authorization under Section 564(c) of the Act are met, I am authorizing the emergency use of the Janssen COVID-19 Vaccine for the prevention of COVID-19, as described in the Scope of Authorization section of this letter (Section II) and subject to the terms of this authorization.

I. Criteria for Issuance of Authorization

I have concluded that the emergency use of the Janssen COVID-19 Vaccine for the prevention of COVID-19 when administered as described in the Scope of Authorization (Section II) meets the criteria for issuance of an authorization under Section 564(c) of the Act, because:

1. SARS-CoV-2 can cause a serious or life-threatening disease or condition, including severe respiratory illness, to humans infected by this virus;

2. Based on the totality of scientific evidence available to FDA, it is reasonable to believe that the Janssen COVID-19 Vaccine may be effective in preventing COVID-19, and that, when used under the conditions described in this authorization, the known and potential benefits of the Janssen COVID-19 Vaccine when used to prevent COVID-19 outweigh its known and potential risks; and

3. There is no adequate, approved, and available alternative to the emergency use of the Janssen COVID-19 Vaccine to prevent COVID-19.[3]

II. Scope of Authorization

I have concluded, pursuant to Section 564(d)(1) of the Act, that the scope of this authorization is limited as follows:

[3] No other criteria of issuance have been prescribed by regulation under Section 564(c)(4) of the Act.

- Janssen Biotech, Inc. will supply the Janssen COVID-19 Vaccine, either directly or through authorized distributor(s)[4] to emergency response stakeholders[5] as directed by the U.S. government, including the Centers for Disease Control and Prevention (CDC) and/or other designee, for use consistent with the terms and conditions of this EUA;
- The Janssen COVID-19 Vaccine covered by this authorization will be administered by vaccination providers[6] and used only to prevent COVID-19 in individuals ages 18 and older; and
- The Janssen COVID-19 Vaccine may be administered by a vaccination provider without an individual prescription for each vaccine recipient.

Product Description

The Janssen COVID-19 Vaccine is supplied as a suspension in multi-dose vials. The Janssen COVID-19 Vaccine does not contain a preservative.

Each 0.5 mL dose of the Janssen COVID-19 Vaccine is formulated to contain $5x10^{10}$ virus particles of the Ad26 vector encoding the S glycoprotein of SARS-CoV-2. Each dose of the Janssen COVID-19 Vaccine also includes the following inactive ingredients 2.19 mg sodium chloride, 0.14 mg citric acid monohydrate, 2.02 mg trisodium citrate dihydrate, 0.16 mg

[4] "Authorized Distributor(s)" are identified by Janssen Biotech, Inc.or, if applicable, by a U.S. government entity, such as the Centers for Disease Control and Prevention (CDC) and/or other designee, as an entity or entities allowed to distribute authorized Janssen COVID-19 Vaccine.

[5] For purposes of this letter, "emergency response stakeholder" refers to a public health agency and its delegates that have legal responsibility and authority for responding to an incident, based on political or geographical boundary lines (e.g., city, county, tribal, territorial, State, or Federal), or functional (e.g., law enforcement or public health range) or sphere of authority to administer, deliver, or distribute vaccine in an emergency situation. In some cases (e.g., depending on a state or local jurisdiction's COVID-19 vaccination response organization and plans), there might be overlapping roles and responsibilities among "emergency response stakeholders" and "vaccination providers" (e.g., if a local health department is administering COVID-19 vaccines; if a pharmacy is acting in an official capacity under the authority of the state health department to administer COVID-19 vaccines). In such cases, it is expected that the conditions of authorization that apply to emergency response stakeholders and vaccination providers will all be met.

[6] For purposes of this letter, "vaccination provider" refers to the facility, organization, or healthcare provider licensed or otherwise authorized by the emergency response stakeholder (e.g., non-physician healthcare professionals, such as nurses and pharmacists pursuant to state law under a standing order issued by the state health officer) to administer or provide vaccination services in accordance with the applicable emergency response stakeholder's official COVID-19 vaccination and emergency response plan(s) and who is enrolled in the CDC COVID-19 Vaccination Program. For purposes of this letter, "healthcare provider" also refers to a person authorized by the U.S. Department of Health and Human Services (e.g., under the PREP Act Declaration for Medical Countermeasures against COVID-19) to administer FDA-authorized COVID-19 vaccine (e.g., qualified pharmacy technicians and State-authorized pharmacy interns acting under the supervision of a qualified pharmacist). See, e.g., HHS. *Fourth Amendment to the Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 and Republication of the Declaration*. 85 FR 79190 (December 9, 2020).

polysorbate-80, 25.5 mg 2-hydroxypropyl-B-cyclodextrin, 2.04 mg ethanol. Each dose may also contain residual amounts of host cell proteins (≤0.15 mcg) and/or host cell DNA (≤3 ng).

The dosing regimen is a single dose of 0.5 mL

The manufacture of the authorized Janssen COVID-19 Vaccine is limited to those facilities identified and agreed upon in Janssen's request for authorization.

The Janssen COVID-19 Vaccine vial label and carton labels are clearly marked for "Emergency Use Authorization." The Janssen COVID-19 Vaccine is authorized to be distributed, stored, further redistributed, and administered by emergency response stakeholders when packaged in the authorized manufacturer packaging (i.e., vials and cartons), despite the fact that the vial and carton labels may not contain information that otherwise would be required under the FD&C Act.

The Janssen COVID-19 Vaccine is authorized for emergency use with the following product-specific information required to be made available to vaccination providers and recipients, respectively (referred to as "authorized labeling"):

- Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers): Emergency Use Authorization (EUA) of the Janssen COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19)

- Fact Sheet for Recipients and Caregivers: Emergency Use Authorization (EUA) of the Janssen COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 18 Years of Age and Older

I have concluded, pursuant to Section 564(d)(2) of the Act, that it is reasonable to believe that the known and potential benefits of the Janssen COVID-19 Vaccine, when used to prevent COVID-19 and used in accordance with this Scope of Authorization (Section II), outweigh its known and potential risks.

I have concluded, pursuant to Section 564(d)(3) of the Act, based on the totality of scientific evidence available to FDA, that it is reasonable to believe that the Janssen COVID-19 Vaccine may be effective in preventing COVID-19 when used in accordance with this Scope of Authorization (Section II), pursuant to Section 564(c)(2)(A) of the Act.

Having reviewed the scientific information available to FDA, including the information supporting the conclusions described in Section I above, I have concluded that the Janssen COVID-19 Vaccine (as described in this Scope of Authorization (Section II)) meets the criteria set forth in Section 564(c) of the Act concerning safety and potential effectiveness.

The emergency use of the Janssen COVID-19 Vaccine under this EUA must be consistent with, and may not exceed, the terms of the Authorization, including the Scope of Authorization (Section II) and the Conditions of Authorization (Section III). Subject to the terms of this EUA and under the circumstances set forth in the Secretary of HHS's determination under Section 564(b)(1)(C)

described above and the Secretary of HHS's corresponding declaration under Section 564(b)(1), the Janssen COVID-19 Vaccine is authorized to prevent COVID-19 in individuals 18 years of age and older as described in the Scope of Authorization (Section II) under this EUA, despite the fact that it does not meet certain requirements otherwise required by applicable federal law.

III. Conditions of Authorization

Pursuant to Section 564 of the Act, I am establishing the following conditions on this authorization:

Janssen Biotech, Inc. and Authorized Distributor(s)

A. Janssen Biotech, Inc. and authorized distributor(s) will ensure that the authorized Janssen COVID-19 Vaccine is distributed, as directed by the U.S. government, including CDC and/or other designee, and the authorized labeling (i.e., Fact Sheets) will be made available to vaccination providers, recipients, and caregivers consistent with the terms of this letter.

B. Janssen Biotech, Inc. and authorized distributor(s) will ensure that appropriate storage and cold chain is maintained until delivered to emergency response stakeholders' receipt sites.

C. Janssen Biotech, Inc. will ensure that the terms of this EUA are made available to all relevant stakeholders (e.g., emergency response stakeholders, authorized distributors, and vaccination providers) involved in distributing or receiving the authorized Janssen COVID-19 Vaccine. Janssen Biotech, Inc. will provide to all relevant stakeholders a copy of this letter of authorization and communicate any subsequent amendments that might be made to this letter of authorization and its authorized labeling.

D. Janssen Biotech, Inc. may develop and disseminate instructional and educational materials (e.g., video regarding vaccine handling, storage/cold-chain management, preparation, disposal) that are consistent with the authorized emergency use of the vaccine as described in the letter of authorization and authorized labeling, without FDA's review and concurrence, when necessary to meet public health needs during an emergency. Any instructional and educational materials that are inconsistent with the authorized labeling are prohibited.

E. Janssen Biotech, Inc. may request changes to this authorization, including to the authorized Fact Sheets for the Janssen COVID-19 Vaccine. Any request for changes to this EUA must be submitted to the Office of Vaccines Research and Review (OVRR)/Center for Biologics Evaluation and Research (CBER). Such changes require appropriate authorization prior to implementation.[7]

F. Janssen Biotech, Inc. will report to Vaccine Adverse Event Reporting System (VAERS):
- Serious adverse events (irrespective of attribution to vaccination);
- Cases of Multisystem Inflammatory Syndrome in adults; and
- Cases of COVID-19 that result in hospitalization or death, that are reported to Janssen Biotech, Inc.

These reports should be submitted to VAERS as soon as possible but no later than 15 calendar days from initial receipt of the information by Janssen Biotech, Inc.

G. Janssen Biotech, Inc. must submit to Investigational New Drug application (IND) number 22657 periodic safety reports at monthly intervals in accordance with a due date agreed upon with the Office of Biostatistics and Epidemiology (OBE)/CBER, beginning after the first full calendar month after authorization. Each periodic safety report is required to contain descriptive information which includes:
- A narrative summary and analysis of adverse events submitted during the reporting interval, including interval and cumulative counts by age groups, special populations (e.g., pregnant women), and adverse events of special interest.
- A narrative summary and analysis of vaccine administration errors, whether or not associated with an adverse event, that were identified since the last reporting interval
- Newly identified safety concerns in the interval; and
- Actions taken since the last report because of adverse experiences (for example, changes made to Healthcare Providers Administering Vaccine (Vaccination Providers) Fact Sheet, changes made to studies or studies initiated).

H. No changes will be implemented to the description of the product, manufacturing process, facilities, or equipment without notification to and concurrence by the Agency.

I. All manufacturing facilities will comply with Current Good Manufacturing Practice requirements.

[7] The following types of revisions may be authorized without reissuing this letter: (1) changes to the authorized labeling; (2) non-substantive editorial corrections to this letter; (3) new types of authorized labeling, including new fact sheets; (4) new carton/container labels; (5) expiration dating extensions; (6) changes to manufacturing processes, including tests or other authorized components of manufacturing; (7) new conditions of authorization to require data collection or study. All changes to the authorization require review and concurrence from OVRR. For changes to the authorization, including the authorized labeling, of the type listed in (3), (6), or (7), review and concurrence is also required from the Preparedness and Response Team (PREP)/Office of the Center Director (OD)/CBER and the Office of Counterterrorism and Emerging Threats/Office of the Chief Scientist.

J. Janssen Biotech, Inc. will submit to the EUA file Certificates of Analysis (CoA) for each drug product lot at least 48 hours prior to vaccine distribution. The CoA will include the established specifications and specific results for each quality control test performed on the final drug product lot.

K. Janssen Biotech, Inc. will submit to the EUA file quarterly manufacturing reports that include a listing of all Drug Substance and Drug Product lots produced after issuance of this authorization. This report must include lot number, manufacturing site, date of manufacture, and lot disposition, including those lots that were quarantined for investigation or those lots that were rejected. Information on the reasons for lot quarantine or rejection must be included in the report. The first report is due June 1, 2021.

L. Janssen Biotech, Inc. and authorized distributor(s) will maintain records regarding release of Janssen COVID-19 Vaccine for distribution (i.e., lot numbers, quantity, release date).

M. Janssen Biotech, Inc. and authorized distributor(s) will make available to FDA upon request any records maintained in connection with this EUA.

N. Janssen Biotech, Inc. will conduct post-authorization observational studies to evaluate the association between Janssen COVID-19 Vaccine and a pre-specified list of adverse events of special interest, along with deaths and hospitalizations, and severe COVID-19. The study population should include individuals administered the authorized Janssen COVID-19 Vaccine under this EUA in the general U.S. population (18 years of age and older), populations of interest such as healthcare workers, pregnant women, immunocompromised individuals, subpopulations with specific comorbidities. The studies should be conducted in large scale databases with an active comparator. Janssen Biotech, Inc. will provide protocols and status update reports to the IND 22657 with agreed-upon study designs and milestone dates.

Emergency Response Stakeholders

O. Emergency response stakeholders will identify vaccination sites to receive authorized Janssen COVID-19 Vaccine and ensure its distribution and administration, consistent with the terms of this letter and CDC's COVID-19 Vaccination Program.

P. Emergency response stakeholders will ensure that vaccination providers within their jurisdictions are aware of this letter of authorization, and the terms herein and any subsequent amendments that might be made to the letter of authorization, instruct them about the means through which they are to obtain and administer the vaccine under the EUA, and ensure that the authorized labeling [i.e., Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers) and Fact Sheet for Recipients and Caregivers] is made available to vaccination providers through appropriate means (e.g., e-mail, website).

Q. Emergency response stakeholders receiving authorized Janssen COVID-19 Vaccine will ensure that appropriate storage and cold chain is maintained.

Vaccination Providers

R. Vaccination providers will administer the vaccine in accordance with the authorization and will participate and comply with the terms and training required by CDC's COVID-19 Vaccination Program.

S. Vaccination providers will provide the Fact Sheet for Recipients and Caregivers to each individual receiving vaccination.

T. Vaccination providers administering the Janssen COVID-19 Vaccine must report the following information associated with the administration of the Janssen COVID-19 Vaccine of which they become aware to VAERS in accordance with the Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers):
   - Vaccine administration errors whether or not associated with an adverse event
   - Serious adverse events (irrespective of attribution to vaccination)
   - Cases of Multisystem Inflammatory Syndrome in adults
   - Cases of COVID-19 that result in hospitalization or death

   Complete and submit reports to VAERS online at https://vaers.hhs.gov/reportevent.html. The VAERS reports should include the words "Janssen COVID-19 Vaccine EUA" in the description section of the report. More information is available at vaers.hhs.gov or by calling 1-800-822-7967. To the extent feasible, report to Janssen Biotech, Inc. by contacting 1-800-565-4008 or by providing a copy of the VAERS form to Janssen Biotech, Inc.; Fax: 215-293-9955, or by email JNJvaccineAE@its.jnj.com.

U. Vaccination providers will conduct any follow-up requested by the U.S. government, including CDC, FDA, or other designee, regarding adverse events to the extent feasible given the emergency circumstances.

V. Vaccination providers will monitor and comply with CDC and/or emergency response stakeholder vaccine management requirements (e.g., requirements concerning obtaining, tracking, and handling vaccine) and with requirements concerning reporting of vaccine administration data to CDC.

W. Vaccination providers will ensure that any records associated with this EUA are maintained until notified by FDA. Such records will be made available to CDC, and FDA for inspection upon request.

Conditions Related to Printed Matter, Advertising, and Promotion

X. All descriptive printed matter, advertising, and promotional material, relating to the use of the Janssen COVID-19 Vaccine shall be consistent with the authorized labeling, as well as the terms set forth in this EUA, and meet the requirements set forth in section 502(a) and (n) of the FD&C Act and FDA implementing regulations.

Y. All descriptive printed matter, advertising, and promotional material relating to the use of the Janssen COVID-19 Vaccine clearly and conspicuously shall state that:
   - This product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and
   - The emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

IV. Duration of Authorization

This EUA will be effective until the declaration that circumstances exist justifying the authorization of the emergency use of drugs and biological products during the COVID-19 pandemic is terminated under Section 564(b)(2) of the Act or the EUA is revoked under Section 564(g) of the Act.

Sincerely,

_____

RADM Denise M. Hinton
Chief Scientist
Food and Drug Administration

Enclosures

COVID-19 Vaccine Equity Subcommittees
Risk Assessment & Recommendations (R&R) Template

Operations to Maximize Vaccine Access & Use for Most at Risk Populations

Population(s) At Risk For Inequity	**Barrier or Challenge to Access or Use Description** ***Next Step: Include evidence reference if available***	**Recommendation, Solution or Suggestion** ***Next Step: Include evidence reference if available***	**Priority Ranking** ***Next Step***
		Overarching recommendations: • When these recommendations (including all of the other subgroups) are submitted we need a process for tracking • We need a central location or understanding who do we send additional suggestions, sites, etc. beyond the equity committee	
immigrant populations without status, homeless, African American community, underserved communities, foster care youth, low digital and language literacy populations, formerly incarcerated, uninsured/underinsured, (but really so many)	Need more vaccinators in the community that represent the community, are well primed to reach those who are hardest to reach and may be missed through traditional strategies. They are also well-positioned to support community outreach and education. Having more community vaccinators also • Provides skills that can lead to career opportunities. • strengthens our healthcare system that currently has a limited workforce getting even worse. • Ensures we have vaccinators for possible future pandemics.	Need a clear understanding of how many vaccinators are already supporting the vaccine roll out and what are the capacity needs. Leverage existing community clinics/FQHCs and other medically trained professionals. Even medical/nursing students who can also receive residency hours. The county should advance a vaccine training and certification program for community groups/non-medical professionals. Work with existing training facilities such as CDU that is already training allied health professionals. These educational institutions could receive a contract to support this effort. *Need to provide the following details:* • Timeframe - should be prepping for this now (especially CDU - talk to Dr. Vargas & Dr. Flores) • # Goal (may depend on the vaccine #) • Recommendations around logistics and supports (Need to understand the prerequisites) Additional recommendations/things to consider. • Create a vetting program to avoid any vaccination misuse. • Work with groups that are already testing or providing other vaccines such as the HIV mobile testing units	

		For those who can support with outreach, they need to be able to have the most updated information to share with the community.	

same as above	Need to ensure that there are enough locations offering vaccines in the community. These locations need to be accessible and welcoming.	**DATA REQUEST:** the committee wants to understand the current vaccination site plan. We need an overlay of the current/anticipated MPODS and heat maps (using data that Dr. Mays has collected) so that we can understand the gaps and provide more strategic recommendations. However, the following are some possible recommendations:
		
		• The county needs to Identify vaccination sites in low-income/diverse communities and hard to reach places throughout the county. This needs to be determined soon so that we are ready not just for the final phase but to support Phase 1b and 1C.
		• As we look at the frontline workers, we need to be able to a target plan that addresses the intersection of workers, crowded housing, and other critical disparity issues.
		• The plan should leverage existing processes/plans like the MPods (which is why we need the data referenced above) and other programs such as
		  ○ mobile units (currently being used for testing, others providing support and testing for other health issues such as homeless, HIV testing, etc). Also, need to consider funding recommendations to support the use of these units in a variety of sites like grocery stores
		  ○ American Red Cross blood drive infrastructure
		• Sites should be near transportation hubs, parking access, language access, disability access. One of the committee members found this list from other states:
		
		Site requirements/preferences include:
		• 5-6k sq ft in one large space or multiple divided spaces
		• Proximity to public transportation
		• Parking is a preference, but not required
		• Located in hardest-hit areas and/or underserved neighborhoods
		• Space for storage and staff break room
		• ADA compliant (if the site meets other requirements, the City can provide needed equipment for compliance, ramps, etc.)
		• Ability to connect to power (standard electrical)
		• Operational HVAC system (no additional filtration requirements)
		• 24/7 access is a preference, but not required	

		The City will provide tables, chairs, room dividers, IT equipment, and other necessities for a "basic flu shot clinic set-up". ● Should also include water stations, restrooms, shaded seating areas, ● Plans for holding spots if they are in line, or can we think of a ticketing or call system. ● *Check with Commissioner Mike Davis (public works - the city of LA) on how we can improve the systems and logistics problems* ● The plan must include financial and non-financial support to assist organizations with readiness, creating collaborations, trainings and more. Provide support and education on how to become a certified vaccination; need to get this moving in the next month so there is time. http://publichealth.lacounty.gov/acd/ncorona2019/vaccine/ http://cairweb.org/enroll-now/ http://cairweb.org/lcrs/ ● There needs to be a transportation plan that includes free passes to and from vaccination sites. This should include working with Metro, LADOT, app-based services, Access services and other public/private transportation services. ● We need to work with organizations that serve at each of the tiers and are considered trusted sources: Potential sites include but is not limited to: ○ Syringe location sites ○ LAUSD, Community Colleges and other educational sites ○ food banks, ○ Boys and Girls Clubs, ○ churches ○ worker organizations ○ community based/service organizations	
same as above	There is so much confusion about the tiers, especially with the constant changes and the variances across the state and the nation. Ensuring people understand the subphases and tiers will limit the number of people who	**IMMEDIATE RECOMMENDATION** – as a group we need a better definition of who qualifies within the initial tiers. This will help us to provide better overall recommendations for how to encourage more people into the first Phase and then who will be left in Phase 2. However, here are some initial recommendations:	

	will need to be vaccinated in Phase 2.	Provide broad education and clarification about the tiers, who qualifies within each, and how the process will go. • Explain the dissemination by tier and when they move to the next tier. • Need a very succinct document that can be understood by multiple communities. • Be clear about social service agencies that could be seen as essential work and whether the staff are eligible for the initial phase 1 tiers or not. *This needs to be a priority of the communication committee* As part of the listening sessions, there need to be questioned on how the community needs to hear the information to reduce confusion. Make sure that the outreach is broad to diverse populations and can also leverage the existing communications channels and organizations that serve these populations. Richard Rideout - should be tapped around communications strategies For prioritization, workers need to be able to also get in their place of employment however, it should be clear if they live in another county or health district (i.e. Long Beach/Pasadena) that they can go to those locations so that the vaccine batch can be spread.	
same as above	there is a need to address the unique decisions made at hospitals or for the distribution of leftovers. These may not seem as concerns but as individuals hear about shifts in who is served in the initial phase it can potentially create mixed messages and misinformation that could cause further vaccine hesitancy.	• Need better protocols/structure for the initial phase to minimize any later division and confusion or a better explanation of what happens when there are leftovers. Should consider going to the next tier so we are moving in the prioritized fashion. • Reporting – any challenges or changes need to go to DHS so that decisions to address can be made in an orderly fashion. • Create a scheduling system to reduce waiting times. • Create a waitlist within the tiers so that an entity could identify others within that tier in need of vaccines vs just searching for where to give out vaccines.	

same as above	While uninsured rates have been significantly lowered since the launch of the Affordable Care Act there still remains 10% or over 1 million still do not have coverage. Additionally, over 17% of LA County residents are without a usual source of care (even among those who have health coverage).	• Connect people with health coverage and/or a provider.
		• work with existing healthcare navigators (within clinics, community groups, health plans, and other groups)
		  ○ LA County Public Health currently funds local groups across the county http://publichealth.lacounty.gov/mch/choi/choi.htm
		  ○ Additionally, the Community Clinic Association of Los Angeles County has a broad network and regularly bring together the	

	While the vaccine does not require health insurance, many will need to connect with a provider for questions, to address safety concerns, and deal with any health issues as a result of the vaccine should they arise.	healthcare enrollers and navigators that can be easily tapped https://ccalac.org/	

Los Angeles County Department of Public Health

COVID-19 Vaccination Strategy

Phase 1B, Tier 1

Updated 2.25.21

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Overview

As with all aspects of the COVID vaccine rollout, the federal and state Phase 1b priority groups and rollout strategy is evolving. This is a dynamic document that will be updated as policies, dose allocation strategies, and methods of administration change.

Priority Groups

The Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) made recommendations on groups of people who should be prioritized to receive COVID-19 vaccine while supply is limited. The state of California created a Priority Population Workgroup to help think through the epidemiology of the COVID-19 pandemic and refine the CDC recommendations specific to the local context.

During this process four main criteria were used to evaluate the sequence of the allocation of vaccine for groups of essential workers. They are listed below but not in a ranked order.

- Societal impact of job
- Equity
- Impact on economy
- Occupational exposure

Additional considerations included:

- Geography – Prioritizing regions and neighborhoods that have been disproportionately impacted
- Death/Adverse health outcomes risk – Not just consideration of risk of spread, but also likelihood of death or severe health outcomes
- Risk of community spread – potential vectors for community spread

After review and evaluation of the mortality and morbidity data as well as the outlined criteria, the following groups are determined to be in Phase 1b, tier 1:

- Persons 65 years and older
- Those at risk of exposure at work in the following sectors (not in ranked order):
    - Emergency Services/First Responders
    - Food and Agriculture workers
    - Education and Daycare

Table 1. Estimating Phase 1b, Tier 1 Groups

Phase 1B		
Tier 1	**Estimated Population**	**Source**
Persons aged > = 65 years old	1,449,926	CDPH LHJ Estimates
Emergency Services/First Responders		
Police/law enforcement officers	45,934	EMS work w/jurisdictional law enforcement
National Security	2,861	CDPH LHJ estimates (QCEW Data)
Corrections officers and workers	4,746	4746 juvenile facilities (US Census, 2010 (Table PCT20)
Courts/Legal Counsel & Prosecution	4,159	LA County DHR reported numbers
Campus and school police	1,048	School/Police Chief Reported numbers
Rehabilitation and Re-entry	1,923	Partner estimate
Federal law enforcement agencies	5,467	Agency reported numbers
Security staff to maintain building access control and physical security measures	40,713	US Bureau of Labor Statistics, Occupational Employment Statistics, May 2019
DCFS, APS (workers physically responding to abuse and neglect of children, elderly and dependent adults)	9,100	DCFS webpage, Jan 2021
TOTAL	**115,951**	
Food and Agriculture		
Food service workers	323,600	BLS Occupational Estimates, 2019; extrapolated for LA County (25.32% of CA) + informal food service workers
Food manufacturing	37,900	CDPH LHJ estimate (QCEW Data)
Grocery store workers	82,692	US Bureau of Labor Statistics, June 2020 Estimates for LA County; NAICS 4451
Animal agriculture workers including those involved in Vet health	4500	US Bureau of Labor Statistics, Occupational Employment Statistics, May 2019
Farm workers	32,000	UFW foundation data based on 2015 census by UC Davis
Veterinarians	8,190	CDPH LHJ estimate (QCEW Data)
Food and Agriculture-associated Port and transportation workers	14,000	Port of LA and Port of LB CEOs
TOTAL	**502,882**	
Education and Daycare		
Public Schools (K-12)	180,000	LACOE
Daycare and ECE workers	100,175	LAC unions, partners, daycare and childcare associations

Independent Schools	22,908	California Department of Education https://www.cde.ca.gov/ds/si/ps/index.asp
Contracted Educational Support Staff	98,000	Discussions with education partners
Charter Schools	20,000	California Charter School Association (LA)
Junior Colleges	26,200	CDPH LHJ estimate (QCEW Data)
Colleges & Universities	98,944	CDPH LHJ estimate (QCEW Data)
TOTAL	**546,227**	
GRAND TOTAL	**2,614,986**	

Limited Vaccine Supply Necessitating Equitable Prioritization

On January 25, 2021, Governor Newsom announced the three frontline sectors of Education and Childcare, Food and Agriculture, and Emergency Services should be vaccinated in the same tier as the already initiated priority population of those individuals 65 years and older. With constrained vaccine supply and uncertainty on timing for increased production and new vaccine Emergency Use Authorization, a realistic and carefully developed plan for expanding vaccination to these additional sectors is needed.

The initial priority remained focused on ensuring our most vulnerable residents, those 65 years and older, are vaccinated. The data support this focus as the death rate due to COVID-19 among those 65 years and older in Los Angeles County (LAC) is approximately 502 per 100,000 population; more than 5 times that of the next highest death rate, among people 50-64 years old (Appendix table 1). LAC rates of hospitalization associated with COVID are highest among 80+ followed by people 65-79 years old, and these two age groups make up the majority of hospitalizations in LAC (Appendix figure 1).

It is important to note that people aged 65 and older in LAC are not equal in their risk of infection, being hospitalized, and dying from COVID-19. We consistently observe a significantly higher past 14-day, daily age-adjusted case rate among Hispanic/Latino residents of LAC than any other group since May 2020, with the second highest past 14-day daily age-adjusted case rate among Black LAC residents since December 2020 (Appendix figure 2). This is a very similar trend, unfortunately, in the Hispanic/Latino and Black communities in the past 14-day cumulative age-adjusted death rates in LAC (Appendix figure 3).

In addition, the weekly age-adjusted rate of hospitalization among Hispanic/Latino residents is the highest at approximately 80 per 100,000, almost double that of the next highest rate of hospitalizations seen among Black residents of LAC (Appendix figure 4). The hospitalization disparity among traditional marginalized communities of color is even more pronounced when we look at the age-adjusted cumulative hospitalization rates by race/ethnicity (Appendix table 2).

Timeframe

Using the latest information from the federal government and assumptions that our weekly allocation will remain relatively constant or slightly increase during February, and knowing that our percentage of second doses will increase to cover those given a first dose, it is likely to take until the third week in March to vaccinate our 65+ population (table 2). The additional sectors becoming eligible on March 1 and Governor Newsom's announcement of persons with underlying co-morbidities becoming eligible on

March 15, will of course influence the numbers needed to vaccinate and how quickly we move through these populations. The FDA recently reviewed the Johnson & Johnson COVID vaccine Phase III clinical trial data. This approximation below includes an assumption J&J will receive an Emergency Use Authorization and begin shipping during the first week in March.

Table 2. Allocation Projections to Vaccinate 65+ (excluding Multi-County Entities)

	LAC LHJ Vaccine Dose Allocation				65+ Pop = 1,449,926 - 25% decline = 1087445		
Delivery Week	**Pfizer**	**Moderna**	**J&J**	**Total allocated to LAC**	**% second doses**	**# new 65+ vaccinated**	**# of 65+ still needing vaccination**
2/1/2021	45,825	133,700		179,525	60%	71810	1015635
2/8/2021	93,600	122,800		216,400	70%	64920	950715
2/15/2021	91,650	142,150		233,800	75%	58450	892265
2/22/2021	101,985	116,300		218,285	65%	76400	815865
3/1/2021	124,020	145,900	20,000	289,920	45%	159456	656409
3/8/2021	144,000	148,000	40,000	332,000	50%	166000	490409
3/15/2021	155,000	150,000	65,000	370,000	50%	185000	305409
3/22/2021	165,000	175,000	80,000	420,000	45%	231000	74409
3/29/2021	200,000	286,650	95,000	581,650	40%	348990	-274581
Total	**1,121,080**	**1,420,500**	**300,000**	**2,841,580**		**1302900**	

Phase 1B Tier 1

Residents 65 Years and Older

LAC Department of Public Heath (DPH) is working to understand the needs of the various sub-groups of the 65+ adult population in LAC and ensure there is equitable access to vaccine. The State of California (CA) recently announced a shift toward using a more centralized healthcare system approach utilizing a third-party administrator (TPA) to rapidly vaccinate this population.

In LAC, it is estimated that 64% of the 1,443,186 individuals in the 65+ group have public health insurance, 8.8% have private insurance, 26.2% have a combination of both public and private, and 1% do not have insurance at all (Appendix table 3). In LA County, there are 1.48 million Medicare beneficiaries. Working with and through the healthcare systems to immunize those with insurance and a medical home will be essential as a part of the more rapid immunization rollout, and complemented by smaller, community clinics and other mobile strategies to meet those with the greatest needs where they are.

Relationships have been forged with the Accountable Care Organizations/Managed Care Organizations (ACO/MCO) and health plans such as L.A. Care, HealthNet, Kaiser Permanente, Optum, CareMore, SCAN, Adventist Health, Anthem Blue Cross/Blue Shield, and other partners such as the LAC Department of

Health Services, to support their efforts to vaccinate their 65+ empaneled patients, including developing strategies to reach their patients at highest risk for adverse outcomes of COVID.

Concerns of inequitable access to vaccines for sub-groups within the 65+ age group include persons experiencing homelessness, homebound individuals due to medical/psychiatric conditions, those living in multi-generational housing, those that lack insurance including undocumented individuals, those with limited or no access to technology, those that lack transportation options, those with language barriers, and racial and ethnic groups disproportionately affected by COVID-19.

To address these concerns, various stakeholders have been engaged to help LAC DPH implement a strategy that utilizes already established networks and identifies new partners and innovative methods of reaching the 65+ population including but not limited to:

- Area Agencies on Aging
    - LAC Department of Workforce Development, Aging, and Community Services, which serves LA County minus LA City
    - Los Angeles City Dept of Aging, which serves LA City
    - Both include the network of Senior Centers, home delivery meal programs etc.
- Health plans known to cover underserved 65+ populations:
    - My Health Los Angeles (MHLA)
    - SCAN
- Los Angeles Alliance for Community Health and Aging (LAACHA) and Office of Women's Health (OWH), which is an alliance of many community-based organizations targeting the elderly
- Community Based Organizations:
    - WISE & Healthy Aging has helped link us to affordable senior housing sites and home delivery meal programs.
    - MSSP (Multipurpose Senior Services Program): waiver program for Medi-Cal eligible 65+ who would be nursing home eligible as a target for mobile vaccination. There are 6 agencies serving 6 geographical areas in LA County: Partners in Care Foundation, Huntington Hospital, AltaMed, SCAN, Jewish Family Services, Human Services Association
- Rideshare and transportation services
    - Using Uber Health to provide round-trip transportation to vaccination PODs
    - Ongoing discussions with Lyft for similar rides to vaccination sites
    - Coordination with LA Mayor's Office, Metro, and other city's transit lines to identify routes that access vaccination sites and ensure free rides for vaccination
    - Coordination with TAP to load 2 free rides for seniors for vaccination
- LAC Department of Mental Health to help link to affordable senior housing
- LAC Department of Health Services
- LAC Department of Public Social Services (DPSS)
    a. In-Home Supportive Services (IHSS) and Personal Assistance Services Council
    b. Great Plates Program/CalFresh/EBT, serve elderly (defined as 60+)
- American Association of Retired Persons (AARP)
- Housing for Health

- Federally Qualified Health Centers are best situated in their communities to reach those underinsured and uninsured
    a. *Clinica Romero*: collaborating with *promotoras* to connect with the community, providing transportation (own clinic shuttle and Uber Health), working with consulates for vaccine outreach
- Los Angeles Homeless Service Authority (LAHSA)
- Los Angeles County Vaccine Workgroup (includes community-based organizations, essential worker groups, emergency management, health organizations, pharmacies, school districts, universities, funders, and county and city members)

Strategies to Reach the Most Vulnerable 65+ Population

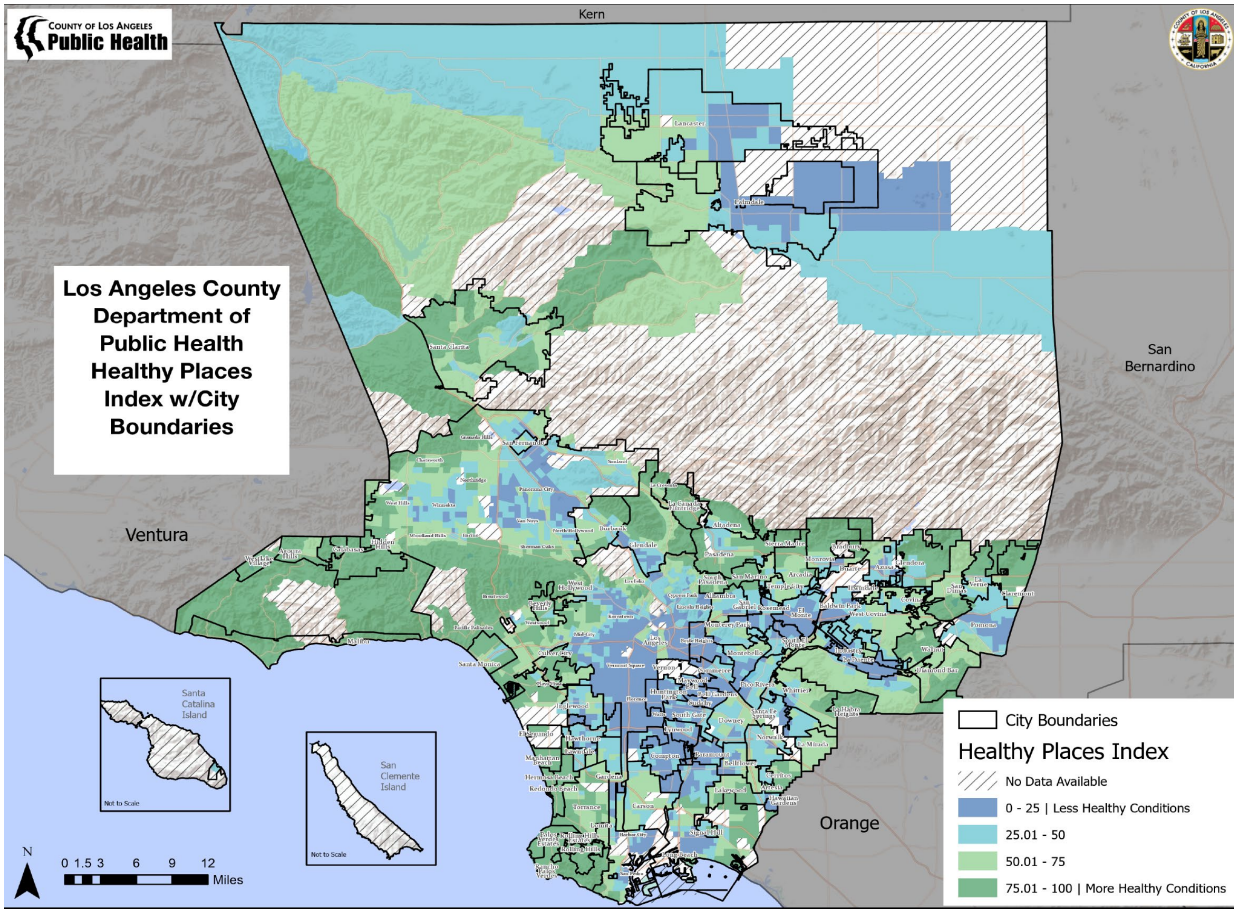
DPH is utilizing a multipronged approach to reach the most vulnerable 65+ population that includes identifying sub-populations with the least amount of access and the greatest need through mapping; working with community and faith-based partners, utilizing established networks that engage with this population; and working with our other Phase 1b, Tier 1 sector partners to have them identify their 65+ populations across education, emergency services, and food and agriculture and begin to stand up their models now in order to easily scale up once more vaccine becomes available. DPH is working with partners LA City, Curative and CARE ambulance and is in discussion with other partners to increase mobile vaccination units dispersed to those communities with the highest need and highest density of 65+; working with clinical partners to vaccinate 65+ with underlying medical conditions such as dialysis patients at their dialysis clinics; and collaborating with partners, such as In-home Supportive Services and other home care agencies that support the homebound, to encourage caregiver and client to be vaccinated together. In addition, we have been working to expand our network of registered pharmacy partners to hundreds of retail chain and neighborhood pharmacies that reach deep into communities.

Operationally, to address potential barriers in signing up for vaccination appointments, residents with disabilities or without computer access may call a toll-free phone number 7 days a week for assistance.

Mapping Data to Identify Areas with the Least Access and Greatest Need

Mapping is a strategy to visualize variability across a geographic region. DPH mapped a variety of data sources to better understand the geographic representation of the high density of 65+ populations with the least amount of access and the greatest need. The Healthy Places Index (HPI) is a social vulnerability index that combines 25 community characteristics into a single indexed HPI Score. HPI scores for each census tract can be compared across all of LAC and even California.

Map 1. Healthy Places Index and City Boundaries based on Census Tract, Los Angeles County

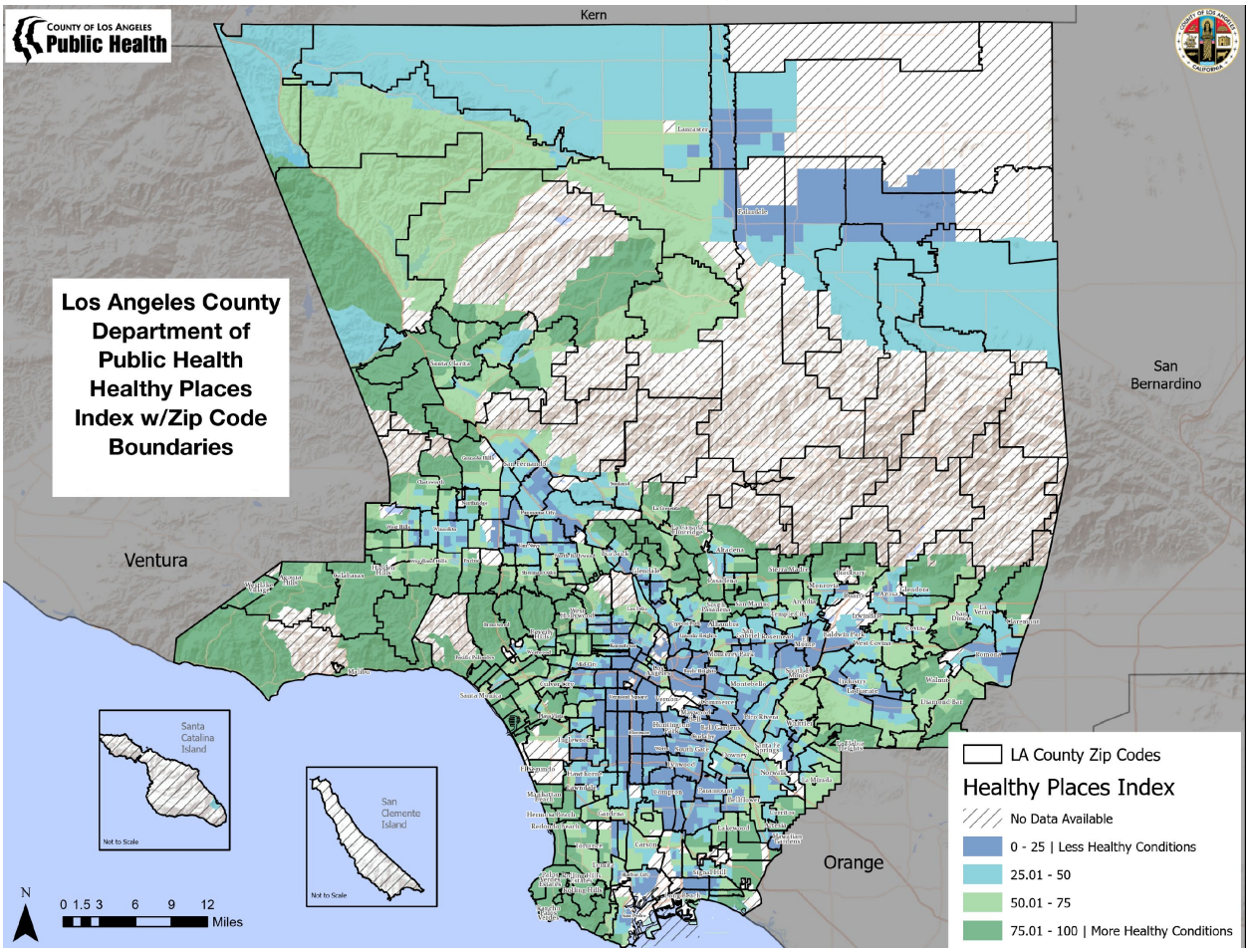


It serves to paint an overall picture of health and well-being in each neighborhood. The tool also allows multiple census tracts to be pooled together into a single score, allowing the comparison of zip codes, project areas, and other geographies.

In the map above (map 1), the census tract HPI scores are ranked and quartiles are created to visualize the scale of social vulnerability. The HPI for LAC shows great variability; the light purple areas represent communities that are most vulnerable/have less healthy conditions with a gradient to green, indicating the healthiest/least vulnerable communities. City boundaries are overlaid on the HPI base layer.

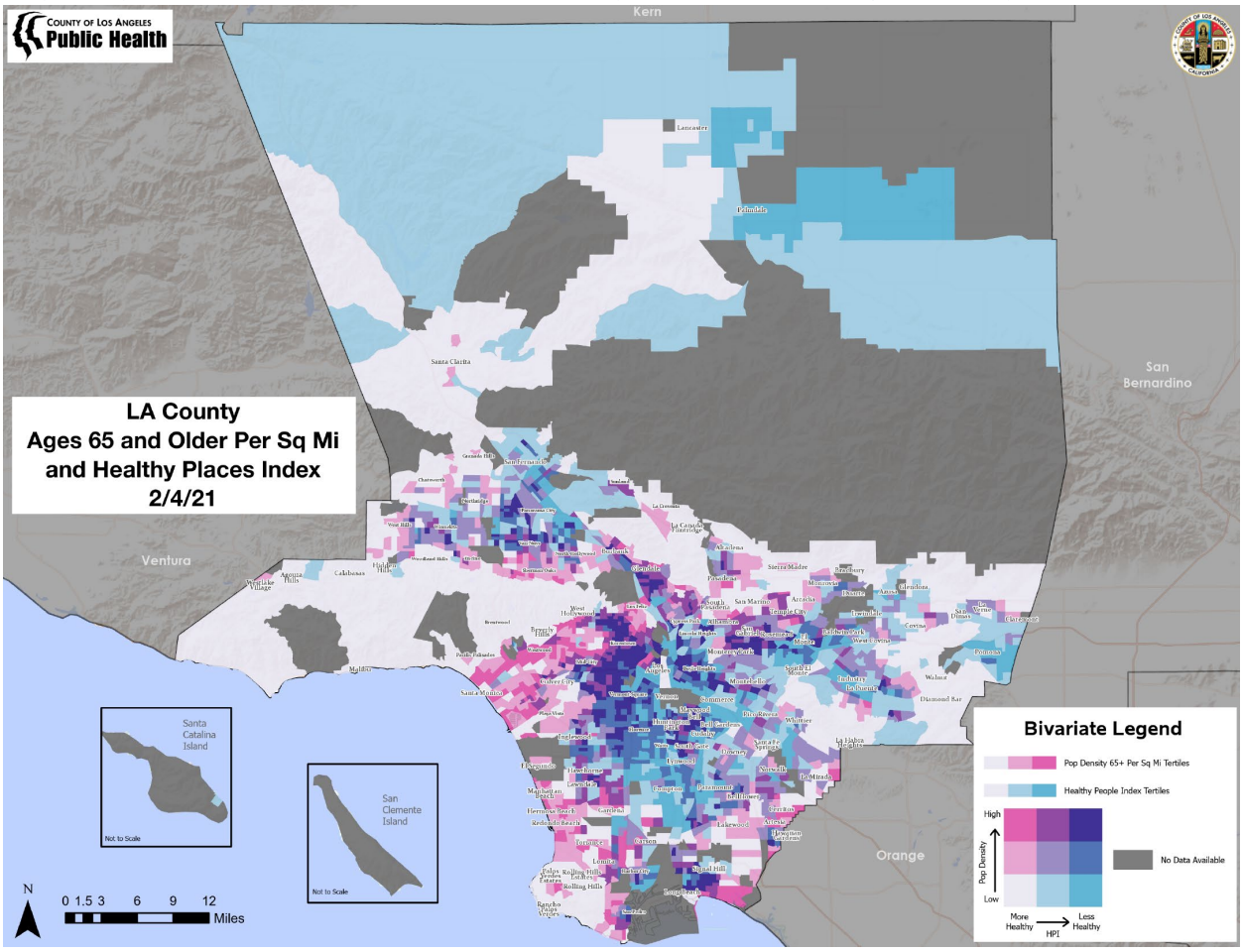
In terms of operationalizing the HPI, we see that some cities are too large and vary greatly within their boundaries, so we look to zip code (map 2). Zip codes do not map perfectly to census tract boundaries as you can see in Map 2, but they provide a way to operationalize interventions to publicly recognized units and liken the HPI to a tangible set of guiding principles for vaccine implementation.

Map 2. Healthy Places Index and Zip Code Boundaries, Los Angeles County



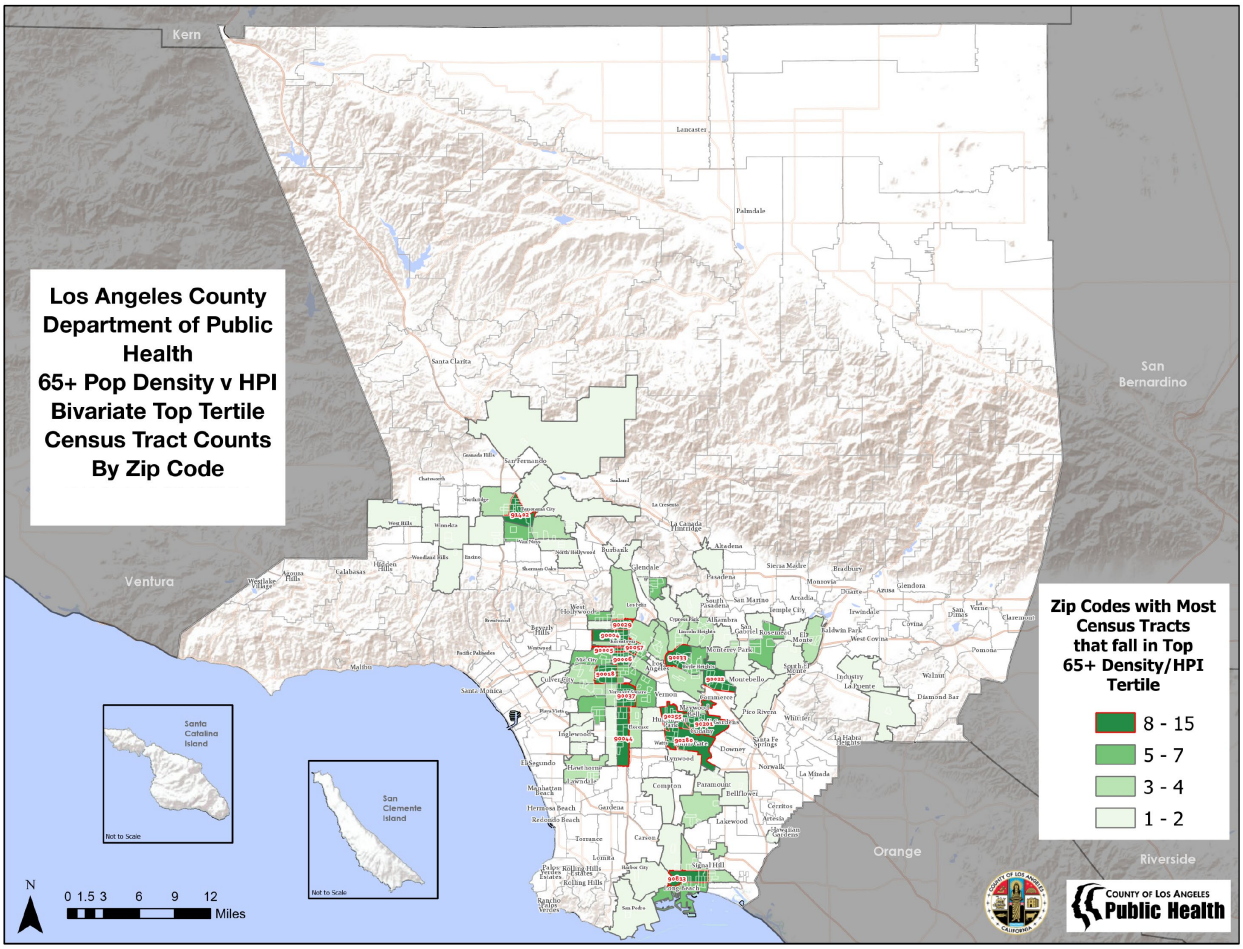
The darkest purple areas are the communities with the greatest needs. Presenting data by geographic units that have different underlying age distributions could be misleading, so we also cross-referenced the HPI scores for each census tract with the population density of 65+ per square mile (map 3). We can see the purple areas are the geographic regions that both are the most socially vulnerable and have the highest density of 65+ population in LAC. This tells us where we should reach out to community groups serving the 65+ in those areas, set up additional clinical vaccination sites, and work to understand the mobile vaccination needs as well as the education and information needs.

Map 3. Population Density of 65+ overlaid on Healthy Places Index, Los Angeles County



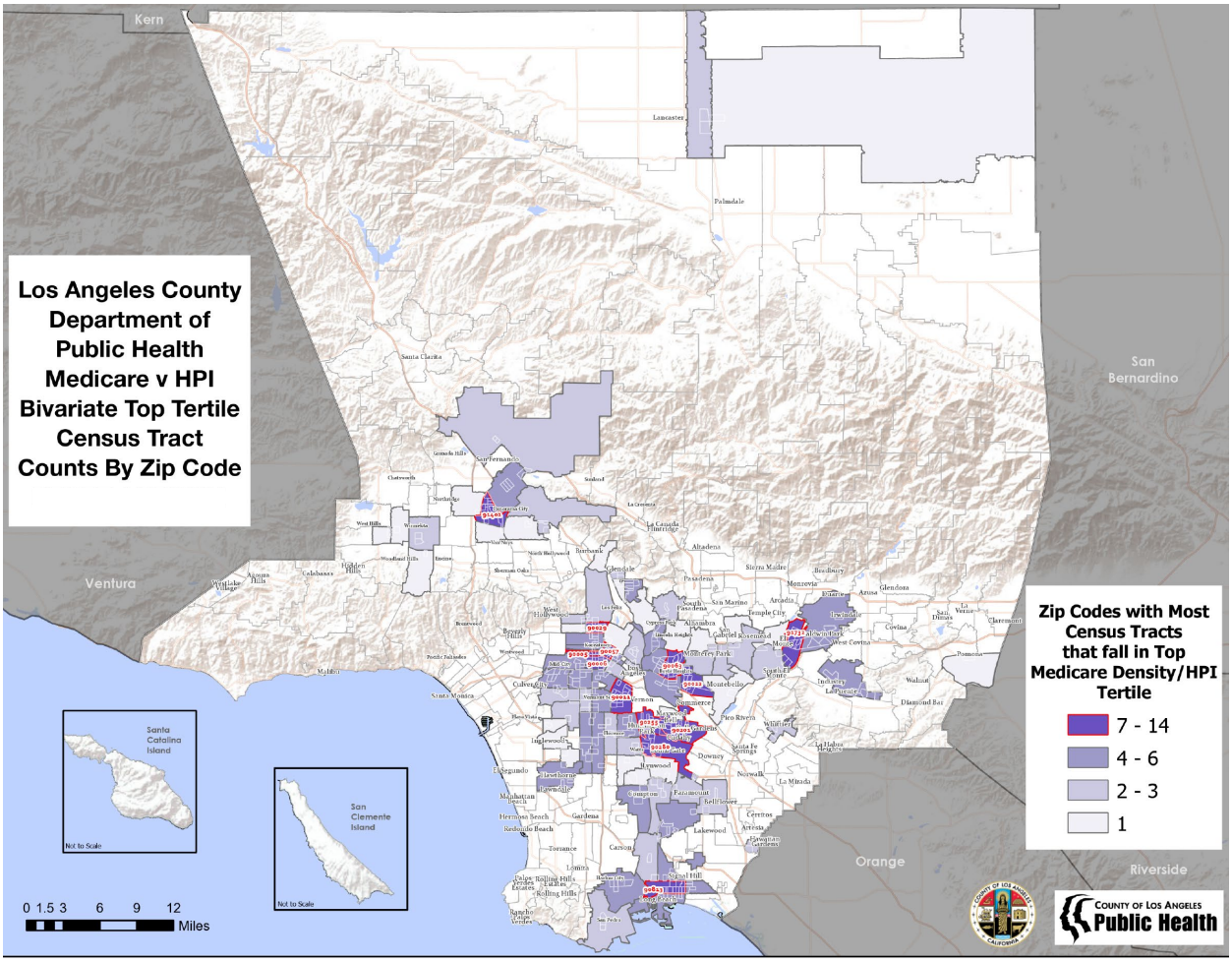
To operationalize this map to identify the most vulnerable, we mapped the census tracts with the highest density of 65+ and the HPI scores to zip codes (map 4). The darker green areas represent the zip codes with the greatest number of census tracts that have both the most vulnerable population by HPI and the greatest density of 65+. This allows us to target these zip codes (90004, 90005, 90006, 90018, 90022, 90029, 90033, 90037, 90044, 90057, 90201, 90255, 90280, 90813, 91402) for community-based and localized approaches to vaccination, including standing up mobile vaccine teams, targeted kiosks, pop-ups, and where we need to concentrate our community-based organization (CBO) engagement and coordination. We can also work to prioritize vaccination for the 65+ age group in these zip codes at FQHCs, pharmacies, and other points of dispensing.

Map 4. Zip codes with the most census tracts with high density population of 65+ and low Healthy Places Index score, Los Angeles County



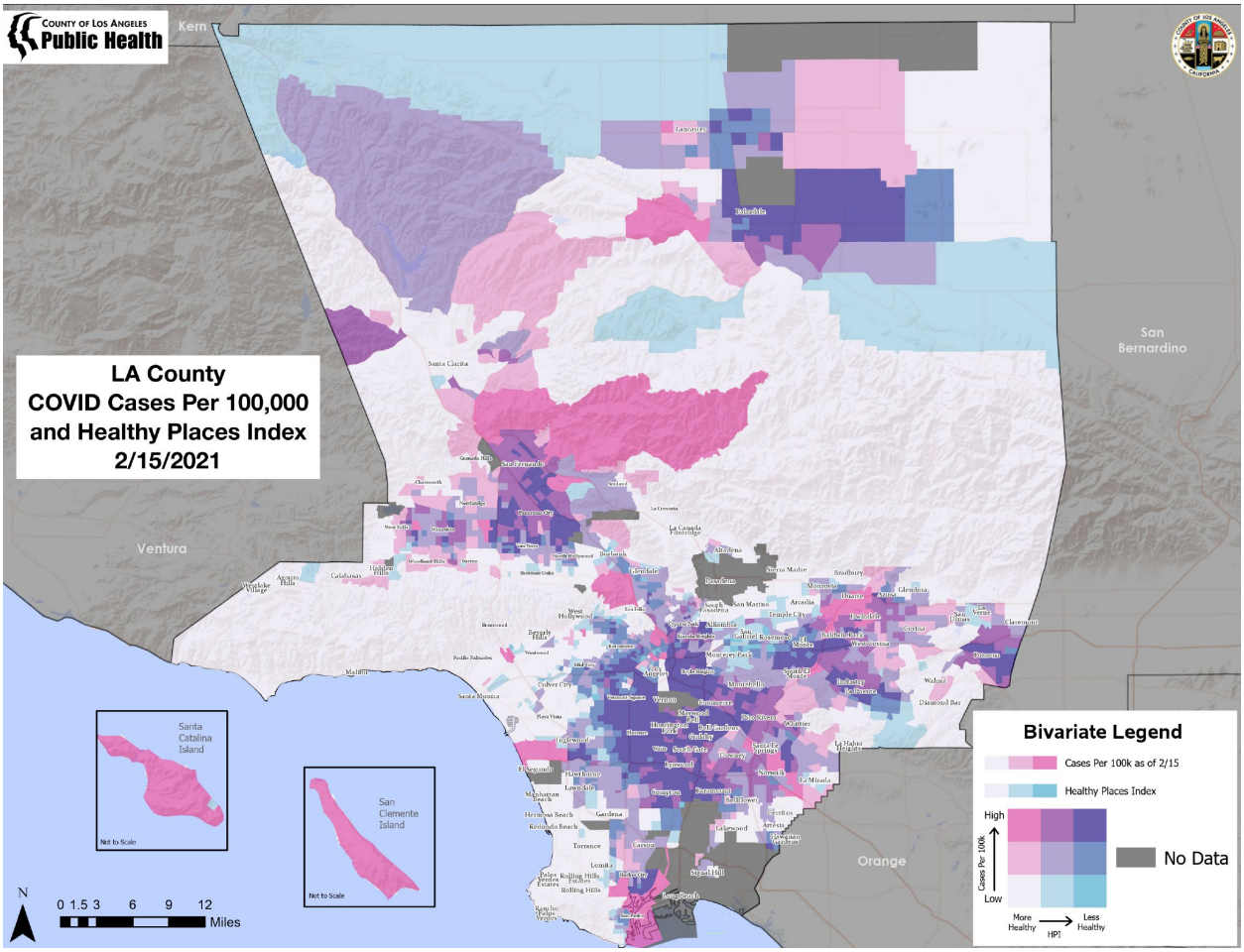
We also underwent a similar process looking at our 65+ Medicare population since they represent a sub-population (map 5). There is some variability in the zip codes from the just 65+ and HPI map (90005, 90006, 90011, 90022, 90029, 90057, 90063, 90201, 90255, 90280, 90813, 91402), and the darkest purple are those with the most census tracts with high density population of 65+ on Medicare and least healthy based on HPI. DPH has also engaged with the US Assistant Secretary for Preparedness and Response (ASPR) to work on a Medicare dashboard that drills down to LAC and they are making data available so we can identify those most recently in the hospital and at highest risk of needing emergency care.

Map 5. Zip codes with the most census tracts with high density population of 65+ on Medicare and low Healthy Places Index score, Los Angeles County



To verify that highest need as determined by the HPI also aligns with the impact of COVID we have experienced in LAC, we mapped COVID cases and deaths per 100,000 population against HPI. In Map 6 we can see the purple areas represent communities with the highest COVID case rates per 100,000 and have the highest vulnerability/least healthy per the HPI. We see that the purple areas in Map 6 largely correlate with the most vulnerable/least healthy areas of just the HPI map (map 2) suggesting a strong relationship between social vulnerability and COVID case rates. Specifically, zip codes with largest number of census tracts in the highest tertile of COVID cases per 100,000 people and HPI include 90201, 90011, 90044, 90001, 90255, 90280, 91402, 90023, 90063, 90037, 90006, 90002, 90022, 90033, 91331.

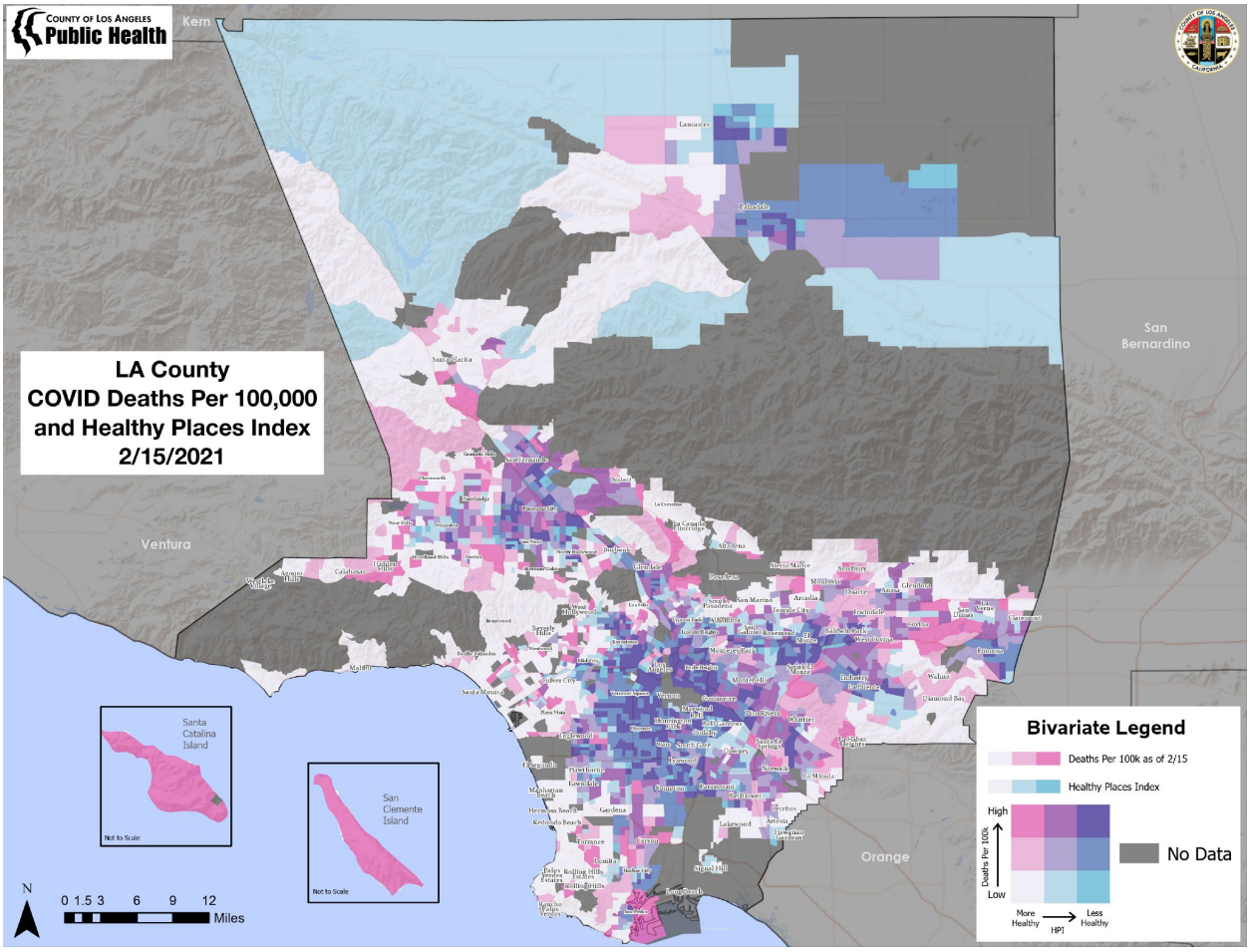
Map 6. COVID-19 Cases per 100,000 residents in Los Angeles County by Healthy Places Index Percentile, February 15, 2021



COVID-19 deaths in Los Angeles County by HPI percentile is shown in Map 7 and we can see it closely aligns to Map 4 where the population density of those 65+ and HPI are represented. The dark purple once again represents the areas with the highest needs and highest death rates. Zip codes with the largest number of census tracts in in the highest percentile of COVID deaths and HPI include 90011, 90044, 90006, 90057, 90001, 90023, 90255, 90063, 90201, 91402, 90033, 90037, 91732.

This exercise in better understanding the geography and the population through mapping is only one tool to target our efforts, but it does help triangulate data to outline the zip codes where we need to focus our limited vaccination resources. Using these maps, we can tailor specific outreach, education, and vaccination strategies in association with our LA County Vaccine Workgroup, Equity Committee and CBO partners. Further stratification by race/ethnicity and primary language is underway to help target these groups.

Map 7. COVID-19 Deaths per 100,000 residents in Los Angeles County by Healthy Places Index Percentile, February 15, 2021



As we work with our partners to better understand the needs of the most vulnerable 65+ population, targeted messaging/education on vaccine safety and increased access to vaccine will be prioritized. In addition, we have established relationships with two third-party entities (Curative and CARE Ambulance) to conduct mobile outreach specifically to DPH identified priority populations. Curative has logistics expertise in operating large fixed site PODs but has been expanding its mobile capacity. Curative is currently completing three visits as part of the initial 2-dose vaccine roll-out to all facilities licensed by Health Facilities and Inspection Division (SNFs, intermediate care facilities, and congregate living health facilities). Curative is now supporting vaccine outreach to senior residential developments and day centers. However, there are hundreds of senior residential developments that house low-income seniors or seniors in communities with high COVID-19 rates where vaccination rates are lagging the LA County average. Anticipating the increasing demand for mobile teams as a key tool for ensuring equity in vaccine distribution, we recently onboarded CARE Ambulance company to provide additional mobile outreach capacity. CARE has 12,000 clinically trained vaccinators (EMTs and MAs) so they have a very high ceiling for the number of mobile outreaches they can conduct, which allows them to scale up to

meet demand as more doses become available. They are available 24/7, so they are well-suited to support outbreak response. Both Curative and CARE Ambulance are CalVax approved, recover their costs by billing insurance, and have made a commitment to not balance bill their clients.

Although the mobile outreach teams are primarily focused on going into senior residential developments at this point, they are also available to support other sectors as needed (e.g., food and agriculture, education). These companies can coordinate close POD one day clinics targeting specific populations within these sectors. It is the role of the sector leads, in consultation with other community leaders and stakeholders, to identify the specific populations that would be best served by mobile outreach and work with stakeholders to provide a list of groups to coordinate with for organizing mobile vaccination. We recently expanded the call center to call the groups identified by community stakeholders to verify eligibility, assess interest in vaccination, and capacity to support a mobile team. Groups/facilities meeting the above criteria will be assigned to either Curative or CARE Ambulance for scheduling.

In addition to CARE and Curative, which work in close direct coordination with DPH under an MOU, there are other community partners who have established mobile vaccination capacity. Some of these partners are summarized in the table below. We plan to maintain a list of providers offering mobile vaccination as we become aware of them. For community groups interested in mobile vaccination and who do not meet criteria for a DPH coordinated mobile clinic (i.e., with CARE or Curative), we plan to connect those groups with providers in their community to see if they can meet their needs.

Community-Based Pilots to Improve Vaccination Access for High-Risk Persons 65+

Active Recruitment and Scheduling Assistance for Pharmacy Patients

Beginning on February 8, fifty-one (51) Albertsons umbrella pharmacies (Vons, Pavilions and Sav-On) throughout the county began actively assisting pharmacy patients with scheduling 1st dose and 2nd dose appointments by 1) Calling patients on current waitlists, 2) Reaching out to patients with high-risk medical conditions (similar to flu, pneumonia and shingles vaccine recruitment), and 3) Consulting with patients at drop-off/pick-up window during regular pharmacy visits. This effort has allowed each pharmacy to provide individual assistance to their community members and further strengthen provider-patient ties. Ralph's began a similar effort at thirty-seven (37) pharmacies on February 22nd.

City/Federally Qualified Health Center Vaccination Partnership

On February 8, 9 and 11, Herald Christian Health Center partnered with the cities of Monterey Park and San Gabriel for two walk-up and one drive-through vaccination clinics. They successfully vaccinated 900 seniors, recruiting participants from the nearby community who may have had difficulty accessing mass vaccination sites through traditional websites and call centers. This partnership was composed of city staff, Herald Christian staff, CORE, community volunteers, and student nurses and faculty from nearby Azusa Pacific University. Tri-State Community Healthcare Center conducted a similar vaccination clinic with the City of Glendale on February 20, and JWCH is planning clinics in the cities of Lancaster and Palmdale on February 23, 25 and 27.

Health Plan Support for Mobility Challenged 65+ Age Group

The 65+ group with limited mobility cannot get into a car to reach a POD or even a local vaccination clinic. DPH has engaged with health plans to determine if they can offer supplemental payments to providers for mobile vaccination services. The health plans are willing to consider supplemental payments and have agreed to identify in-home service providers that have existing contracts with most of the health plans, to offer supplemental payments pending additional allocations of vaccines. DPH would rely on health plans to identify their members who meet criteria for limited mobility to qualify for the mobile service.

Lastly, messaging from DPH has been disseminated to In-Home Supportive Services (IHSS) and other home health agencies to ask these caregivers to bring themselves (eligible under Phase 1a) and their 65+ clients to vaccination sites to be vaccinated together if the circumstances are safe to leverage relationships of individuals already in close contact with each other and limit new potential exposures.

Vaccination for 65+ with Underlying Medical Conditions

Adults 65+ with underlying medical conditions, such as those requiring dialysis, are particularly vulnerable to COVID both due to their need to visit clinics and the high probability that if they become infected with SARS-COV-2 they would very likely end up in the hospital. DPH has engaged our dialysis center partners to directly vaccinate their approximately 10,000 populations of those aged 65 and older on-site, beginning February 2021.

65+ Population Experiencing Homelessness

In alignment with the continuum of care for people experiencing homelessness (PEH), our vaccination plan aims, in partnership with DHS, to deliver COVID-19 vaccine to individuals currently experiencing homelessness, both sheltered and unsheltered, and includes formerly homeless persons who have been successfully placed in permanent supportive housing.

Our key partners from DHS, DMH, and LAHSA have provided estimated counts of currently eligible persons: healthcare worker (HCW) staff for the people experiencing homelessness (PEH) sector and PEH who are 65 and older. We begin with staff who support the IQ sites as these medical shelters also support the LAC hospital infrastructure. The remaining order was determined by risk of COVID-19 exposure and infection, and risk for poor medical outcome if infected. The last group listed, PEH 65+ in unsheltered settings, reflects anticipated difficulty in tracking and assuring a second dose of vaccine. However, we think that this unsheltered group should not be excluded out of hand without some preliminary pilots that could help assess ability to complete 2 doses and help develop protocols and procedures to immediately implement when a 1-dose vaccine is available.

Table 5. First Prioritization, Order, and Estimated Number of Persons Needing Vaccination

Site-Based Strategy	DPH Phase	Total Estimate
QI Sites (Staff only)	Phase 1a/Tier 2	1,200
Outreach Workers, CHWs, HCWs working with PEH	Phase 1a/Tier 2	2,000
Recuperative Care Centers (HCWs and PEH 65+)	Phase 1a/Tier 2	570

PEH 65+ Shelters	Phase 1b/Tier 1	500
PEH 65+ in Project RoomKey (PRK) and Project HomeKey (PHK)	Phase 1b/Tier 1	2,400
Former PEH 65+ in other permanent supportive housing (PSH)	Phase 1b/Tier 1	5,000
PEH 65+ Unsheltered	Phase 1b/Tier 1	1,200

Approach

DPH is using our collective experience in delivery of care and services to this population; experience that has been tested and validated in prior vaccination efforts (hepatitis A, influenza) as well as in our current COVID-19 disease control and testing interventions. Key learning includes:

- Care is most effectively delivered when brought into the communities where PEH reside and where PEH access services. We are proposing a multipronged approach to vaccination delivery, that includes vaccine delivery by mobile teams that will bring vaccine to PEH where they live and access services, as well as vaccine delivery through vaccination PODs and clinics open to walk-ups and pre-registered persons in areas frequented by PEH and in areas where COVID clusters of outbreaks have occurred.
- Organizations and personnel with knowledge and existing ties with the community are the most effective in engaging and gaining vaccine acceptance for both staff and PEH. We ask partner organizations to begin or increase vaccine education and outreach immediately, prior to vaccine availability, to prep the community. Key partners in this work include LAHSA, DMH, and DHS, as well as various FQHCs that are currently engaged in outreach work, wellness checks, and surveillance testing. To engage former PEH in permanent supportive housing, potential partners identified are LA City and its connections with the Southern California Association of Non-Profit Housing, and the Skid Row Housing Trust. We will ask for their assistance to help amplify our messaging on eligibility and where to go for vaccination.
- Data collection needs to be streamlined and housing status needs to be uniformly collected to allow for adequate vaccination tracking and reporting. In partnership with LAHSA and DHS, expanding the build of our shared data platform developed by Akido Labs for testing and contact tracing will be necessary to also collect the required vaccination information and additional variables that capture housing status and geolocations of vaccination. DPH met with State data teams to discuss the possibility of data integration from Akido reports into CAIR. In addition, protocols have been developed for improving data capture in the various electronic health systems and State clinic registration platforms, and outreach to vaccinators has been initiated to assist FQHCs and other partners in the adoption of these data collection protocols.

Vaccine Distribution and Delivery Strategy

Vaccine distribution and delivery will mirror the COVID-19 testing strategy in PEH, and the organizations that supported that testing. For example, we are onboarding Housing for Health (HFH) and its COVID Response Teams as key vaccinators in the PEH sector, leveraging their established relationships with many shelters where they have been performing surveillance testing and outbreak management throughout the pandemic. Housing for Health began vaccinating HCWs, outreach workers, and PEH the first week of February with a small quantity of 500 Moderna doses via the DHS parent organization

registered through CalVax. Vaccine was delivered to the central pharmacy at LAC-USC and repositioned by HFH throughout the 8 SPAs. This smaller initial rollout allowed them to smooth out operations before scaling up. When supply is sufficient, HFH will begin picking up vaccine at other DHS pharmacies/sites to further broaden their geographic reach.

In addition, we have begun discussions with FQHCs that are already registered through CalVax and have been vaccinating their communities and are ready to vaccinate PEH: LA Christian Health Center and JWCH, for example, to help vaccinate at the large Missions and URM (LACHC), and the Weingart (JWCH). We have connected with the FQHCs that have been supporting our Project RoomKey (PRK) and Project HomeKey (PHK) sites for site-based vaccination at PRK and PHKs. We are also reviewing the possibility of opening the Satellite Clinic in Skid Row for DPH's vaccination presence in the PEH community and considering the feasibility of utilizing our DPH mobile van as well.

Selection of Sites for Vaccination Clinics
We have mapped our outbreak locations and begun to layer locations proposed by Housing for Health and our FQHC partners to hold vaccination clinics. Our goal is to select areas that have experienced frequent outbreaks, ensure adequate geographic coverage, and coordinate among all the entities interested in helping us vaccinate. We have regularly scheduled weekly workgroup meetings to coordinate the vaccination work among our identified partners.

Emergency Services/First Responders/Law Enforcement

The Emergency Services Sector (ESS) is a community of highly skilled, trained personnel (with physical and cyber resources) who provide a wide range of prevention, preparedness, response, and recovery services during both day-to-day operations and incident response. The ESS includes both paid and volunteer capacities, organized primarily through city police departments and fire stations, county sheriff's offices, and Department of Defense police and fire departments. The ESS also includes some private sector resources, such as industrial fire departments, private security organizations, and private emergency medical services providers.

Essential workforce, if remote working is not possible, may include public, private, and voluntary personnel (front line and management) in:

- Emergency management, law enforcement, fire and rescue services, emergency medical services, corrections, rehabilitation and reentry, search and rescue, and technicians supporting maritime and aviation emergency response.
- Public Safety Answering Points and 911 call center employees.
- Personnel conducting, supporting, or facilitating wildfire mitigation activities
- Courts/Legal Counsel & Prosecution
- Workers physically responding to abuse and neglect of children, elders and dependent adults.
- Workers in emergency communication centers, public safety communications centers, emergency operation centers, fire and emergency medical services stations, police and law enforcement stations and facilities.

First Responders – Non-Law Enforcement

These agencies include fire and rescue services, public safety answering points, wildfire mitigation activities, workers who physically respond to abuse and neglect of children/elders/dependent adults, courts/legal counsel and prosecution, and workers in emergency communication centers. Given the diversity of this category, Public Health has been working with each type of agency to ensure it is connected to appropriate and allied partners to receive vaccine. For those groups where a partner has not been identified they will be routed to Emergency Response specific days at the County run mass vaccination sites. Adult Protective Services and Department of Children and Family Services workforce has been collated and stratified based on occupational risks (moderate and high occupational risk) to prioritize vaccine allocation. These identified individuals will be vaccinated in DPH clinics.

First Responders – Law Enforcement

The law enforcement sector in LA County is composed of County, city, federal and school police departments. Given the range of jurisdictional and non-jurisdictional entities, a strategic and coordinated approach is necessary to ensure all law enforcement partners have access to vaccine.

Jurisdictional Entities

Jurisdictional law enforcement entities have partnered with EMS and health clinic stakeholders to administer vaccine. The largest departments—Los Angeles County Sheriff's Department (LASD) and Los Angeles Police Department (LAPD)—have partnered with LASD Emergency Services Detail and Los Angeles Fire, respectively. Public health is working closes with LA County EMS to ensure allocations are appropriately distributed to EMS agencies partnered with police departments to provide vaccination.

In addition to LASD and LAPD, Los Angeles County is home to 44 independent city police departments. All city police departments have partnered with LA County Fire Department (LACoFD), local hospitals, or fire departments to receive vaccine. Allocations will be incorporated in local hospitals and fire department to account for these police department.

There are 13 California Highway Patrol (CHP) departments across the County. Care Ambulance – a private ambulance service provider – is slated to provide vaccine for this sector.

The Department of Probation, which has a workforce of over 5,000 employees, will be vaccinated through DPH clinics. Department of Probation employees have been aggregated to generate a list of eligible individuals that have then been stratified into moderate and high-risk categories that will be eligible for sequential vaccination.

Non-jurisdictional Entities

Non-jurisdictional law enforcement departments include twelve school police departments. Public Health has identified the police chiefs of these departments and has reached out to them. Large school police departments have all been partnered either by an allied health system (UCLA) or the LAUSD. UCLA and LAUSD has committed to vaccinating all school police departments that have not established prior vaccine partners. Vaccines for these school police department will be included in LAUSD and UCLA weekly allocation to cover the addition of these police departments.

DPH will be designating one day a week at LA County Mega PODs open only to specific emergency service individuals. Security staff to maintain building access control and physical security measures that

are include in Phase 1b, Tier 1 will have access to a secure day at the Mega PODs to receive vaccination. Additional eligible Emergency Management, Search and Rescue, Emergency and public safety communication centers, and EOC personnel within Phase 1b, Tier 1 will have access to this secure emergency service day at the Mega PODs to ensure vaccination.

Federal Entities

Public Health has identified 13 federal law enforcement entities in LA County. These departments are under the FBI, Department of Homeland Security, Department of Justice, technicians supporting maritime and aviation emergency response, TSA, and other federal agencies. Public Health has identified points of contacts with these various agencies to explore vaccine roll out. The largest federal agencies - including the FBI Field Office, TSA and Customs and Border Protection - have been partnered with LAFD. Additionally, select federal entities are partnering with local VA hospitals to receive federally allocated vaccine. LA County has established one day per week at the 5 County Mega PODs open only to emergency services where federal agencies can book vaccine appoint slots.

Correctional Facilities

Within LA County are 5 correctional facilities: 1 County jail, 1 County juvenile probation department, 2 federal prisons under Bureau of Prisons (BOP), and 1 state prison under the California Department of Corrections and Rehabilitation (CDCR).

County Jail and Juvenile Probation

The population of County jail and juvenile probation inmates is estimated to be about 20,000. Public Health has already begun providing vaccine for the County jail as of 1/19/2021 for eligible personnel and inmates. All HCW staff have been vaccinated through DHS as well as inmates who meet criteria for 1A (inmates who are in the jail infirmary and receive SNF level of care) and inmates who are 65 and older. In addition, non-HCW staff who work in high-risk clinical settings have been offered vaccine that was supplied by Public Health. In total, 716 staff and inmates who meet this category have been vaccinated to date. Correctional Health Services providers (under DHS) administer the vaccine.

Non-County Correctional Facilities

The state and federal correctional facilities have been allocated vaccine by their respective parent agencies for use within their facilities. Federal correctional facilities receive vaccine allocations directly from the Bureau of Prisons. The state prisons (California State Prison Lancaster) receives vaccine allocations from CDPH.

Releases Prior to Receiving Second Dose

Incarcerated populations are transient, and an estimated 50% of those in jail are released within 14 to 21 days (median LOS is 2 months). Eligible inmates that qualify under Phase 1a or those who are over the age of 65 may be released prior to receiving the second dose of vaccine.

Although this poses a challenge in terms of follow up, Public Health has communicated that vaccine should not be withheld from eligible inmates due to these concerns. In addition to the CDC vaccination card, Public Health has provided a letter stating the date their second dose is due, and information on where to schedule a second dose of vaccine (website and phone number). Public Health is in discussions

with Whole Person Care and the Office of Diversion and Re-entry to provide additional case management for the inmates who are released into their programs.

Eligible Court Personnel

Public Health is prioritizing eligible personnel of the Courts in Phase 1b Tier 1 based on Public Health's definition. This includes the Public Defender's Office, Alternate Public Defender, District Attorney's Office, Judges and court administrators/staff that are required to be in-person at court routinely and interact with clients in correctional facilities. Lists of court personnel have been collated to generate a list of eligible individuals which was then stratified into moderate and high-risk categories that will be eligible for vaccination through Public Health Clinics. Additionally, these individuals will be eligible to be vaccinated on emergency service days through the Mega POD.

Food and Agriculture

The Food and Agricultural (FA) Sector is composed of complex production, processing, and delivery systems and has the capacity to feed people and animals both within and beyond the boundaries of the United States. Beyond domestic food production, the FA Sector also imports many ingredients and finished products, leading to a complex network of growers, processors, suppliers, transporters, distributors, and consumers. This sector is critical to maintaining and securing our food supply.

Essential workforce, if remote working is not possible, may include:

- Grocery store employees.
- Workers supporting restaurant carry-out and quick serve food operations, including food preparation, carry-out and delivery food employees.
- Food manufacturer employees and their supplier employees to include those employed in food ingredient production and processing facilities; aquaculture and seafood harvesting facilities; livestock, poultry, seafood slaughter facilities; pet and animal feed processing facilities; human food facilities producing byproducts for animal food; beverage production facilities; and the production of food packaging, including recycling operations and processing.
- Farmers, farm and ranch workers, support service workers producing food supply and engaged in raising, cultivating, harvesting, packing, storing agricultural or horticultural commodity for human consumption.
- Workers in cafeterias used to feed workers.
- Government, private, and non-governmental organizations' workers essential for food assistance programs (including school lunch programs) and government payments.
- Animal agriculture workers to include those employed in veterinary health (including those involved in supporting emergency veterinary or livestock services).
- Food and Agriculture-associated Port and transportation workers.
- At risk food service and restaurant workers.

According to the listening sessions conducted by LAC for Food and Agricultural workers and surveys done by stakeholders (United Food and Commercial Workers Union) representing FA workers across Los Angeles County a 60%-80% interest was seen by FA workers in being vaccinated. A major driver of

vaccination in this sector is fear of disease and death due to the high incidence of both within this sector.

Food and Agricultural (FA) Community

The FA community is incredibly diverse. Key to the vaccine strategy in this sector is equitable distribution of vaccines to reach vulnerable and hard-to-reach individuals within this sector. At least half of the 2.4 million farmworkers in the United States are undocumented, as per advocates. A text message survey conducted by the United Farmworkers Foundation found that 78% of respondents said they lacked health insurance, 13% had never been to a doctor, 17% had not been in the last three years, and 30% had not been in a while or ever. Eighty percent were in California. Additionally, somewhere between 30%-50% of the meat-packing workforce is made up of undocumented workers from Mexico, Guatemala, and El Salvador as well as immigrants from East African countries.

Barriers to Vaccination

FA workers have been disproportionally impacted by the COVID-19 pandemic. It is important to provide easy access to vaccination to prevent any added stressor. Workers have expressed concern about accessibility to obtain the vaccine if only available during regular working hours and fear of missing work to receive the vaccine. It will be important to work with employers to ensure employees are supported to take time from work to obtain the vaccine when available. Undocumented individuals, workers without employee identification, or workers who receive cash payment without a traditional paystub will remain eligible for vaccination. DPH is working to develop appropriate eligibility protocols applicable to this group.

Community Outreach and Vaccination Strategy

Understanding that a "one size fits all approach" is inadequate, DPH will utilize a combination of approaches, communications, and messages at the public health level, plus support communications and engagement at the community level. Coordination with trusted sources is crucial to reaching individuals within the FA sector for widespread COVID vaccine acceptance. Authority figures, leaders in the workplace, or community leaders hosting in-person meetings and providing testimonials of receiving the vaccine both in-person and on social media would serve as valuable trust builders for vaccine acceptance. Trusted community-based organizations and LatinX consulates will be crucial in assisting their communities with vaccine registration and eligibility documentation.

Additionally, vaccine educational material will be developed and available in multiple languages and literacy levels, and in a variety of formats, including visual aids, to include those who are unable to read. Toolkits will be distributed through trusted community members with emphasis on target points of distribution, including but not limited to Spanish TV and radio, social media, community churches and faith-based organizations, unions, medical communities and community health workers, *promotoras*, grassroots organizations, and employers. Toolkits will be developed to be flexible so they can be easily customized for specific communities, employers, employees, and a range of sectors and audiences.

Toolkit with key communication topics include:

- When, where, and how to get the vaccine

- Vaccine safety and efficacy to promote vaccine confidence
- Risks and side effects for people with underlying or preexisting conditions
- Data showing diversity of people included in clinical trials
- What to expect when receiving the vaccine
- Cost.

To ensure equitable distribution, vaccine distribution must utilize a multipronged approach leveraging stakeholders and employers to deliver vaccinations by mobile teams that will bring vaccine to FA sector worksites and hard-to-reach communities, as well as vaccination PODs and pre-approved FQHCs. Organizations and personnel with knowledge and existing ties with the community are the most effective in engaging and gaining vaccine acceptance for both employers and employees of the FA community. We will ask partner organizations to begin or increase vaccine education and outreach now, prior to vaccine availability, to prepare the community.

Main points that were emphasized and synthesized for brevity, include:

- Workers may struggle to get time off to get vaccinated—can there be a paid time off programs or workplace protection if going to get vaccinated.
- How to get vaccinated if undocumented.
- Use of community health workers/*promotoras* to help build off already defined trusted networks.
- Bring vaccines to them rather than them having to go and find somewhere to be vaccinated – this was the most frequent comment.

Strategies to Reach These Populations Include

- Collaboration with agricultural and farm workers unions, food service industry workers unions, grocery store worker unions, and other unions
- Collaboration with the
    - Unions and labor partners
    - California Restaurant Association
    - California Grocers Association
    - Local Independent Grocer Association
    - Produce Association Trust
    - Food Manufacturers Association
    - Los Angeles County Farm Bureau
    - Agricultural and agribusiness associations
    - Produce Association Trust
    - Los Angeles County Department of Agricultural Commissioner/Weights and Measures
    - California Women for Agriculture-Los Angeles Chapter
    - Beekeepers Association and Southern California Beekeepers Association
    - Los Angeles County 4H-UC Cooperative Extension
    - Cal Poly Pomona
    - International Longshore and Warehouse Union
    - City of Vernon
- Collaboration with Veterinary Health

- Collaboration with food delivery entities (GrubHub, UberEats, InstaCart, DoorDash)
- Work with Environmental Health and Cities to identify relevant food-associated manufacturing facilities

Vaccination Verification

Due to the diverse background and jobs within this sector traditional method of verification may not be practical. If available, use of a union or workers ID (with name and photo) is acceptable as verification of employment. For workers who do not have a union or worker ID, a pay stub is also acceptable with photo ID. For employees who do not have any of these forms of ID, worker attestation with job title and address of worksite plus photo ID is required.

Additionally, approved vaccine providers FQHC and community health centers that serve food and agricultural workers in their networks can verify eligibility based on their own screening protocols.

Vaccination Methods

Strategy planning meetings with community leaders, FA employers, Unions, and other stakeholders within the FA sector reinforced the need for easy accessibility and access to the vaccine, as FA workers may be constrained by compounding health disparities, including geographic location and socioeconomic status. To help address the needs of this sector we will work with already established partnerships, local stakeholders, and FA employers to establish equitable distribution through the following strategies:

1) Grocery Store
    a. Partnering with 51 Albertsons (Vons, Pavilions and Sav-on), 21 Costco and 37 Ralph's grocery store pharmacy chains to provide vaccination to approximately 22,000 in-store, food distribution and transport workers for these chains.
2) County Run Mass Vaccination sites
    a. Sector specific vaccination days will be held across the county run large capacity vaccination sites each week in order to make vaccination available to the following groups:
        i. The estimated 14,000 Port Workers that work in LA County most of whom work at both the Ports of LA and Long Beach. Long Beach will be providing an estimated 3000 vaccinations for this population and the remaining 11,000 will be offered vaccination through these county mass vaccination sites.
        ii. The estimated 32,000 Farm Workers identified in collaboration with the United Farm Workers Union.
        iii. 323,600 food service workers including those identified through the California Restaurant Association
        iv. The roughly 8200 Veterinarians and 4500 Animal Agricultural Workers identified through licensing boards and unions.
        v. The 60,692 Grocery Store Workers who do not work at a facility providing vaccination through onsite pharmacies
        vi. The 7450 Food manufacturing workers who are not captured through other means noted in this section.

3) Curative
    a. Partnering with UFCW 770 to provide vaccinations to an additional 22,000 Grocery store workers.
    b. They are willing to expand to other areas of the food and agriculture industry and have the capacity to provide an additional 1000 doses/day at a fixed location or between 150-400 vaccinations through mobile teams.
4) City of Vernon
    a. Stacey Medical will be assisting to vaccinate the estimated 11,500 individuals working in food manufacturing in the City of Vernon as well as those identified through the Produce Association through both fixed site locations and mobile units.
5) Targeted county FQHCs and approved vaccine providers
    a. Recognizing that mass vaccination sites may not be ideal for all individuals within the groups noted above, DPH has worked with food stakeholders, unions, and workgroups to identify approximately 20 approved vaccine providers in communities with a high concentration of food and agriculture workers. DPH will be working to encourage these providers to vaccinate not only their own members working in the food and ag industry but will assess their ability to provide services to those within the sector that are outside of their patient population.

Education and Childcare

This sector includes those in the education sector that may currently be home, but who are essential to vaccinate to resume in-person education services. Included in this sector are:

- Licensed and license-exempt childcare service providers
- K-12 Teachers currently providing routine instruction either in-person or at home
- K-12 Essential education support staff to run these schools
- Higher education instructors, teachers and professors currently providing routine instruction either in-person or at home
- Higher education essential support staff to run these entities

Early Childcare and Education

Given that ECE providers have been offering in-person service over the course of the pandemic, they are a priority to be vaccinated. DPH has been in close contact with the Office for the Advancement of Early Childhood Care and Education (OAECE) and participated in several meetings to discuss vaccination rollout for the nearly 100,000 staff in the ECE programs, including attending the Community Care Licensing call for providers on January 19, 2021, and Policy Roundtable for Child Care and Development Monthly Meeting on January 12, 2021 and will participate in an educational webinar on 2/19/2021.

Of note, there are several different categories of ECE as described in table below. The 10 Resource and Referral Centers in Los Angeles are acting as liaisons between our vaccine sites and the over 8,000 ECE centers that are dispersed throughout the county. Children's Hospital Los Angeles (CHLA) has begun vaccinating ECE staff at its main campus. It is working with the Pathways Resource and Referral Center to do outreach to all Family Childcare Care Centers and calling all eligible participants 65 years of age and older to invite them to their clinic and making their appointments. DPH is actively seeking other

partners that can work with us to vaccinate remaining sectors. Childcare workers will also have dedicated days at the county vaccination sites.

ECE Vaccine Delivery

Below are the current vaccine delivery methods by ECE provider type and estimated workforce.

ECE Provider Type	CCLD Licensing Status	Employment Documentation	Considerations	Numbers of Workforce
Center-based ECE	Licensed	-Copy of CCLD license -Employee ID or a letter signed by director on letterhead (ECE Response Team will draft template)		40,000 (estimate from CCALA Cristina Alvarado and Christina Acosta)
Family Child Care Homes (FCC)	Licensed	-Copy of CCLD license -Letter signed from operator on FCC/R&R letterhead (ECE Response Team will draft template)	Since the childcare is provided in the home, there is a need to vaccinate the entire household. Resource and Referral agency has information on all household members.	30,000 (estimate from Ed Sudario)
School District Based ECE	N/A	-School district ID or pay stub	Since the childcare is provided in the home, there is a need to vaccinate the entire household. Resource and Referral agency has information on all household members.	TBD
Family, Friends, and Neighbors (FFN) providing subsidized care	License Exempt	-Letter from local Alternative Payment Agency (AP)/R&R. (ECE Response Team will draft template.)	Since the childcare is provided in the home, there is a need to vaccinate the entire household. Resource and Referral agency has information on all household members.	20,000
Public Parks and Rec	License Exempt	-City/County Parks and Recreation IDs		460 -LA City TBD – Other cities

Youth Recreation (Boys and Girls' Clubs, YMCA, Community Based Organizations)	License Exempt	-Employee ID or a letter signed by director on letterhead (ECE Response Team will draft template.)		TBD
Resource and Referral /Alternate Payment Agencies		-Employee ID or a letter signed by director on letterhead (ECE Response Team will draft template.)	Administrators may go into classroom and provide direct support to ECE providers	3,044

K-12

To begin vaccinating K-12 teachers and essential staff, since December 2020, LAC DPH has been partnering with LA County Office of Education (LACOE) to engage superintendents from all public school districts, including surveying them regarding their interest and capacity for hosting school district-based PODs. DPH hosted a meeting on January 5 with 20+ school districts with previous capacity to distribute vaccines, and discussed the logistics involved in standing up COVID-19 vaccine PODs for their staff. With the cooperation of LACOE, we met with all superintendents again on January 13 to discuss vaccination strategies and answer questions. DPH met with school nurses on February 1 to answer questions and has been in close contact with Susan Chaides and LACOE to answer questions regularly. We have also met with Los Angeles Unified School District several times to discuss its plans to create PODs, offering them regular logistical support as well as connecting them with St Johns Wellness Center to train its nurses in vaccine administration. Dr. Ferrer has also met with union leaders to hear and address concerns and incorporate suggested strategies in vaccination plans.

DPH has reviewed vaccine distribution plans for various school districts, reviewed the process of creating school-based PODs, timeline for vaccine dispensing, and responded to other questions. We have discussed the various options with all stakeholders, including becoming a vaccine provider and hosting a closed POD for their staff; becoming a vaccine provider and creating open PODs for their community, or partnering with a pre-existing vaccine provider (hospitals, clinics, pharmacies, cities) to offer vaccine either on-campus or off-campus to staff and community.

Additionally, Dr. Ferrer and Dr. Gilchick continue to have weekly meetings with school district superintendents hosted by LACOE to discuss several items, including vaccinations, and Dr. Ferrer continues to update participants on her weekly telebriefing sessions for various sectors. Education leaders have been apprised of the significant shortage of vaccine allocation LAC is currently experiencing, and understand they are due to be vaccinated in the Tier 1 of Phase 1b. They are aware that a number of Local Education Agencies (LEA) are in process to receive vaccine and implement their own PODs when supply is available, although the sector as a whole has been advised to partner with another community provider to staff PODs and administer vaccine, such as a health care entity or city government.

In addition to speaking to public school districts, LAC DPH has reached out to the head of the California Association of Independent Schools (CAIS) to discuss vaccine strategy and has met with leaders from parochial schools to answer their questions and offer insights. Additionally, we have spoken with several private schools to discuss vaccine plans (Harvard Westlake, Brentwood, Sierra Canyon, and Viewpoint),

and reviewed how to become a vaccine provider versus partnering with local health systems that are already vaccine providers.

- For school districts that have asked to create PODs
    - Our medical epidemiologists and logistics team have met with them, answered questions, and provided the vaccine checklist and the POD Planning Guide. If the school cannot meet the requirements of creating a school-based POD, we then recommend they partner with community partners. Current schools that are planning to create PODs are LAUSD, Glendora and Culver City.
- For school districts that want to partner with outside organizations
    - DPH is facilitating regionally appropriate partnerships with Acute Care Hospitals, Pharmacies, Federally Qualified Health Centers, and Health Departments to create Closed PODs. All school districts have found an appropriate partnering health care facility.
- For independent/parochial schools
    - DPH has requested they partner with their local school districts for vaccine plans or to use county PODs that will have appointments specifically reserved for them.

Vaccinations for the Education Sector – Overview

Starting March 1, Los Angeles County education staff are eligible to be vaccinated through a) MyTurn vaccination appointments at sites across the county, b) appointments made through their health care providers, or c) district-specific pods/partnerships.

- All education staff will have access to vaccinations through mega pods and their health care providers. Educators are encouraged to sign up for MyTurn to receive notification for when appointments become available at the many community vaccination sites across the county.
- Being mindful of persistent inequities and COVID-19's disproportionate impact, the LA County Department of Public Health and the Los Angeles County Office of Education have identified a strategy to distribute a proportional number of doses to each school district weekly, with consideration for district size, equity, COVID-19 community impact, and those districts offering in-person instruction and school-based services.
- A percentage of the county's weekly doses will be set aside for the education sector.
    - Of that amount, ~9% will be provided to private school teachers and staff, as private schools educate an estimated 9% of the county's K-12 students.
    - The remaining amount will be allocated to public school districts. Most school districts have created through vaccination partnerships with health care facilities who will receive and administer vaccine to school staff. Three school districts have become vaccine providers and will hold vaccine clinics independent of health care facilities.

Public School Districts Vaccine Allocation - Process Flow

All districts receive weekly allocation of doses. Allocations are made by LACDPH to each district's confirmed vaccination partner. Allocation amount depends on which vaccination group the district falls in and proportionality. Vaccination allocations for districts include allotment for public schools and charter schools authorized by the district.

District Vaccination Allocation/Grouping to create five (5) vaccination groups

- Districts grouped into five (5) vaccination groups, each group reflects ~20% of total public school student enrollment.
    - The creation of five vaccination groups allows for increased vaccine allocations to districts with highest need. To account for the difference in district sizes, each of the five groups will represent districts that serve roughly 20% of LA County's student population.
- Grouping is based on three metrics:
    - % Students Eligible for Free/Reduced Lunch (Source: CALPADS 19-20)
    - Case Rate (Source: LACDPH monthly case rate)
    - School Opening Status: In-Person/Cohorts/Remote (Source: LACOE 2/16 District Survey)
- Weighted Average gives equal consideration to all three metrics

Weekly Dose Allocation

- Total weekly allocation is split across 5 vaccination groups (see below). This ensures all districts receive an allocation each week.
- Within each vaccination group, doses are split proportionately by district size (determined by student population, source: CALPADS 19-20)

Group A	Group B	Group C	Group D	Group E
30% weekly doses	25% weekly doses	15% weekly doses	15% weekly doses	15% weekly doses
~20% LA County Student Population	~20% LA County Student Population	~20% LA County Student Population	~20% LA County Student Population	~20% LA County Student Population
Antelope Valley Union High Azusa Unified Baldwin Park Unified Bassett Unified Centinela Valley Union High Compton Unified Downey Unified Eastside Union Elementary El Monte City El Monte Union High El Rancho Unified Garvey Elementary Keppel Union Elementary Lancaster Elementary Lawndale Elementary Lennox Little Lake City Elementary Lynwood Unified	LAUSD-E LAUSD-C LAUSD-S	LAUSD-NE LAUSD-XS LAUSD-W LAUSD-NW	ABC Unified Acton-Agua Dulce Unified Bellflower Unified Bonita Unified Charter Oak Unified Covina-Valley Unified East Whittier City Elementary Glendale Unified Glendora Unified Gorman Joint Hawthorne Inglewood Unified Lowell Joint Montebello Unified Newhall Norwalk-La Mirada Unified Pomona Unified San Gabriel Unified Saugus Union South Whittier Elementary Torrance Unified	Alhambra Unified Arcadia Unified Beverly Hills Unified Burbank Unified Castaic Union Claremont Unified Culver City Unified Duarte Unified El Segundo Unified Hacienda la Puente Unified Hermosa Beach City Elementary Hughes-Elizabeth Lakes Union Elementary La Canada Unified Las Virgenes Unified Los Angeles County Office of Education (+state charters) Los Nietos Manhattan Beach Unified Monrovia Unified Palos Verdes Peninsula Unified Redondo Beach Unified Rowland Unified San Marino Unified

Mountain View Elementary Palmdale Elementary Paramount Unified Rosemead Elementary Sulphur Springs Union Valle Lindo Elementary Westside Union Elementary Wilsona Elementary			Whittier City Elementary Wiseburn Unified	Santa Monica-Malibu Unified South Pasadena Unified Temple City Unified Walnut Valley Unified West Covina Unified Whittier Union High William S. Hart Union High

*Long Beach and Pasadena student counts are not included in LA County student population for vaccination allocation considerations.

Weekly Dose Allocation - District Level

- Allocations are made directly from LACDPH to vaccination partner; districts provided with total allocation per week and the percentage of the allocation that should be provided to charter schools authorized by the district.
    - For districts that authorize charter schools, a percentage of each district's allocation goes to charter schools (based on proportion of district's charter students, source: CALPADS 19-20)
    - District has discretion over weekly staff dose assignments for remaining allocation and must prioritize staff working in person in schools with the highest risk of exposure.
        - Based on state and county guidance, districts are advised to **prioritize distribution** of vaccinations through an equity lens and to staff who are at higher risk of exposure due to serving students at **school sites** through in-person teaching or providing services such as food service, custodial staff, transportation, etc.
        - Districts should be mindful that the risk for contracting COVID-19 increases when individuals have increased and sustained interactions with a greater number of people, and when physical social distancing is not possible (whether due to the requirement of the job, e.g., food distribution, or the needs of students, e.g., serving students who require close contact).
- Districts coordinate with vaccination partner to provide weekly vaccination list for appointments, notify & confirm staff appointments, and staff the vaccination site to certify individuals getting doses are on the approved, district-provided list (which must include district + charter staff names)
- Certification - districts coordinate with vaccination partner to follow LACDPH requirements (e.g., state-issued ID, AND district ID or paystub AND picture ID)

Private/Independent Schools Vaccine Allocation

Private school vaccinations will be available through MyTurn via closed POD appointments.

Weekly Dose Allocation

- Private school students account for roughly 9% of LA County students (excluding Long Beach and Pasadena) and employ an estimated 22,370 staff.
- LACDPH allocates 9% of weekly Ed Sector doses to Closed Teacher POD days. Private schools are given access to closed POD appointments via MyTurn and share with staff.
- Private school staff are also eligible to schedule through general vaccination appointments with vaccination sites across the county
    - Certification - LACDPH requirements are state-issued ID, AND school ID/paystub AND picture ID

Instructions for School Districts

1. Allocations will be made on Thursdays. DPH will email the health partner and district contact with the weekly allocation amount. Doses will only be allocated to the district's one (1) identified vaccination partner on record with DPH.
2. Districts who are working with a health care facility are required to work directly with their vaccination partner to create a process for appointment scheduling and provide a weekly roster of staff names who are eligible for allocated vaccination appointments.
3. In general, the health care facility will be responsible for receiving vaccine, storing vaccine with appropriate cold-chain requirements, and administering vaccine to school staff. School district should be in charge of prioritizing staff, making sure the appropriate staff members make appointments, and having one or more school district staff at the facility site to help with registration and verification of employment.
4. We recommend the following strategies to support vaccination scheduling and tracking:
    a. Work with the vaccination partner to select one day each when they will distribute to the district/s they serve (i.e., Tuesday will be the distribution date for District X and/or Y).
    b. Districts should maintain a roster of prioritized staff to notify staff of vaccination appointments. Before providing the link for the vaccination clinic to staff, the weekly list of staff names, districts must verify that identified staff members are interested in receiving vaccine. will receive the vaccine.
    c. Districts are encouraged to have a representative at the vaccination site to assist the partner and verify that all individuals being vaccinated in the district's weekly allocation are district staff members. The individual performing this on-site task can be vaccinated after their shift should receive vaccination in the first round.
    d. Districts should consider maintaining a stand-by list, in the event additional doses are available at the end of vaccine clinic. weekly appointment scheduling is needed.
    e. Districts should develop a process where staff can notify district if they have been vaccinated elsewhere.
5. Staff should be notified to bring district-issued, staff identification to the vaccination site (District issued badge OR paystub AND picture ID).

If Districts do not have enough staff to accept a weekly allotment, they must IMMEDIATELY notify LACOE and LACDPH - no doses may be re-allocated to individuals who are not district staff members.

If a district authorizes charter schools, DPH will notify the district what percentage of their weekly doses must be allocated to charter schools and districts are responsible to coordinate this allocation with charter schools. Charter schools that are located in Pasadena and Long Beach, regardless of their authorizer, should partner with their local health departments for vaccination.

COVID-19 Vaccine Communications Plan

Objective: To provide critical information to LA County residents and partners about the development, safety, efficacy, and distribution of the COVID-19 vaccine in a timely and effective manner through traditional media, earned media, digital platforms, and partner communications.

Values: In addition to empathy, the following values will influence our communication efforts.

Messaging Pillars: The messaging pillars below will guide and unify the communications strategy and inform content creation with the overarching goal of getting as many people vaccinated as possible. Each pillar will cover a series of themes, which include, but are not limited to the following:

Confidence	Development/Process	Distribution
Is the vaccine safe? How are we sure?	When will the vaccine be available?	How will the vaccine be distributed?
Why do I need to get a vaccine? Why is it important?	Why is it taking so long to get the vaccine? Why/How was this vaccine made so quickly compared to other vaccines?	When can I get the vaccine?
What is in the vaccine? Components? Preservatives?	Which vaccine am I receiving? Which company manufactured the vaccine?	Where can I get the vaccine?
Are there side effects?	How does the vaccine work?	How many doses will I need and why is a booster necessary?
Are there enough vaccines?	Is it mandatory to take the vaccine?	Should I get my kids vaccinated?
How do we know it works? How was it tested?	What happens if I refuse to take the vaccine?	Will I need to go through my health insurance? Or will insurance cover it?
How was it approved? By what agencies?	What groups are eligible for the vaccine?	How much does the vaccine cost?
How much testing/studying was done?		
Will I still need to physically distance, wear masks, etc.?		
Does it take time to take effect?		Why are some people receiving the vaccine before others?
Is there a chance I could still infect others?		

Threshold Languages: To ensure these messages are accessible to LA County's diverse population and communities, information and fact sheets have been translated into the languages most spoken in LA County, including Arabic, Armenian, Cambodian, Chinese (Traditional and Simplified), Farsi, Japanese, Korean, Russian, Spanish, Tagalog, and Vietnamese.

Messaging Pillar Timeline: The messaging pillars will be communicated throughout the campaign, although it will be rolled out strategically as development continues and the vaccine distribution plan is finalized.

- Beginning December 2020: What? Why? How? (Confidence & Development)
- Beginning December 2020/January 2021: How? When? Who? (Development/Process & Distribution)
- Beginning January-July 2021: Where? When? Who? (Distribution)

Audiences: Communication efforts will be tailored along two tracks 1) to the general public and 2) to targeted audiences, which include but are not limited to the following:

- Medical providers
- Healthcare workers/First responders
- SNF Residents and Staff
- High Risk (underlying conditions)
- Older adults
- Communities of color
    - Black
    - Latinx
    - Asian
    - Native Hawaiian/Pacific Islander
    - American Indian/Alaska Native
- Non-English speakers
- Low-resourced communities
- Education (teachers, staff, students, parents)
- Essential workers
- People experiencing homelessness
- Incarcerated
- Food and Agricultural Workers

List of Desired Assets:

- Key Messages
- How were the COVID-19 Vaccines Developed?
- How Safe is the COVID-19 Vaccine?
- Priority Population Flyers
- Where Can I Get the COVID-19 Vaccine?
    - Uninsured
    - Insured
- COVID-19 Distribution by Population Timeline
- Providers
- COVID-19 Vaccine Myths

Tactics: The tactics used to communicate messages about the COVID-19 vaccine includes but is not limited to:

- Media Relations - Working with media outlets to spread messaging on the vaccine.
    - Earned Media – Pitching stories and securing interviews for subject matter experts and local media outlets.
    - Editorial Board – Conduct editorial board meetings with select outlets to provide greater context and information on the vaccine plan.
- Media Availabilities – Our top vaccine spokesperson should join already established media availabilities to provide an overview and answer questions (recommending they be added to Dr. Davis' Thursday Media Avails).
- Ads – Paid/Donated ads focusing on the general public and select targeted audiences to communicate the three pillars.
    - Print
    - TV
    - Radio
    - Digital
- Social Media – Communicating the messaging pillars and dispel misinformation through graphics, videos, and influencers.
- Email – Bimonthly newsletters residents can sign up for to receive updates about the vaccine.
- Web – Displaying information about the vaccine and the distribution of the vaccine in an easily digestible, high-visibility format on a vaccination webpage.
- Telebriefings – Communicating important information to sector partners through telebriefings.
    - Each telebriefing will have top level vaccine information inserted into talking points.
    - Additionally, there will be dedicated vaccine telebriefings for specific sectors based on rollout (HCWs, SNFs, etc.)
- Virtual Town Hall Events – Coordinating monthly virtual town hall events for residents. Events will be conducted in partnership with hyper local community leaders, influencers and CBOs.
- Partner Communications – Partnering with community-based organizations, local government agencies, healthcare providers, faith-based organizations, businesses, and unions to elevate messaging and information to residents using assets such as pamphlets, flyers, or other pieces of literature.
- Local Influencers – Partner with local influencers (local clinicians, local leaders, elected officials, personalities, celebrities) to elevate messaging on the vaccine.
- 2-1-1 – Having a detailed script providing information about the COVID-19 vaccination to residents who call in.

Communication Strategies to Address Vulnerable Communities

Outreach

Public Health will coordinate and develop materials and assets with community partners to promote the COVID-19 vaccine, including how it is safe and effective. Public Health will also provide messaging intended to encourage and persuade residents to receive the COVID-19 vaccine when they are eligible. To maximize message resonance, messaging will be culturally and linguistically relevant to the community, and in various formats to account for illiteracy, disability, and other language limitations. Outreach partners will include:

- Community-based Organizations
    - Community Health Worker Initiative

- Faith-based Organizations
- Labor Unions

DPH will create a Community Leader Toolkit that includes educational materials and presentations that can be tailored to support community discussion, outreach, and education and build trust for the vaccine in the leaders' communities. In addition, a Listening Session Toolkit may be created for community leaders to understand and address specific community concerns, including how to report outcomes to DPH. An Employer Toolkit can support employers in building vaccine confidence, including a sample project plan with sample resources for outreach to employees.

Departmental Collaborations
Public Health will collaborate with other county departments and other local governmental agencies to provide information on the COVID-19 vaccine, including its safety and efficacy, as well as persuasive messaging to address hesitancy, and when and where to receive the vaccine when residents are eligible. Departmental collaborators may include, but are not limited to:

- Los Angeles County Office of Education (LACOE)
- Los Angeles Unified School District (LAUSD)
- Metro
- Department of Consumer and Business Affairs (DCBA)
- Workforce Development, Aging and Community Services (WDACS)
- Los Angeles Homeless Services Authority (LAHSA)
- First5LA
- Department of Public Social Services
- Local City Elected Officials/Government
- State Elected Officials
- Federal Elected Officials

Press
Public Health will engage in an aggressive earned media campaign targeting key media outlets for residents newly eligible for the vaccine, including culturally and linguistically relevant outlets that carry greater message resonance than typical local media outlets. Earned media opportunities include information on the vaccine, interview with local health officials, leaders, and influencers to persuade residents to receive the vaccine, and information on how to get the vaccine once they are available.

- Local Black Community Media Outlets (*The Sentinel*, *The Bulletin*, etc.)
- Non-English-Speaking Community papers
    - Spanish
    - Chinese
    - Korean
    - Armenian
- Radio
    - Spanish
    - Chinese
    - Korean
    - Armenian
- TV
    - Spanish
    - Chinese

- Korean
- Armenian

Paid Media
Public Health will also create a comprehensive paid media campaign to inform, educate, persuade, and promote the COVID-19 vaccine. Messages and creative will be culturally and linguistically relevant to maximize message resonance.

- Radio (PSAs)
- TV (PSAs)
- Digital billboards in Highly Impacted Communities
- Social Media (targeted by zip code, languages)

Social Media
Public Health will engage in with residents in highly impacted communities through a variety of strategies to inform, education, persuade and promote the COVID-19 vaccine, including informing residents when they are eligible to receive the vaccine.

- Influencers (across race/ethnicity, languages, etc.)
- Targeted Social Media Posts (geo-location, languages, race/ethnicity)

Appendices

Table 1. Lab Confirmed COVID-19 Cases and Deaths, by Age, LA County (Excluding Long Beach and Pasadena) as of December 25, 2020

Age	Cases	Case Rate per 100k	Deaths	Death Rate per 100k
0 to 17	85,002	4,054	1	<1
18 to 29	164,099	9,633	59	3
30 to 49	227,875	8,361	597	22
50 to 64	127,168	6,849	1,707	92
65+	65,978	5,201	6,366	502

*Rate is per 100,000 population (2018 Population Estimates)

Figure 1. Hospitalization rate per 100,000 by age category

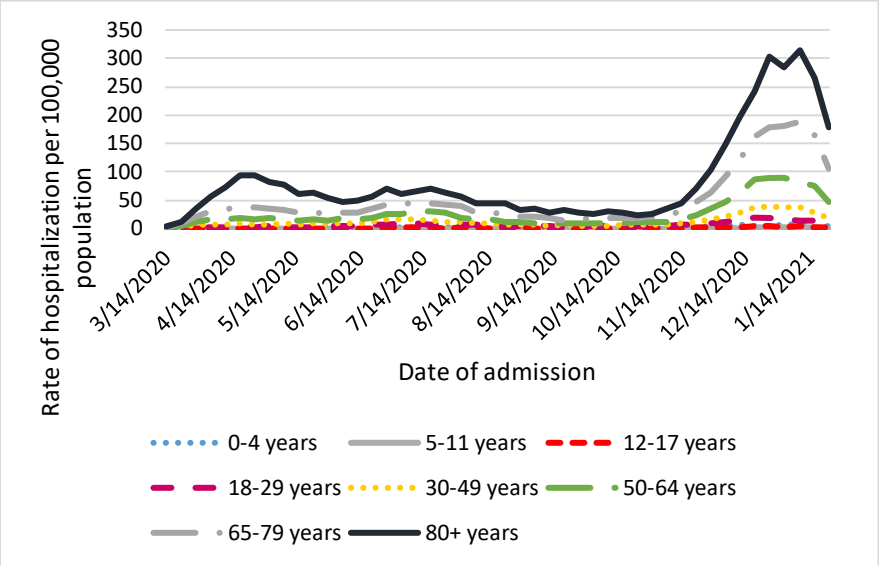


Figure 2. Daily Age-adjusted Case Rate per 100,000 Population by Race/Ethnicity, January 18, 2021

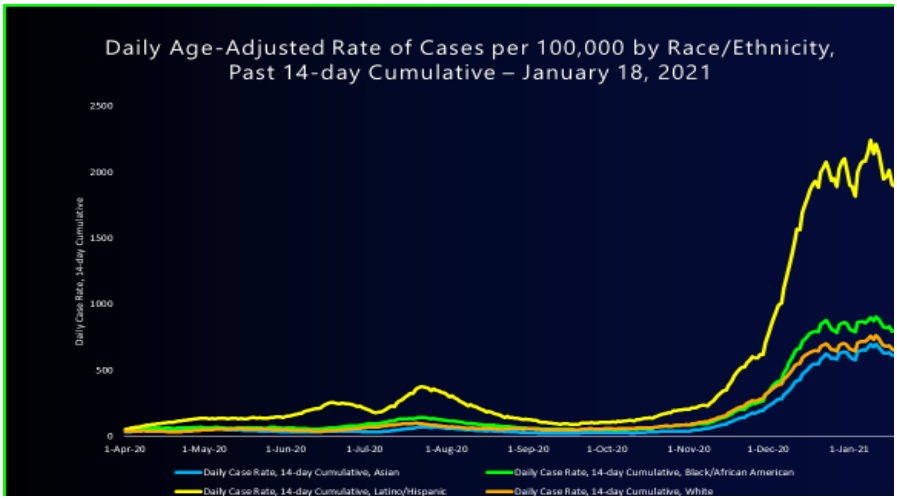


Figure 3. Daily Age-adjusted Death Rate per 100,000 Population by Race/Ethnicity, January 15, 2021

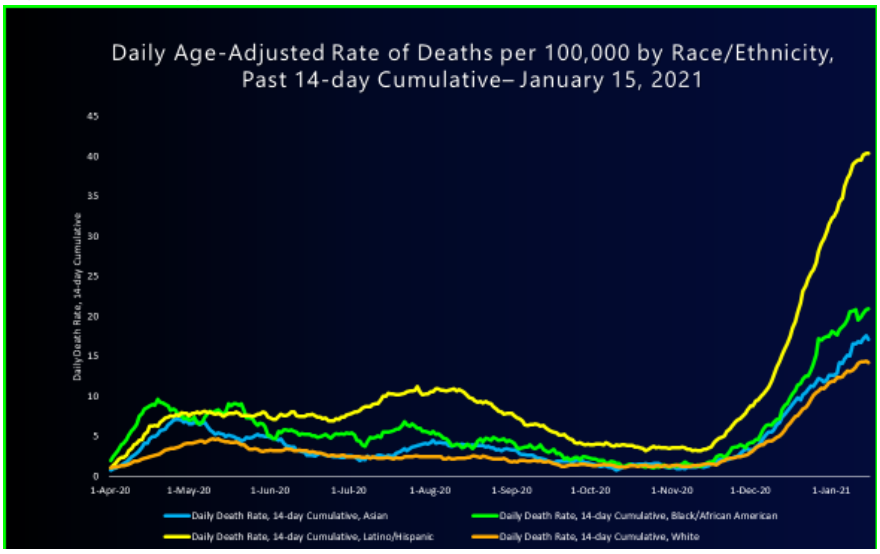


Figure 4. Age-adjusted hospitalization rate per 100,000 by race/ethnicity category

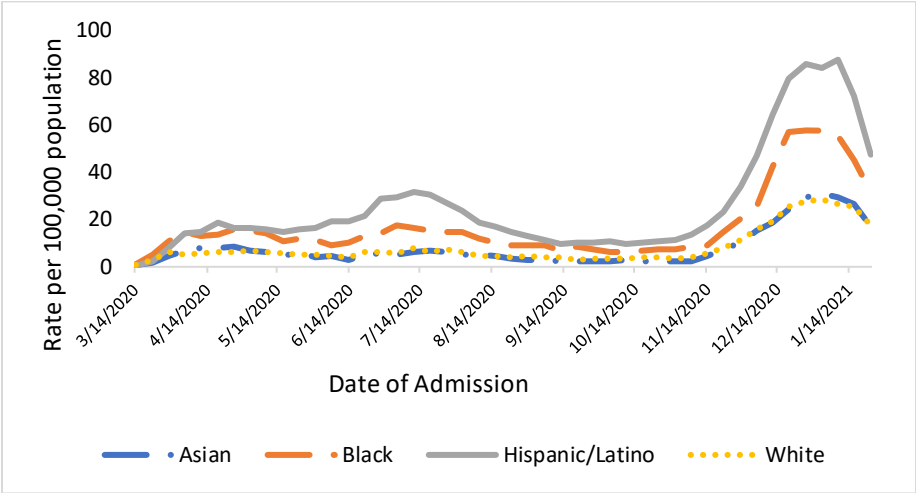


Table 2. Age-adjusted* cumulative hospitalization rate per 100,000 population by race/ethnicity category

Race/ethnicity	Age-adjusted cumulative hospitalization rate per 100,000
Asian	367.9
Black	796.9
Hispanic/Latino	1202.5
American Indian/Alaska Native	301.1
Native Hawaiian/Pacific Islander	2366.0
White	385.5

*Using general LAC population estimates as the standard population.

Table 3. Type of Insurance for Adults (Ages 65 and Older, Los Angeles County Health Survey, 2018.

			2018 [15a]		
Type of Insurance			**Percent**	**95% CI**	**Estimated #**
LA County	Public		64.0%	61.1 - 66.9	834,000
	Private		8.8%	7.2 - 10.4	115,000
	Private & Public		26.2%	23.6 - 28.9	342,000
	No Insurance	*	1.0%	0.3 - 1.7	13,000
Gender					
Male	Public		64.0%	59.6 - 68.4	358,000
	Private		9.9%	7.3 - 12.4	55,000
	Private & Public		25.8%	21.8 - 29.7	144,000
	No Insurance		-	- - -	-
Female	Public		64.0%	60.1 - 67.9	473,000
	Private		7.9%	5.9 - 9.9	59,000
	Private & Public		26.6%	23.0 - 30.3	197,000
	No Insurance	*	1.5%	0.3 - 2.6	11,000
Race/Ethnicity					
Latino	Public		76.6%	71.8 - 81.3	254,000
	Private		8.2%	5.2 - 11.1	27,000
	Private & Public		13.2%	9.5 - 17.0	44,000
	No Insurance	*	2.0%	0.4 - 3.6	7,000
White	Public		57.7%	53.9 - 61.4	362,000
	Private		8.4%	6.4 - 10.5	53,000
	Private & Public		33.3%	29.7 - 36.8	209,000
	No Insurance		-	- - -	-
African-American	Public		55.4%	47.5 - 63.4	64,000
	Private		16.3%	9.7 - 23.0	19,000
	Private & Public		28.2%	21.2 - 35.2	33,000
	No Insurance		-	- - -	-
Asian	Public		71.1%	60.0 - 82.3	137,000
	Private	*	5.6%	1.0 - 10.2	11,000
	Private & Public		23.1%	12.4 - 33.8	44,000
	No Insurance		-	- - -	-

NHOPI	Public		-	-	-	-	-
	Private		-	-	-	-	-
	Private & Public		-	-	-	-	-
	No Insurance		-	-	-	-	-
Asian/Pacific Islander	Public		N/A	N/A	-	N/A	N/A
	Private		N/A	N/A	-	N/A	N/A
	Private & Public		N/A	N/A	-	N/A	N/A
	No Insurance		N/A	N/A	-	N/A	N/A
American Indian/Alaska Native	Public	*	60.6%	17.8	-	100.0	n/a
	Private		-	-	-	-	-
	Private & Public		-	-	-	-	-
	No Insurance		-	-	-	-	-
Education							
Less than high school	Public		82.0%	76.3	-	87.6	216,000
	Private	*	5.1%	2.1	-	8.2	14,000
	Private & Public		10.0%	5.6	-	14.3	26,000
	No Insurance	*	2.9%	0.1	-	5.7	8,000
High school	Public		71.4%	63.9	-	78.8	154,000
	Private		9.6%	5.0	-	14.2	21,000
	Private & Public		18.3%	12.1	-	24.5	40,000
	No Insurance		-	-	-	-	-
Some college or trade school	Public		59.1%	53.4	-	64.7	243,000
	Private		7.7%	5.2	-	10.2	32,000
	Private & Public		32.5%	26.9	-	38.0	133,000
	No Insurance		-	-	-	-	-
College or post graduate degree	Public		52.8%	48.6	-	57.1	213,000
	Private		12.1%	9.1	-	15.0	49,000
	Private & Public		35.0%	31.0	-	39.1	141,000
	No Insurance		-	-	-	-	-
Federal Poverty Level							
0-99% FPL	Public		87.9%	83.3	-	92.6	167,000
	Private	*	3.8%	0.9	-	6.7	7,000
	Private & Public		7.9%	4.2	-	11.5	15,000
	No Insurance		-	-	-	-	-
100%-199% FPL	Public		80.9%	76.0	-	85.8	235,000
	Private		3.4%	1.6	-	5.2	10,000
	Private & Public		14.5%	10.0	-	18.9	42,000
	No Insurance	*	1.2%	0.0	-	2.6	3,000
200%-299% FPL	Public		59.6%	51.6	-	67.6	141,000
	Private		10.2%	5.7	-	14.7	24,000
	Private & Public		26.6%	18.9	-	34.2	63,000
	No Insurance	*	3.6%	0.3	-	6.9	9,000

300% or above FPL	Public	49.6%	45.3 - 53.8	290,000
	Private	12.5%	9.9 - 15.1	73,000
	Private & Public	37.9%	33.8 - 41.9	222,000
	No Insurance	-	- - -	-

YOU CALL THE SHOTS

Temperature Log
when Transporting Vaccine at Refrigerated Temperatures

When transporting refrigerated vaccines, use:

- A portable refrigerator or vaccine storage container qualified to maintain temperatures between 2°C and 8°C (36°F and 46°F).
- A digital data logger (DDL) with a thermal buffer and external temperature display (preferred). Place the probe as close as possible to the vaccine.
- This temperature log to document temperatures and how long the vaccine is in the portable storage container.

Temperature monitoring and transport time frames

- Most DDLs display minimum/maximum (min/max) temperatures.*
- Record the time and min/max temperatures:
  - At the start of transport
  - Every time the portable storage container is opened
  - When transport is completed
- The total time for transport alone or transport plus clinic workday should be a maximum of 8 hours.±
- Beyond-use date/time (BUD), if applicable, are included in transport time. For example, if the vaccine may be stored at refrigerated temperature for 120 hours, transport is included in this time frame.

If the temperature is out of range, TAKE ACTION!

1. Do **NOT** discard the vaccine.
2. Label the vaccine **"Do Not Use."**
3. Complete the Vaccine Troubleshooting Record.
4. Contact the manufacturer to determine under what conditions (refrigerated) to store the vaccine as quickly as possible.

Today's date: _____ **Transport start time:** _____ **Transport end time:** _____

Provider name: _____ **Facility name:** _____ **PIN number:** _____

Temperatures measured in (circle one): **Celsius** **Fahrenheit**

Time															
Staff initials															
Min/max temperatures															

Temperatures lower than 2°C (36°F) and higher than 8°C (46°F) are out of range.± Complete a Vaccine Troubleshooting Record. Contact the manufacturer and your immunization program.

- After packing the vaccine, open the portable storage container only when necessary.
- If using a company or personal vehicle, transport vaccines inside the passenger compartment (not in the trunk or bed of a truck, which may be too hot or too cold).
- Avoid leaving the portable storage container in direct sunlight or unattended.
- If needed, transport diluents with their corresponding vaccines to ensure there are equal amounts of vaccines and diluents. Follow the manufacturer's guidance for specific temperature requirements for diluents.
- Save this record for 3 years, unless your state/local jurisdiction requires a longer time period. See CDC's *Vaccine Storage and Handling Toolkit* for additional guidance.
- Refer to CDC's *Vaccine Storage and Handling Toolkit* for additional guidance when transporting vaccines.

* If the DDL does not measure min/max temperatures, check and record temperatures hourly.

± Follow the manufacturer's guidance if it differs from this time frame.

Based on available supply, individuals described below are or will be eligible for COVID-19 vaccines:

- Phase 1A* (healthcare workers and LTC residents): 3,142,166 Californians
- Phase 1B
    - Food/Agriculture***, Education/Childcare**, and Emergency Services***: 5,960,528 Californians
    - 65+: 6,254,300 Californians

Beginning March 15, healthcare providers may use their clinical judgement to vaccinate individuals age 16-64 who are deemed to be at the very highest risk for morbidity and mortality from COVID-19 as a direct result of one or more of the severe health conditions included in this provider bulletin.

Achieving equity

This age-based framework will be coupled with a vaccine distribution and engagement approach that prioritizes disproportionately impacted communities, settings, and populations to ensure those eligible for vaccines within these communities are more likely to receive it.

Minimizing disuse of scarce COVID-19 vaccine

To avoid wastage or disuse of scarce supplies and maximize their benefit to Californians:

- Allocations of doses are made on the assumption that immunization will be accepted by some but not all who are offered the vaccine, and then adjust later allocations based on the number of doses that are accepted.
- After focused and appropriate efforts to reach the groups prioritized at that moment, providers may offer vaccine promptly to persons in lower priority groups when:
    - Demand subsides in the current groups, or
    - Doses are about to expire according to labeling instructions.
- Providers may temporarily adjust prioritization based on other resource constraints while continuing efforts to immunize higher priority groups as soon as feasible.

Other Frequently Asked Questions:

If someone was given a first dose of vaccine that does not meet the most up to date vaccine eligibility criteria, should they receive a second?

Individuals who have already received their 1st dose of COVID-19 vaccine should receive their 2nd dose at the recommended interval for that vaccine.

Are family member caregivers of regional center consumers eligible as healthcare providers for Phase 1A?

Yes, family member caregivers with direct risk of COVID-19 exposure who care for regional center consumers at high risk of COVID-19 complications and related fatalities including the following conditions: cerebral palsy, down syndrome, epilepsy, and individuals who have specialized health care needs, including dependence upon ventilators, oxygen, and other technology are eligible. This does not include other family members within the same household who do not provide direct care to the regional center consumer. Eligible family members must obtain documentation from their regional centers, verifying the qualifying condition of the family member cared for and caregiver status.

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*Phase 1A eligibility

Occupation: Persons at risk of direct patient exposure in settings included in the Health Care and Public Health Sector from the CA Essential Workforce list. This includes both clinical and non-clinical roles. In addition, workers who come into direct contact with the virus through research, development, manufacturing or testing are included. Finally, workers who are manufacturing vaccine, therapeutics, devices, supplies or personal protective equipment supporting the COVID-19 response are included due to the adverse public health impact that delays in production would cause. Workers included in the Health Care and Public Health Sector from CA Essential Workforce that are not considered eligible above for Phase 1A vaccinations include:

- #12. Workers that manage health plans, billing, and health information (as opposed to administrative workers in clinical or other settings referenced elsewhere in this sector).
- #22. Workers supporting operations of outdoor recreational facilities for the purpose of facilitating physically distanced personal health and wellness through outdoor exercise. Activities to facilitate outdoor exercise does not translate to direct occupational risk for COVID-19 patient exposures.

Technical notes: Due to overlapping definitions in the Health Care and Public Health and Food and Agriculture Essential Workforce definitions, the following clarifications are necessary:

- #7. Cannabis industry employees are included in Phase 1a for medicinal cannabis and Phase 1b Food and Agriculture for growing, production, storage, transport and distribution. Medical cannabis workers should be accommodated as necessary in Phase 1b, Tier 1, by nature of their designations in eligible essential workforce classifications.

- #21. Workers supporting veterinary services. Phase 1b, Tier 1 Food & Agricultural workers, includes veterinary work in a wider variety of work settings. In the context of COVID-19 vaccine, the focus for phase 1A is on human-to-human exposures in human clinical settings. As such, veterinary services employees may be more appropriately vaccinated in Phase 1b.

Settings - High-risk Congregate Residential Facilities:

- Residents of skilled nursing facilities, assisted living facilities, and similar long-term care settings for older or medically vulnerable individuals

**Persons at risk of occupational exposure to SARS-CoV-2 through their work in any role in the following Education and Child Care settings

- All formal and informal childcare workers, including day care providers
- All staff in colleges, universities, junior colleges, community colleges, and other postsecondary education facilities
- All staff in educational support services and administration
- All staff in Pre-kindergarten, elementary, middle, and high schools
- All staff in technical and trade schools
- Any other workers involved in child and/or student care, including school bus drivers and monitors, crosswalk guards, etc.

***Persons at risk of occupational exposure to SARS-CoV-2 through their work in any role in the Emergency Services & Food and Agriculture Sectors from CA Essential Workforce list and any employee working in a restaurant to the extent not described in the Food and Agriculture Sectors from the CA Essential Worker list.

Vaccine Transport Checklist

Prior to Pick Up

☐	Verify pick-up location and time
☐	Bring your driver's license and employee identification.
☐	Bring a Cold Cube or other purpose-built vaccine transport container. • If not available use a hard-sided cooler (at least 15 quart) or styrofoam insulated cooler (at least 12 x 12 x 12"). • Vaccine transport guidance: https://eziz.org/assets/docs/IMM-983.pdf
☐	Bring a digital data logger with a buffered probe has been pre-chilled for at least 2 hours in a refrigerator before transport. • If digital data loggers are not available, bring digital Min/Max thermometers with a buffered probe that has been pre-chilled for at least 2 hours. • Please note that, per the CDC, alternative thermometers not allowed for transport of the Moderna Vaccine include the following » Alcohol or mercury thermometers, even if placed in a fluid-filled, biosafe, liquid vial » Bimetal stem Temperature Monitoring Devices (TMD) » TMDs used for food » Chart recorders » Infrared TMDs » TMDs that do not have a current and valid Certificate of Calibration Testing
☐	Bring at least 4 frozen cold packs (approx. 6 x 4 x 3/4") or frozen water bottles.
☐	Bring insulating materials such as bubble wrap or cardboard, enough to form two layers (stacked horizontally) per container.
☐	Bring the COVID-19 Vaccine Transport Log https://eziz.org/assets/docs/COVID19/IMM-1336.pdf

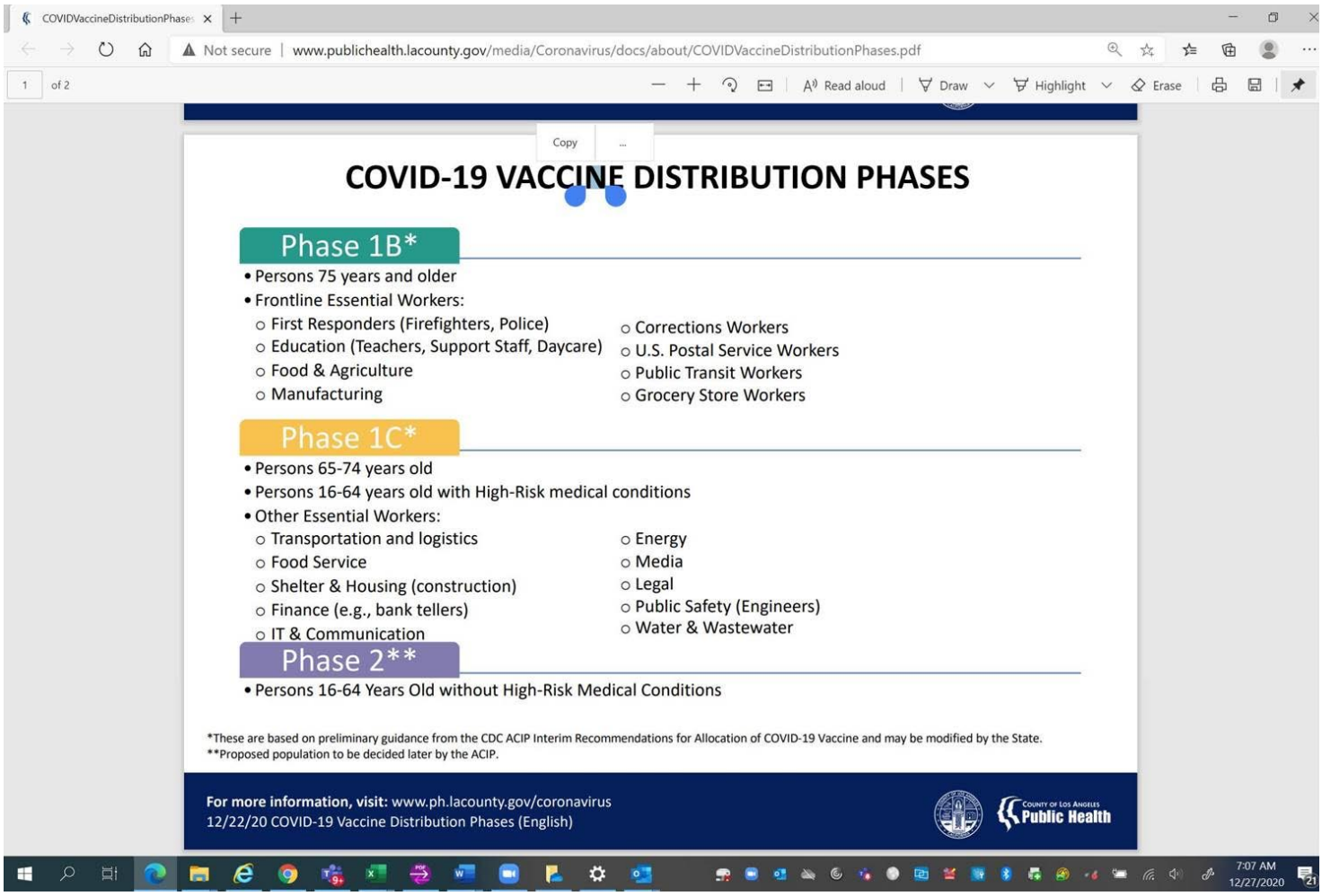
At Pick-Up Location

☐	Present your identification to the onsite point of contact.
☐	Verify your skilled nursing facility name, number of doses, and quantity of supplies to be transported with onsite personnel.
☐	Provide onsite personnel with transport container.
☐	Review and sign required paperwork. Obtain a copy for your records.
☐	Take the containers to your vehicle. Do not open the containers.
☐	Document departure time and temperature on Transport Log.
☐	Place all containers carefully into your vehicle, securing them so that they do not move while in transit.

Return to Your Facility

☐	Immediately go to your facility. Do not stop unless there is an emergency. If there is any delay, call your facility.

☐	Return to your facility note the end time and temperature on the Transport log.
☐	Please vaccine in your facility storage unit.
☐	Provide all paperwork to the facility administrator.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1 of 2
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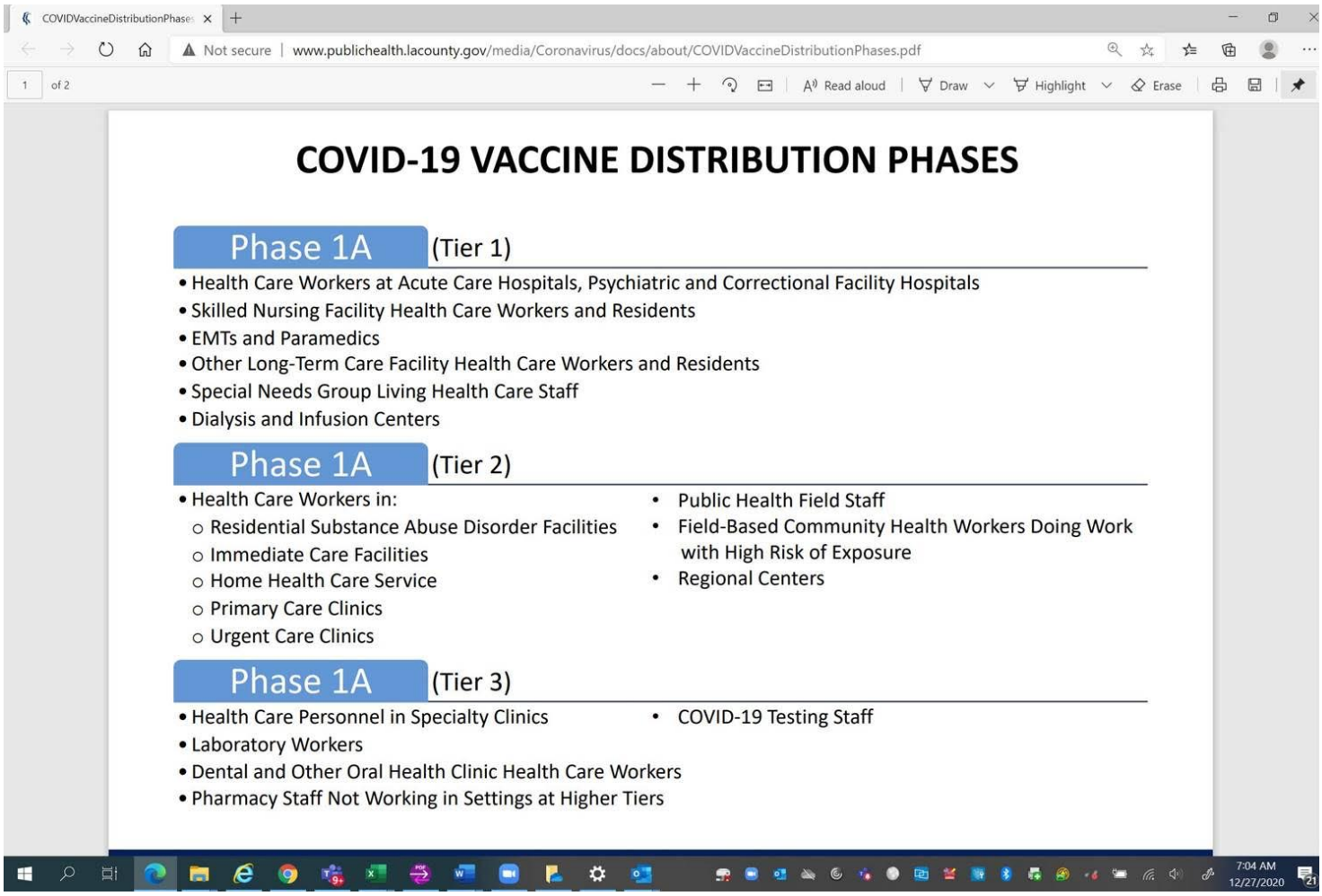
COVID-19 VACCINE DISTRIBUTION PHASES
Phase 1B*
• Persons 75 years and older
• Frontline Essential Workers:
○ First Responders (Firefighters, Police)
○ Education (Teachers, Support Staff, Daycare)
○ Food & Agriculture
○ Manufacturing
○ Corrections Workers
○ U.S. Postal Service Workers
○ Public Transit Workers
○ Grocery Store Workers
Phase 1C*
• Persons 65-74 years old
• Persons 16-64 years old with High-Risk medical conditions
• Other Essential Workers:
○ Transportation and logistics
○ Food Service
○ Shelter & Housing (construction)
○ Finance (e.g., bank tellers)
○ IT & Communication
○ Energy
○ Media
○ Legal
○ Public Safety (Engineers)
○ Water & Wastewater
Phase 2**
• Persons 16-64 Years Old without High-Risk Medical Conditions
*These are based on preliminary guidance from the CDC ACIP Interim Recommendations for Allocation of COVID-19 Vaccine and may be modified by the State.
**Proposed population to be decided later by the ACIP.
For more information, visit: www.ph.lacounty.gov/coronavirus
12/22/20 COVID-19 Vaccine Distribution Phases (English)
County of Los Angeles Public Health
7:07 AM
12/27/2020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1 of 2
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COVID-19 VACCINE DISTRIBUTION PHASES
Phase 1A (Tier 1)
• Health Care Workers at Acute Care Hospitals, Psychiatric and Correctional Facility Hospitals
• Skilled Nursing Facility Health Care Workers and Residents
• EMTs and Paramedics
• Other Long-Term Care Facility Health Care Workers and Residents
• Special Needs Group Living Health Care Staff
• Dialysis and Infusion Centers
Phase 1A (Tier 2)
• Health Care Workers in:
○ Residential Substance Abuse Disorder Facilities
○ Immediate Care Facilities
○ Home Health Care Service
○ Primary Care Clinics
○ Urgent Care Clinics
• Public Health Field Staff
• Field-Based Community Health Workers Doing Work with High Risk of Exposure
• Regional Centers
Phase 1A (Tier 3)
• Health Care Personnel in Specialty Clinics
• Laboratory Workers
• Dental and Other Oral Health Clinic Health Care Workers
• Pharmacy Staff Not Working in Settings at Higher Tiers
• COVID-19 Testing Staff
7:04 AM
12/27/2020

COVID-19 Vaccine Expiration Date Tracking Tool

Use this tracking tool to record updated expiration dates for COVID-19 vaccine as additional stability data are available from the manufacturer. When the current expiration date gets close, contact the manufacturer before discarding vaccine. Document the current date, the vaccine lot number, and the updated expiration date in the appropriate columns, including the information source and the name of the person completing this form. Keep this document for 3 years or longer if required by your jurisdiction..

Product name: _____ **Manufacturer:** _____ **Original Expiration Date:** _____

Expiration date info is available at (include all available information from manufacturer; website, app, phone number.)

Date	Lot Number	Updated Expiration Date	Info Source	Name
Example: 09/01/2020	*ABC123DEF456*	*06/30/2021*	☒ Website ☐ Barcode	*Susie Smith RN*

COVID-19 VACCINE DISTRIBUTION PHASES

Phase 1A (Tier 1)

- Health Care Workers at Acute Care Hospitals, Psychiatric and Correctional Facility Hospitals
- Skilled Nursing Facility Health Care Workers and Residents
- EMTs and Paramedics
- Other Long-Term Care Facility Health Care Workers and Residents
- Special Needs Group Living Health Care Staff
- Dialysis and Infusion Centers

Phase 1A (Tier 2)

- Health Care Workers in:
  - Residential Substance Abuse Disorder Facilities
  - Immediate Care Facilities
  - Home Health Care Service
  - Primary Care Clinics
  - Urgent Care Clinics
- Public Health Field Staff
- Field-Based Community Health Workers Doing Work with High Risk of Exposure
- Regional Centers

Phase 1A (Tier 3)

- Health Care Personnel in Specialty Clinics
- Laboratory Workers
- Dental and Other Oral Health Clinic Health Care Workers
- Pharmacy Staff Not Working in Settings at Higher Tiers
- COVID-19 Testing Staff

COVID-19 VACCINE DISTRIBUTION PHASES

Phase 1B*

- Persons 75 years and older
- Frontline Essential Workers:
  - First Responders (Firefighters, Police)
  - Education (Teachers, Support Staff, Daycare)
  - Food & Agriculture
  - Manufacturing
  - Corrections Workers
  - U.S. Postal Service Workers
  - Public Transit Workers
  - Grocery Store Workers

Phase 1C*

- Persons 65-74 years old
- Persons 16-64 years old with High-Risk medical conditions
- Other Essential Workers:
  - Transportation and logistics
  - Food Service
  - Shelter & Housing (construction)
  - Finance
  - IT & Communication
  - Energy
  - Media
  - Legal
  - Public Safety (Engineers)
  - Water & Wastewater

Phase 2**

- Persons 16-64 Years Old without High-Risk Medical Conditions

*These are based on preliminary guidance from the CDC ACIP Interim Recommendations for Allocation of COVID-19 Vaccine and may be modified by the State.

**Proposed population to be decided later by the ACIP.

Product Information Guide for COVID-19 Vaccines and Associated Products

Version 2–December 14, 2020

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Version 2–December 14, 2020

Product Information Guide Summary

» Purpose:

This guide provides specifications for COVID-19 vaccine and associated products. **This is NOT a catalog from which you can order products**. It provides key product information including product package dimensions and weight, minimum order quantities, product presentation, distribution method, storage information, and additional information. This guide will be updated as more products become available.

» How to use this guide

Jurisdictional immunization program staff–use this guide to help you:

- Learn about available COVID-19 vaccines and associated products.
- Provide answers to questions from COVID-19 vaccination providers.

COVID-19 vaccination providers–use this guide to help you:

- Learn about available COVID-19 vaccines and associated products.
- Prepare storage space to ensure ordered quantities can be stored at the proper temperature.
- Prepare staff responsible for receipt and storage of vaccine deliveries.

Refer to CDC's *Vaccine Storage and Handling Toolkit* for recommendations and best practices on related topics such as vaccine inventory management.

» Addendum:

The COVID-19 Vaccine Ancillary Supply Kit Guidance in the addendum (page 8) provides more specific information on the ancillary supply kits.

At this time, the products in this guide are only available for use in adults (i.e., persons aged 18 years or older). You will receive additional information, and this guide will be updated to reflect any changes COVID-19 age indications.

Additional COVID-19 vaccine may be authorized or licensed in the future. This guide will be updated as more products become available.

VTrckS: https://www.cdc.gov/vaccines/programs/vtrcks/index.html
Vaccine Storage and Handling Toolkit: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/index.html

Centrally Distributed Vaccines and Ancillary Kits*

Vaccines (Centrally Distributed)

Manufacturer	**Moderna**
NDC # in VTrckS	80777-0273-99
Carton dimensions	53mm x 53mm x 137mm (approximately 2in x 2in x 5 3/8in)
Minimum order size and increment	100 doses
Presentation	10-dose multidose vial/10 MDV per carton
Items automatically added to your VTrckS order when you select this product	Ancillary supply administration kit: standard syringe
Vaccination schedule	2-dose series separated by at least 28 days
Age indications	TBD
On-site vaccine storage	• -25°C to -15°C (-13°F to 5°F) in vaccine storage unit • 2° to 8°C (36° to 46°F) in vaccine storage unit for up to 30 days if the vial is not entered. • Freezer temperature settings will require adjustment if storing this vaccine and varicella-containing vaccines in the same unit. The temperature range for this vaccine is limited compared to varicella-containing vaccines.

*Pfizer's COVID-19 vaccine is **not** centrally distributed; it is distributed directly from the manufacturer. Please refer to the next section for information on Pfizer COVID-19 vaccine.

Moderna: https://www.modernatx.com/

Ancillary Supply Administration Kit: Standard Syringe (Centrally Distributed)

Kit description	Standard syringe kit for vaccine administration		
NDC # in VTrckS	11111-0001-01 (Adult)		
Kit dimensions/weight	14 in x 13 in x 9 in/3.5 lbs (standard ancillary adult kit)		
Minimum order size and increment	Kit to support administration of 100 doses (plus overage)		
Accompanies 0.5mL-dose vaccines	Moderna		
Order Intention	Initially only adult kits will be available, when authorized for use in younger populations, pediatric and mixed (pediatric and adult) will be available for ordering.		
Contents: Each kit contains a label on the outside of the box with a complete inventory list.	**Adult Kit** • 85 needles (22-25G x 1") • 20 needles (22-25G x 1.5") • 105 syringes (1mL or 3mL) • 210 alcohol pads • 100 vaccination record cards • 1 needle gauge and length chart • 2 face shields • 4 surgical masks	**Pediatric Kit** • 105 needles (25G x 1") • 105 syringes (1mL or 3mL) • 210 alcohol pads • 100 vaccination record cards • 1 needle gauge and length chart • 2 face shields • 4 surgical masks	**Mixed Kit** • 95 needles (25G x 1") • 10 needles (22-25G x 1.5") • 105 syringes (1mL or 3mL) • 210 alcohol pads • 100 vaccination record cards • 1 needle gauge and length chart • 2 face shields • 4 surgical masks
Additional information	• Products and brands for kit components may vary. • All needles for vaccine administration are safety needles. • Due to the limited supply of needles and syringes, specification of preferences for needles or syringes is not feasible. • Kit and pallet configuration o 1 kit = 100 vaccinations (plus overage) o 1 pallet = 36 kits (supports 3,600 vaccinations, plus overage) For more information about ancillary kits components: COVID-19 Vaccine Ancillary Supply Kit Guidance		

Centrally Distributed Ancillary Supply Kit Volume

Vaccination provider sites will need to prepare space to store vaccine and ancillary kits. Large volume orders of vaccine can be compactly packaged, however, ancillary supply kits to support these orders will require much more storage space. For each 100 doses of vaccine, an ancillary kit measuring 14 in x 13 in x 9 in and weighing 3.5 pounds will be provided. The below picture demonstrates the number and volume of ancillary kits compared to vaccine in a large volume order of 4,000 doses.

Direct-Ship Vaccine and Ancillary Kit

Pfizer Vaccine (Direct Ship)

Manufacturer	Pfizer
NDC # in VTrckS	59267-1000-02
Tray dimensions	229mm x 229mm x 40mm (approximately 9in x 9in x 1.5in)
Minimum order size and increment	975 doses
Presentation	5-dose multidose vial/195 MDV per tray
Items automatically added to your VTrckS order when you select this vaccine	Combined ancillary supply kit for administration and mixing (includes 0.9% preservative-free normal saline diluent)
Age indications	16 years of age and older
Vaccination schedule	2-dose series separated by at least 21 days
On-site vaccine storage	• -80°C to -60°C (-112°F and -76°F) in ultracold storage unit • -80°C to -60°C (-112°F and -76°F) in the original thermal shipping container with dry ice recharges. Please allow for forthcoming information on the maximum time for storage in these conditions. • 2° C to 8°C (36° F to 46°F) in a storage unit for up to 5 days (120 hours)
Additional information	• Vaccine will be shipped in a container that includes dry ice. Thermal shipping container dimensions are 400mm x 400mm x 560 mm (approximately 15 3/4in x 15 3/4in x 22in). • A thermal shipping container holds up to 5 cartons/trays. • If using the thermal shipping container to store vaccine, add dry ice pellets (9 mm to 16 mm) within 24 hours of delivery and every 5 days or as needed to maintain temperatures. • Unless a provider opts out, dry ice will be delivered within 24 hours of vaccine delivery to refill the thermal shipping container for the first re-ice only. Additional dry ice will not be provided. Locate a dry ice source if planning to use the shipping container to store vaccine for more than 5 days. • Do not use or store dry ice or liquid nitrogen (LN_2) in confined areas, walk-in refrigerators, environmental chambers or rooms without ventilation. A leak in such an area could cause an oxygen-deficient atmosphere. • A full shipping container with vaccine and dry ice weighs approximately 80 pounds.

Pfizer: https://www.pfizer.com/

Combined Ancillary Supply Kit for Administration and Mixing (Direct Ship)

Kit description	Combined kit with small syringes for vaccine administration, mixing supplies, and diluent		
NDC # in VTrckS	11111-0006-02 (Adult)		
Kit dimensions/weight	24 in x 20 in x 24 in/40 lbs		
Minimum order size and increment	Kit to support administration of 975 doses (plus overage), including 0.9% preservative-free normal saline diluent		
Accompanies 0.3mL-dose vaccines	Pfizer		
Order Intention	Initially only adult kits will be available, when authorized for use in younger populations, pediatric and mixed (pediatric and adult) will be available for ordering.		
Contents: Each kit contains a label on the outside of the box with a complete inventory list.	Adult Kit* • 829 needles (22-25G X 1") • 200 needles (22-25G X 1.5") • 205 mixing needles (21-25G X1.5") • 1024 syringes (1mL) • 205 syringes (3mL or 5mL) • 2458 alcohol pads • 1000 vaccination record cards • 10 needle gauge and length charts • 20 face shields • 40 surgical masks • 200 Diluent vials	Pediatric Kit* • 1024 needles (25G X 1") • 205 mixing needles (21-25G X1.5") • 1024 syringes (1mL) • 205 syringes (3mL or 5mL) • 2458 alcohol pads • 1000 vaccination record cards • 10 needle gauge and length charts • 20 face shields • 40 surgical masks • 200 Diluent vials	Mixed Kit* • 926 needles (25G X 1") • 100 needles (22-25G X1.5") • 205 mixing needles (21-25G X1.5") • 1024 syringes (1mL) • 205 syringes (3mL or 5mL) • 2458 alcohol pads • 1000 vaccination record cards • 10 needle gauge and length charts • 20 face shields • 40 surgical masks • 200 Diluent vials
Additional information	• Products and brands for kit components may vary. • All needles for vaccine administration are safety needles. • Mixing needles are conventional. • Due to the limited supply of needles and syringes, specification of preferences for needles or syringes is not feasible. • Kit and pallet configuration o 1 kit = 975 vaccinations (plus overage) o 1 pallet = 8 kits (supports 7,800 vaccinations, plus overage) For more information about ancillary kit components: COVID-19 Vaccine Ancillary Supply Kit Guidance		

*The total number of needles in each adult, pediatric, and mixed combined ancillary supply kit for administration and mixing will vary (adult–1,029; pediatric–1,024; mixed–1,026). The difference in total number is related to increasing the kit build efficiency.

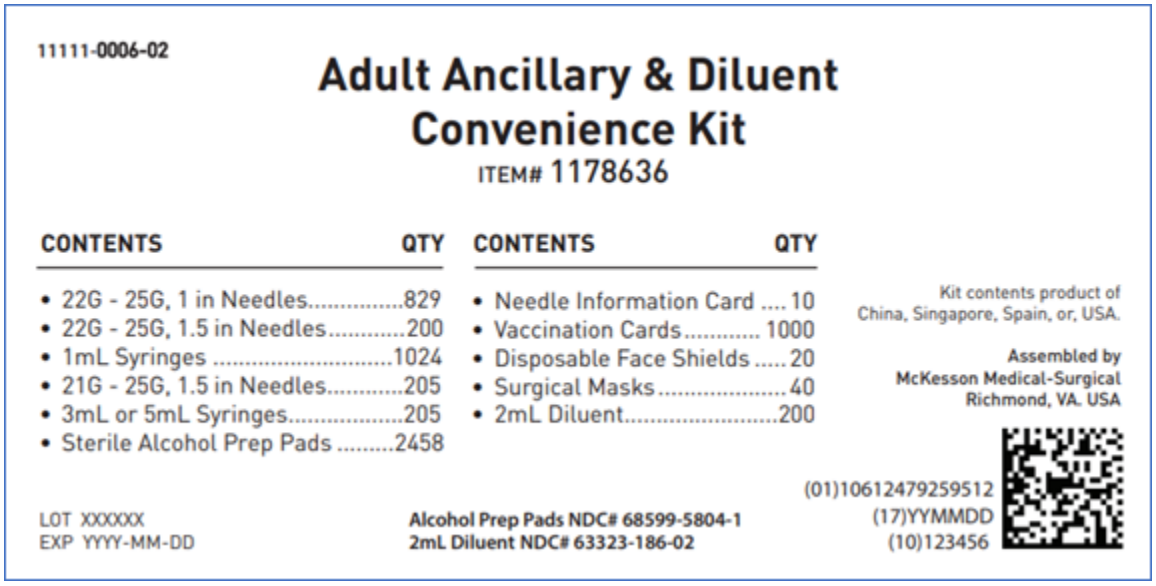
Dry Ice Kit (Direct Ship)

Kit description	Dry ice kit with starter materials
NDC # in VTrckS	11111-0007-03
Kit dimensions/weight	TBD
Minimum order size and increment	Kit to support initial dry ice recharge of one thermal shipping container
Accompanies ultracold vaccine	Pfizer
Contents	• Dry ice (~35 pounds) • Gloves for working with dry ice (1 pair) • Face shield (1) • Ice scoop (1) • OSHA dry ice safety card (1)
Additional information	• Products and brands for kit components may vary. -

Contents and Quantities for Mega Kits to Support Pfizer Vaccine

December 11, 2020

This is a clarification about the needle and syringes included in the COVID-19 ancillary supply kits for administering Pfizer's ultra-frozen vaccine. Based on questions coming into our call centers supporting the distribution of the ancillary supply kits for Operation Warp Speed, there is some confusion about the quantities of needles and syringes included in the kits. Each kit is clearly labeled with a complete inventory list. (See example below.)



11111-0006-02

Adult Ancillary & Diluent Convenience Kit

ITEM# 1178636

CONTENTS	QTY
• 22G - 25G, 1 in Needles	829
• 22G - 25G, 1.5 in Needles	200
• 1mL Syringes	1024
• 21G - 25G, 1.5 in Needles	205
• 3mL or 5mL Syringes	205
• Sterile Alcohol Prep Pads	2458

CONTENTS	QTY
• Needle Information Card	10
• Vaccination Cards	1000
• Disposable Face Shields	20
• Surgical Masks	40
• 2mL Diluent	200

Kit contents product of China, Singapore, Spain, or, USA.

Assembled by McKesson Medical-Surgical Richmond, VA. USA

(01)10612479259512
(17)YYMMDD
(10)123456

LOT XXXXXX
EXP YYYY-MM-DD

Alcohol Prep Pads NDC# 68599-5804-1
2mL Diluent NDC# 63323-186-02

Procuring the sheer number of needles and syringes needed to support an operation of this size involves complex logistics, which is why vaccine administrators may see variance in how the supplies are packaged. The listed products may be received as a combo, defined as a single packaged needle and syringe, or as individual components. The quantities listed on the label represent the minimum number of total combinations in each kit.

- For example, if the kit above was shipped with (829) 1ml-25Gx1" syringe/needle combos and (200) 22Gx1.5" needles for administration, the kit would only contain (200) 1ml syringes to accompany the needles. This would yield a total of (1,029) needles with accompanying syringes (some packaged together, some individually).
- If a kit contained only individual needles and syringes, there may be 5 more needles than syringes. This is intentional and is designed to improve your experience and maximize the inventory across all kits built.
    - In this scenario, the adjustment was to the 22-25Gx1.5" needles. The kit was originally configured to have 195. This was increased by 5 (to 200) to improve the administrators' experience by using two whole boxes.

Please note there will be multiple configurations used as Operation Warp Speed continues to procure products to support the assembly of these and other ancillary supply kits. Regardless of configuration, the kit contents will meet the minimum quantities listed on the kit content labels and will support the same total number of doses.

We hope this communication helps your teams as they review the content in the kits to ensure their readiness for administration when you receive the vaccine doses.

Please direct any issues regarding the ancillary kits to support the Pfizer COVID-19 vaccine to McKesson Customer Service at:

McKesson Customer Service
Phone #: 833-272-6634
Email: SNSSupport@McKesson.com

Addendum: COVID-19 Vaccine Ancillary Supply Kit Guidance

COVID-19 Vaccine Ancillary Supply Kit Guidance

»Purpose:

This guidance provides an overview of the COVID-19 vaccine ancillary supply kits the U.S. Department of Health and Human Services (HHS) is providing to enrolled COVID-19 vaccination providers as part of the federal COVID-19 vaccination program. It includes a general description of seven different COVID-19 vaccine ancillary kit configurations, as well as a list of select corresponding products, product descriptions, and product quantities. For reference and to access additional product-specific information and training resources, this document also includes website hyperlinks and contact information for select product manufacturers.

»Background:

HHS is providing ancillary supply kits for the administration of COVID-19 vaccine. The Strategic National Stockpile (SNS), managed by the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR), is partnering with McKesson Corporation to produce, store and distribute these vaccine ancillary supply kits on behalf of the SNS.

» How to use this guide:

Jurisdictional immunization program staff–use this guide to help you:

- Learn about products that will arrive in ancillary kit(s).

COVID-19 vaccination providers–use this guide to help you:

- Learn about products that will arrive in ancillary kit(s).
- Prepare storage space for the ancillary kit products you will receive.

» Ancillary kit basics:

How does a provider order ancillary kits?

You do not need to order ancillary kits. When you order COVID-19 vaccine in VTrckS, ancillary supplies will automatically be ordered in amounts to match the vaccine orders.

Note: To receive COVID-19 vaccine, vaccination provider facilities and organizations must enroll in the federal COVID-19 Vaccination Program coordinated through their jurisdiction's immunization program.

How much do ancillary kits cost?

Ancillary kits will be provided at no cost to enrolled COVID-19 vaccination providers.

What products are in ancillary kits?

Refer to page 11 for possible ancillary kits.

Each ancillary kit, **except for the kits designated for use with the Pfizer vaccine**, contains supplies to administer 100 doses of vaccine (with some overage). The **Pfizer vaccination kit** will support 975 doses of vaccine (with some overage). Refer to page 12 for possible variations on kit contents.

How will needles and syringes be packaged?

Needles and syringes for vaccine administration may be packaged as integrated units (i.e. NO assembly required) or as separate items in a kit (i.e. assembly required).

Can I order specific brand(s) of needles and/or syringes?

Due to a limited supply of needles and syringes, specification of preferences for needles or syringes is not feasible. Products included in the kits may vary over time. In order to meet the demand for supplies, the federal government has purchased single-use, sterile needles and syringes from multiple manufacturers (to include foreign sources) to ensure adequate supplies. These products are approved by the Food and Drug Administration, safety-engineered and compliant with standards established by the Occupational Safety and Health Administration.

What is considered "pediatric" and "adult"?

For the purpose of immunizations **pediatric is birth through 18 years** and **adult is 19 years and older**. Refer to each product's EUA for age indications.

» Related guidance and resources:

- Preliminary Strategy for Distributing a COVID-19 Vaccine - PDF
- COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations - PDF

» Contact for questions:

Vaccination providers should contact the manufacturer with questions related to proper product use. Concerns related to needle/syringe quality and performance or other contents of the vaccine ancillary supply kit should be directed to the state or local health department.

Becton Dickinson (BD) Worldwide	https://www.bd.com/en-us/	844-823-5433
Cardinal Health	https://www.cardinalhealth.com/en.html	1-800-964-5227
HTL Strefa	https://htl-strefa.com/home-page/	877-660-1900
Duopross Meditech Corp	https://www.duopross.com/	1-800-844-1350
Retractable Technologies Inc. (RTI)	https://retractable.com/	888-703-1010
Marathon/Smiths Medical	N/A	941-704-7864

Possible Ancillary Kits—COVID-19 Vaccines, *Excluding Pfizer*

The following tables list the contents of each possible ancillary kit by product and quantity. All kits are configured for 100 doses with 5% surplus.

Needle and Syringe Sizes for *Adult* Ancillary Kits

Product	Quantity
Needle (22–25G x 1")	85
Needle (22–25G x 1.5")	20
Syringe (1mL or 3mL)	105
Alcohol Pad (sterile, individually sealed)	210
Vaccination Record Card	100
Needle Gauge and Length Chart	1
Face Shield	2
Surgical Mask	4

Needle and Syringe Sizes for *Pediatric* Ancillary Kits

Product	Quantity
Needle (25G x 1")	105
Syringe (1mL or 3mL)	105
Alcohol Pad (sterile, individually sealed)	210
Vaccination Record Card	100
Needle Gauge and Length Chart	1
Face Shield	2
Surgical Mask	4

Needle and Syringe Sizes for *Mixed* Ancillary Kits

Product	Quantity
Adult/Pediatric Needle (22–25G x 1")	85
Adult Needle (22–25G x 1.5")	20
Syringe (1mL or 3mL)	105
Alcohol Pad (sterile, individually sealed)	210
Vaccination Record Card	100
Needle Gauge and Length Chart	1
Face Shield	2
Surgical Mask	4

Needle and Syringe Sizes for Mixing Kits

Needle and Syringe Sizes for *Mixing* Kits

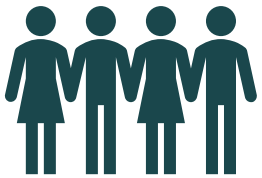
Product	Quantity
Needle (19-21G x 1.5")	11
Syringe (5mL or 6mL)	11
Alcohol Pad (sterile, individually sealed)	22

Needle Gauge and Length Chart: www.cdc.gov/vaccines/hcp/admin/downloads/vaccine-administration-needle-length.pdf

Possible Ancillary Kits—COVID-19 Vaccine, *Pfizer* Only

Needle and Syringe Sizes for Pfizer Mega *Adult* Ancillary Kits

Product	Quantity
Needle (22–25G x 1")	829
Needle (22–25G x 1.5")	200
Needle, Mixing (21-25G x 1.5")	205
Syringe (1mL)	1,024
Syringe, Mixing (3mL or 5mL)	205
Alcohol Pad (sterile, individually sealed)	2,458
Vaccination Record Card	1,000
Needle Gauge and Length Chart	10
Face Shield	20
Surgical Mask	40
Diluent	200



Needle and Syringe Sizes for Pfizer Mega *Pediatric* Ancillary Kits

Product	Quantity
Needle (25G x 1")	1,024
Needle, Mixing (21-25G x 1.5")	205
Syringe (1mL)	1,204
Syringe, Mixing (3mL or 5mL)	205
Alcohol Pad (sterile, individually sealed)	2,458
Vaccination Record Card	1,000
Needle Gauge and Length Chart	10
Face Shield	20
Surgical Mask	40
Diluent	200

Needle and Syringe Sizes for Pfizer Mega *Mixed* Ancillary Kits

Product	Quantity
Needle (25G x 1")	926
Needle (22–25G x 1.5")	100
Needle, Mixing (21–25G x 1.5")	205
Syringe (1mL)	1,024
Syringe, Mixing (3ml or 5ml)	205
Alcohol Pads (sterile, individually sealed)	2,458
Vaccination Record Card	1,000
Needle Gauge and Length Chart	10
Face Shield	20
Surgical Mask	40
Diluent	200

Needle Gauge and Length Chart: www.cdc.gov/vaccines/hcp/admin/downloads/vaccine-administration-needle-length.pdf

General Needle and Syringe Resources

Web Resources

- Vaccine Administration Resource Library: Includes resources for preparing, administering, and documenting vaccines

PDF Resources

- Vaccine Administration: Needle Gauge and Length–PDF
- Vaccine Administration: Intramuscular (IM) Injection Children 7 through 18 years of age–PDF
- Vaccine Administration: Intramuscular (IM) Injection Adults 19 years of age and older–PDF

Video Resources

- Assemble a Manufacturer-filled Syringe: This training addresses how to assemble a manufacturer-filled syringe, available for a variety of vaccines.

Specific Ancillary Kit Products and Product Information

The following tables, organized by manufacturer or broker, list possible ancillary kit products with an example image (colors may vary) and links to more information. Resources for additional information are organized by:

Web resources Pdf resources Video resources

Becton Dickinson Products (Phone: 844-823-5433)

Item	Where to Find more Information
Hypodermic Needle PrecisionGlide™ Conventional* • Gauge: 22-25/Length: 1.5” 	PrecisionGlide™ Conventional Needle overview Visit Becton Dickinson catalog and search product numbers: 305127, 305156, 305194
Safety Hypodermic Needle BD Eclipse™ • Gauge: 22-25/Length: 1-1.5” • Gauge: 23/25/Length: 1-1.25” 	BD Eclipse™ Needle overview Visit Becton Dickinson catalog and search product numbers: *22-25G, 1-1.5”*: 305762, 305761, 305763, 305767 *23/25, 1-1.25”*: 305866, 305891, 305892 BD Eclipse™ directions for use BD Eclipse™ Needle instruction video
Safety Combo, Syringe with BD Eclipse™ Needle 3mL BD Luer-Lok™ Syringe • Gauge: 22-25/ Length: 1-1.5” 	BD Eclipse™ Needle overview Visit Becton Dickinson catalog and search product numbers: 305782, 305783, 305787 BD Eclipse™ directions for use BD Eclipse™ Needle Instruction video

Item	Where to Find more Information
1mL/3mL BD Luer-Lok™ Syringe 	Conventional syringe overview Visit Becton Dickinson catalog and search product numbers: 309628, 309657
Conventional Combo* • Syringe (3mL/5mL) with attached needle Gauge: 22-25/Length: 1-1.5” 	Conventional syringe Overview Visit Becton Dickinson catalog and search product numbers: 309361, 309571, 309572, 309574, 309581, 309582, 309589

*For mixing ONLY and NOT for vaccine administration

PrecisionGlide™ Conventional Needle overview: https://www.bd.com/en-us/offerings/capabilities/syringes-and-needles/conventional-syringes-and-needles/conventional-needles

Becton Dickinson Product catalog: http://catalog.bd.com/

BD Eclipse™ Needle overview: https://www.bd.com/en-us/offerings/capabilities/syringes-and-needles/safety-syringes-and-needles/safety-needles/bd-eclipse-needle

BD Eclipse™ directions for use: https://www.bd.com/documents/guides/directions-for-use/MPS_HY_Eclipse-needle-usage-guidelines_DF_EN.pdf

BD Eclipse™ Needle instruction video: https://www.bd.com/en-us/company/video-gallery?video=6186777712001

Conventional Syringe overview: https://www.bd.com/en-us/offerings/capabilities/syringes-and-needles/conventional-syringes-and-needles/conventional-syringes

Cardinal Health (Phone: 1-800-964-5227)

Item	Where to find more information
Tuberculin Syringe Monoject™ • 1mL Luer Lock Tip Conventional Syringe 	1 mL Luer Lock Syringes product page Visit Cardinal Health webpage and search product numbers: 1180100777, 1180300777
Magellan™ 3mL Syringe with Hypodermic Safety Needle • Gauge: 23/25/Length: 1” 	Magellan™ Safety Needle and Syringe Combination product page Visit Cardinal Health webpage and search product numbers: 8881833310, 8881833510
Magellan™ Hypodermic Safety Needle • Gauge: 23/25 Length: 1” 	Magellan™ Hypodermic Safety Needle Product page Visit Cardinal Health webpage and search product numbers: 8881850310, 8881850510

1 mL luer Lock Syringes product page: https://www.cardinalhealth.com/en/product-solutions/medical/patient-care/sharp-safety/needles-and-syringes/1-ml-luer-lock-syringes.html
Cardinal Health webpage: https://www.cardinalhealth.com/en.html
Magellan™ Safety Needle and Syringe Combination product page: https://www.cardinalhealth.com/en/product-solutions/medical/patient-care/sharp-safety/needles-and-syringes/safety-needles-and-syringes/magellan-safety-needle-and-syringe-combination.html
Magellan™ Hypodermic Safety Needle product page: https://www.cardinalhealth.com/en/product-solutions/medical/patient-care/sharp-safety/needles-and-syringes/safety-needles-and-syringes/magellan-safety-needles.html

Duopross Meditech Corp (Phone: 1-800-844-1350)

Item	Where to find more information
Safety Combo, 1mL Syringe with Safety Needle* • Gauge: 23- 25/Length: 1-1.5” 	Website and product information currently unavailable.
Safety Combo, 3mL Syringe with Safety Needle* • Gauge: 23-25/Length: 1-1.5” 	Website and product information currently unavailable.

*Image for product is a placeholder stock image only. Product image is not currently available.

Goldbelt (Contact information currently unavailable)

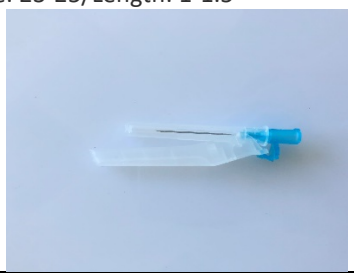
Item	Where to find more information
Safety Needle* • Gauge: 23-25/Length: 1-1.5” 	Website and product information currently unavailable.
Conventional Syringe 1mL* 	Website and product information currently unavailable.
Conventional Syringe 3mL* 	Website and product information currently unavailable.
Conventional Syringe 5mL* 	Website and product information currently unavailable.

*Image for product is a placeholder stock image only. Product image is not available currently.

Gold Coast (contact information not currently available)

Item	Where to find more information
Safety Combo, 1mL Syringe with Safety Needle • Gauge: 23/Length: 1” 	EasyTouch-FlipLock_Syringe_Instructions.p CP Safety_Flyer_Product EasyTouch-Safety_Syringe_Needle_Brochu Product Number: Carepoint 35-8204
Safety Combo, 1mL Syringe with Safety Needle • Gauge: 25/ Length: 1” 	EasyTouch-FlipLock_Syringe_Instructions.p CP Safety_Flyer_Product EasyTouch-Safety_Syringe_Needle_Brochu Product Number: Carepoint 35-8203
Safety Combo, FlipLock 3mL Syringe with Safety Needle • Gauge: 23/Length: 1” 	EasyTouch-FlipLock_Syringe_Instructions.p CP Safety_Flyer_Product EasyTouch-Safety_Syringe_Needle_Brochu Product Number: 822331
Safety Combo, FlipLock 3mL Syringe with Safety Needle • Gauge: 25/ Length: 1” 	EasyTouch-FlipLock_Syringe_Instructions.p CP Safety_Flyer_Product EasyTouch-Safety_Syringe_Needle_Brochu Product Number: 825231
Safety Needle • Gauge: 25/ Length: 1” • Gauge: 23/ Length: 1” 	EasyTouch-FlipLock_Syringe_Instructions.p CP Safety_Flyer_Product EasyTouch-Safety_Syringe_Needle_Brochu Product Numbers: 25G x 1”: EasyTouch 802501 23G x 1”: EasyTouch 812301

HTL Strefa (Phone: 877-660-1900)

Item	Where to find more information
Safety Combo, 1mL Syringe with Safety Needle • Gauge: 25/Length: 1” 	HTL Strefa home page (product 6054 currently unlisted) Appendix 1 Products picture and artwork_la
Safety Combo, 3mL Syringe with Safety Needle • Gauge: 23/Length: 1” 	HTL Strefa home page (product 6053 currently unlisted) Appendix 1 Products picture and artwork_la
Safety Combo, 3mL Syringe with Safety Needle • Gauge: 25/Length: 1” 	HTL Strefa home page (product 6055 currently unlisted) Appendix 1 Products picture and artwork_la

HTL Strefa home page: https://htl-strefa.com/home-page/

Marathon/Smiths Medical (Phone: 941-704-7864)

Item	Where to find more information
Safety Combo, 3mL Syringe with Safety Needle* • Gauge: 22-25/Length: 1-1.5” 	Website and product information currently unavailable. Product numbers: 4234, 4236, 423510

*Image for product is a placeholder stock image only. Product image is not available currently.

Medline (Contact information currently unavailable)

Item	Where to find more information
Safety Combo, 1mL Syringe with Safety Needle • Gauge: 23/Length: 1” • Gauge: 25/Length: 1” 	Website and product information currently unavailable.
Safety Needle • Gauge: 23/Length: 1-1.5” • Gauge: 25/Length: 1” 	Website and product information currently unavailable.
Conventional Syringe • 1mL • 3mL 	Luer Lock Syringe product page Visit Medline webpage and search product numbers: SYR101010, SYR103010

Luer Lock Syringe product page: https://www.medline.com/product/Luer-Lock-Syringes/Syringes-without-Needle/Z05-PF11377?question=SYR103010&index=P1&indexCount=1#mrkOrderingInfoTable

Medline webpage: https://www.medline.com

Quality Impact (Contact information currently unavailable)

Item	Where to find more information
Safety Combo, 1mL Syringe with Safety Needle* • Gauge: 23-25/Size: 1” 	Website and product information currently unavailable.
Safety Combo, 3mL Syringe with Safety Needle* • Gauge: 23-25/Size: 1” 	Website and product information currently unavailable.

*Image for product is a placeholder stock image only. Product image is not available currently.

Retractable Technologies Inc. (Phone: 888-703-1010)

Item	Where to find more information
Safety Combo Unit, 1mL/3ml, with attached needle • Gauge: 23/25/Length: 1” 	Visit Retractable Technologies Inc. webpage and search product numbers: 10161, 10311, 10391 VanishPoint® Syringes brochure VanishPoint® Syringes product usage information VanishPoint® Syringes video

Retractable Technologies Inc. webpage: https://vanishpoint.com/
VanishPoint® Syringes brochure: https://d2ghdaxqb194v2.cloudfront.net/577/166728.pdf
VanishPoint® Syringes product usage information: https://d2ghdaxqb194v2.cloudfront.net/577/166715.pdf
VanishPoint® Syringes video: https://youtu.be/wC-uXq3uUdQ

COVID-19 Vaccination Training Programs and Reference Materials for Healthcare Professionals

Healthcare professionals who are knowledgeable about evidence-based immunization strategies and best practices are critical to implementing a successful vaccination program. They are key to ensuring that vaccination is as safe and effective as possible. Some healthcare professionals administering COVID-19 vaccine may have extensive experience with immunization practices, since they routinely administer recommended vaccines in their clinical practice. For others, administering COVID-19 vaccine may be their first clinical experience with vaccination. Below is a list of immunization training and educational materials, including basic and COVID-19-vaccine-specific information.

Vaccine Storage and Handling

Vaccine storage and handling practices are only as effective as the staff who implement them. Staff who are well-trained in general storage and handling principles and follow standard operating procedures for vaccine management are critical to ensuring vaccine supply potency and patient safety.

Training Program / Reference Material	Description
You Call the Shots: Vaccine Storage and Handling	An interactive, web-based immunization training course on storage and handling best practices and principles.
"Keys to Storing and Handling Your Vaccine Supply" video	This video is designed to decrease vaccine storage and handling errors by demonstrating recommended best practices and addressing frequently asked questions.
Vaccine Storage and Handling Toolkit	Comprehensive guide that reflects best practices for vaccine storage and handling from Advisory Committee on Immunization Practices (ACIP) recommendations, product information from vaccine manufacturers, and scientific studies.
Vaccine Storage and Handling Toolkit, COVID-19 Vaccine Addendum	The *Vaccine Storage and Handling Toolkit,* COVID-19 Vaccine Addendum, provides information, recommendations, and resources on storage and handling best practices to help safeguard the COVID-19 vaccine supply and ensure patients receive safe and effective vaccines.
Epidemiology and Prevention of Vaccine-Preventable Diseases	Comprehensive information on routinely used vaccines and the diseases they prevent. Chapter 5 is dedicated to vaccine storage and handling (updated 2020).

Vaccine Administration

Healthcare professionals who will administer vaccines should receive comprehensive, competency-based training in vaccine administration policies and procedures before administering vaccines. Staff's vaccine administration knowledge and skills should be validated using a skills checklist and maintained using quality improvement processes.

You Call the Shots: Vaccine Administration	An interactive, web-based vaccine administration course that provides training using videos, job aids, and other resources.
Vaccine administration videos	Short, skill-based demonstration videos of vaccine administration activities, including injection techniques based on age and medication preparation.
Skills Checklist for Vaccine Administration	This checklist from the Immunization Action Coalition is a self-assessment tool for healthcare professionals who administer vaccines.
Epidemiology and Prevention of Vaccine-Preventable Diseases	Comprehensive information on routinely used vaccines and the diseases they prevent. Chapter 6 is dedicated to vaccine administration (updated 2020).

Communicating with Patients about Vaccines

Healthcare professionals play a key role in improving vaccine acceptance as they are in contact with patients throughout the office visit. By fostering a culture of immunization in the practice, both providers and patients can vaccinate with confidence.

How Nurses and Medical Assistants Can Foster a Culture of Immunization in the Practice video	Research shows that healthcare professionals are patients' most trusted source of information when it comes to vaccines. By highlighting key points before, during, and after a patient's visit, this presentation will support vaccine conversations and reinforce best practices for improving vaccination coverage.
"#HowIRecommend" vaccination video series	These videos explain the importance of vaccination, how to effectively address questions from patients about vaccine safety and effectiveness, and how clinicians routinely recommend same-day vaccination for their patients.
Provider Resources for COVID-19 Vaccine Conversations with Patients	Information for healthcare providers on how to talk to patients about COVID-19 vaccines, including giving strong recommendations, setting expectations about vaccine availability, and preparing to answer likely patient questions.
Epidemiology and Prevention of Vaccine-Preventable Diseases	Comprehensive information on routinely used vaccines and the diseases they prevent. Chapter 3, discusses essential strategies healthcare professionals can use when talking to patients about vaccines (updated 2020).

COVID-19 Vaccine Training and Clinical Materials

This suite of COVID-19 vaccine training programs and clinical materials for healthcare professionals include general and product-specific information. A variety of topics and formats are available. All are based on manufacturer's guidance and vaccine recommendations made by the Advisory Committee on Immunization Practices (ACIP). **These trainings and materials will be made available as each vaccine product is authorized by FDA.**

COVID-19 Vaccine Training: General Overview of Immunization Best Practices for Healthcare Providers	A web-based training course outlining best practices and principles for healthcare providers when preparing to administer COVID-19 vaccine. It is a high-level overview of the following topics with links to detailed information: vaccine development and safety, safety monitoring programs, Emergency Use Authorizations (EUAs), vaccine storage/handling, preparation, administration, PPE, scheduling, documentation, and reporting adverse events. Information on each vaccine product will be added as each is authorized by FDA.
Ongoing webinars, including posted recordings (CE available)	These webinars will address ACIP recommendations and vaccine products as they become available.
Clinical materials	COVID-19 vaccine screening form for contraindications and precautions Expiration date tracker Reporting a temperature excursion IIS off-line vaccine administration documentation tool Guide to ancillary supplies kit (for staff helping providers order vaccine) COVID-19 vaccine frequently asked clinical questions web page

Pfizer vaccine materials	Online training module Vaccine preparation and administration summary Storage and handling summary Temperature log and beyond use date tracking tool when using the thermal shipping container for storage, including online fillable PDF version Temperature log for ultra-cold freezer units, including online fillable PDF version Beyond use date tracker labels for refrigerator storage Standing orders template
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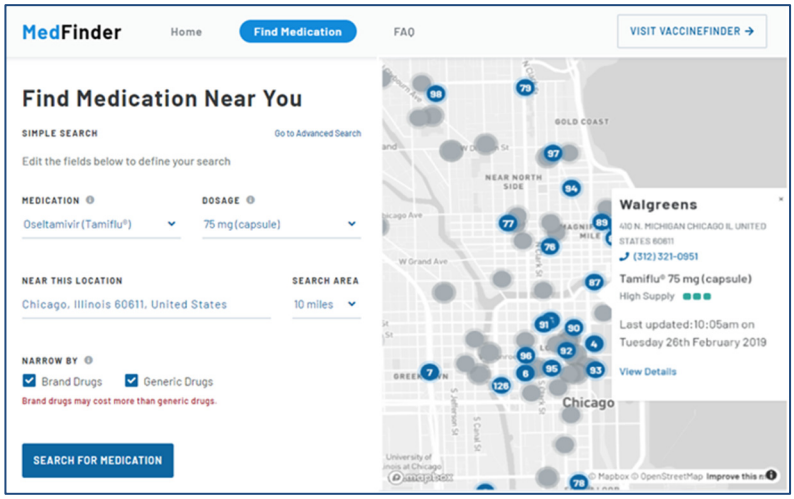
Clinical materials for additional vaccine products, plus specific materials determined by product	Online training module for each vaccine product Vaccine administration summary Vaccine storage and handling summary

MedFinder Improving Access to Medications

What is MedFinder?

The MedFinder website helps providers and patients find nearby pharmacies with available influenza antiviral drugs (www.medfinder.org). MedFinder relies on pharmacy partnerships to report accurate and up-to-date information about available medications. The HealthMap Computational Epidemiology Lab[1] maintains MedFinder in partnership with CDC.



MedFinder connects patients and providers with available influenza antiviral drugs

Overview and Benefits

MedFinder's goal is to make it simple for users to find a nearby location to fill their prescription for influenza medications. Patients prescribed antiviral drugs and healthcare providers sending e-prescriptions can use MedFinder to find locations nearby that have these medications available. Users specify their location and medications, and MedFinder displays mapped results of stores and their ability to fill a prescription based on the drug supply they have:

- High supply of medication (+48 hours of supply)
- Moderate supply of medication (24–48 hours of supply)
- Low supply of medication (less than 24 hours of supply)

Key benefits help save time and resources during a seasonal influenza outbreak or pandemic:

- Easy to use website directs patients to stores with medications on hand and reduces misdirected prescriptions
- Supports timely access to critical medications by improving dispensing time and enabling prompt treatment
- Flexible reporting options allow pharmacies to update supply (manual and automated methods available)

What Pharmacies Need to Know

During an influenza outbreak, timely information on where to go to access influenza antiviral drugs will be critical for: ***providers*** to know where to send prescriptions; ***patients*** to know where to fill their prescription; and ***public health*** decision makers to know when additional antiviral drug supplies from stockpiles may be needed. MedFinder includes locations in all 50 states, DC, and Puerto Rico. All information on MedFinder is updated by participating pharmacies.

Pharmacies enroll and report supply estimates for the medications they carry at each participating location. Reporting options include: (1) manually via a secure online portal (web form or data file upload); or (2) an automated secure data transfer to report medication availability. Pharmacies are encouraged to update medication supply frequently to ensure accurate information is available for the public.

To participate in MedFinder, register your location at https://locating.health/register.
If you are a vaccination provider, help people find your location for the vaccines they need. Learn more at https://vaccinefinder.org.

[1] HealthMap, based at Boston Children's Hospital, is a global leader in applying online tools to public health threats (https://healthmap.org).

Centers for Disease Control and Prevention
National Center for Immunization and Respiratory Diseases

Moderna COVID-19 Vaccine

Storage and Handling Summary

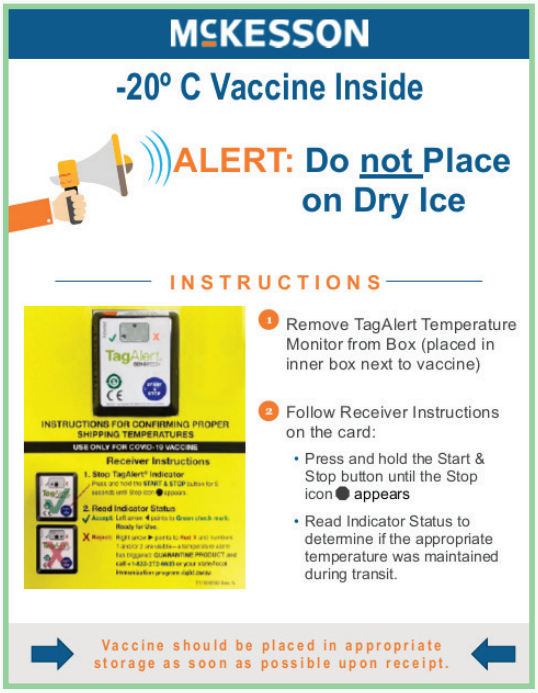
Basics

- Store vaccine in a freezer or refrigerator. See guidance below for each storage unit.
- Each box contains 10 multidose vials (100 doses).
- Use vaccine vials stored in the refrigerator before removing vials from frozen storage.
- This vaccine does not need to be mixed with a diluent before administration.
- Check and record storage unit temperature each workday. See guidance below for each type of temperature monitoring device. Save storage records for 3 years, unless your jurisdiction requires a longer time period.

Deliveries

Vaccine

1. The vaccine will arrive frozen between -25°C and -15°C (-13°F and 5°F).
2. Examine the shipment for signs of damage.
3. Open the box and remove TagAlert Temperature Monitor from box (placed in the inner box next to vaccine).
4. Check the TagAlert temperature monitoring device by pressing the blue "start and stop" button.
   - Left arrow points to a **green checkmark:** The vaccine is ready to use. Store the vaccine at proper temperatures immediately.
   - Right arrow points to a **red X:** The numbers 1 and/or 2 will appear in the display. Store the vaccine at proper temperatures and label **DO NOT USE**! Call the phone number indicated in the instructions or your jurisdiction's immunization program **IMMEDIATELY**!



Ancillary Supply Kit

An ancillary supply kit will be provided for administering the vaccine and includes enough supplies to administer 100 doses of vaccine.

Administration supplies include needles, syringes, sterile alcohol prep pads, vaccination record cards (shot cards), and some PPE.

The kit is delivered separately from the vaccine. Unpack the kit and check for receipt of the correct administration supplies and quantities.

Freezer

Vaccine may be stored in a freezer between -25°C and -15°C (-13°F and 5°F).

Note: These temperatures are within the appropriate range for routinely recommended vaccines BUT the temperature range for this vaccine is tighter.

- If storing the vaccine in a freezer with routinely recommended vaccines, carefully adjust the freezer temperature to the correct temperature range for this vaccine.

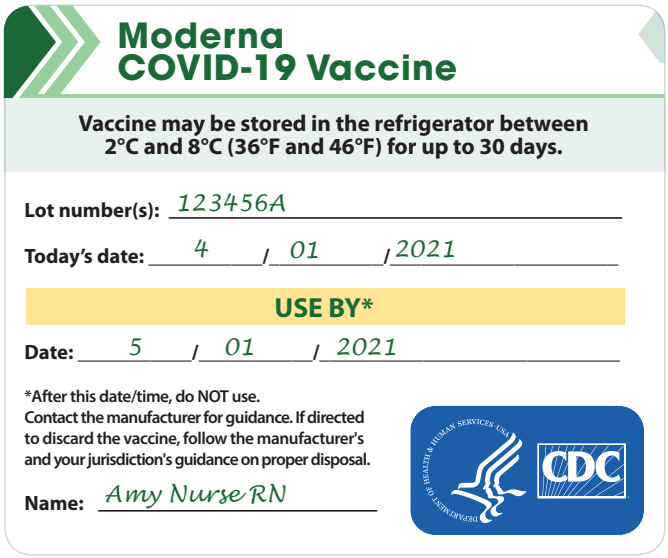
Store in the original carton and protect from light. | Do not use dry ice for storage.

Moderna COVID-19 Vaccine
Storage and Handling Summary

Refrigerator

- Vaccine vials may be stored in the refrigerator between 2°C and 8°C (36°F and 46°F) for up to 30 days before vials are punctured. After 30 days, remove any remaining vials from the refrigerator and discard following manufacturer and jurisdiction guidance on proper disposal.
- Thawed vaccine cannot be refrozen.
- Use beyond-use date labels to track how long the vaccine has been in the refrigerator. Monitor the beyond-use date/time.

  - Remove the box from frozen storage.
  - Complete the information on the storage label and attach it to the box holding the vaccine vials.
  - Once labeled, store vaccine in the refrigerator.



Temperature Monitoring

Storage unit temperatures must be monitored regularly and checked and recorded at the beginning of each workday to determine if any excursions have occurred since the last temperature check. For accurate temperature monitoring, use a digital data logger (DDL) with a detachable probe that best reflects vaccine temperatures (e.g., probe buffered with glycol, glass beads, sand, or Teflon®). Check and record the temperature daily using a temperature log and one of the options below:

- **Option 1: Minimum/Maximum Temperatures (preferred)**
  Most DDLs display minimum and maximum (min/max) temperatures. Check and record the min/max temperatures at the start of each workday.
- **Option 2: Current Temperature**
  If the DDL does not display min/max temperatures, check and record the current temperature at the start and end of the workday. Review the continuous DDL temperature data daily.

For CDC temperatures logs, see https://www.cdc.gov/vaccines/covid-19/info-by-product/moderna/index.html.

For additional information, refer to the manufacturer's product information at https://www.modernatx.com/covid19vaccine-eua/.

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Account for Additional Doses of COVID-19 Vaccine

As the initial doses of Pfizer and Moderna vaccine have been delivered and administered over the past days, immunizers have observed additional volume in the vaccine vials after proper reconstitution and administration of five doses. In response, FDA has issued preliminary advice:

> *"Given the public health emergency, it acceptable to use every full dose obtainable (the sixth, or possibly even a seventh) from each vial, pending our administrative solution to the issue. However, since these are preservative-free vials, any further remaining liquid that does not constitute a full dose should not be pooled from multiple vials to create one."*

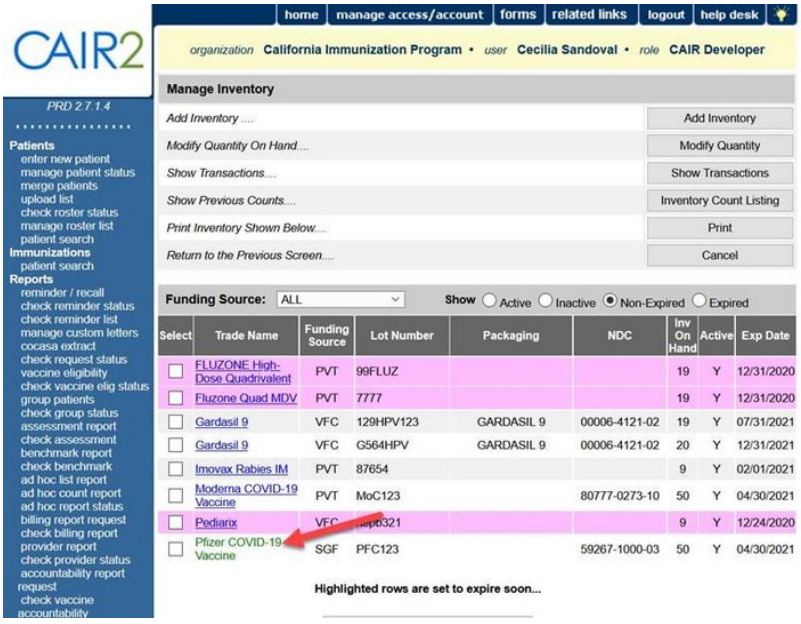
To account for a potential 6th or 7th dose from each vial of COVID-19 vaccine in CAIR2, providers should add the additional doses to your current inventory (e.g., for every 5 doses, add 1-2 more doses). Keep in mind that vaccine inventory only decrements for providers who enter doses manually (CAIR2 user interface) and data exchange (enter doses through EHR) users currently set up for decrementing.

See instructions below on how to adjust your inventory to add additional doses.

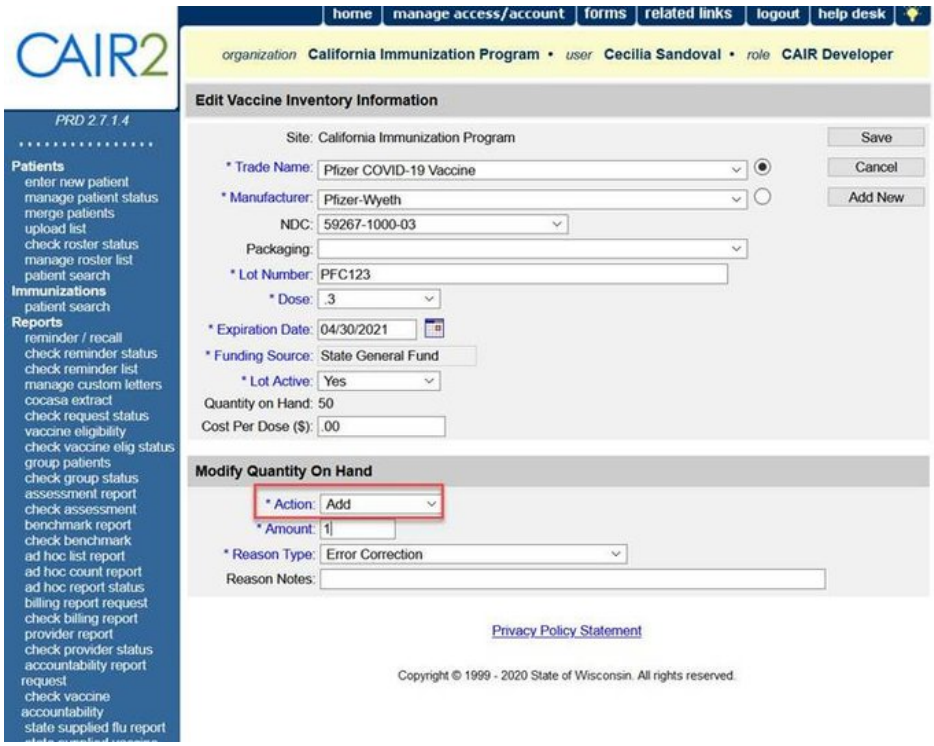
For any questions regarding manually adjusting inventory in CAIR, please contact CAIRHelpDesk@cdph.ca.gov. If you are submitting data to CAIR electronically, please contact CAIRDataExchange@cdph.ca.gov.

How to Adjust Your Inventory to Add Doses in CAIR2

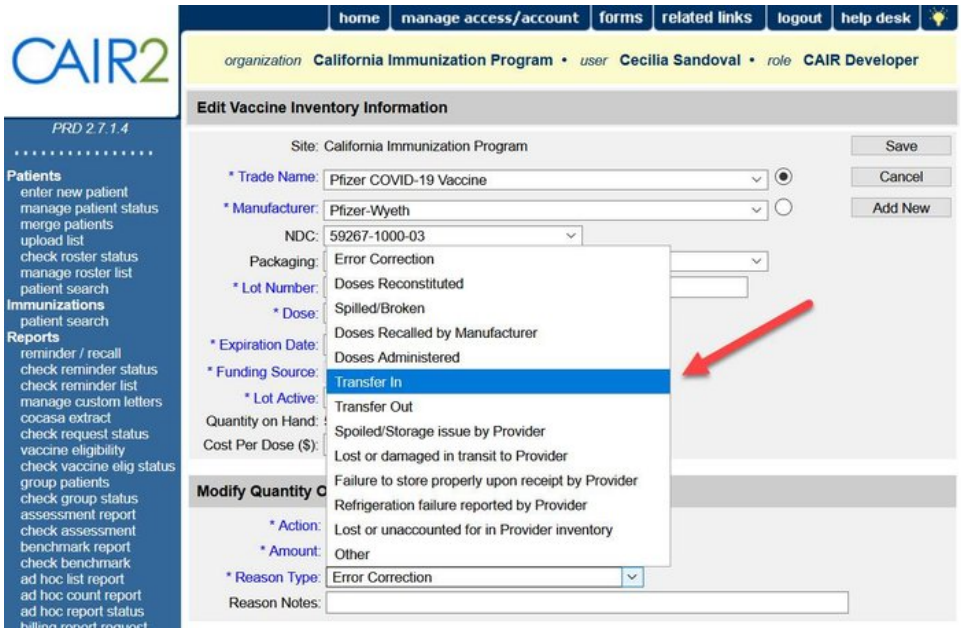
1.Click on the desired Pfizer or Moderna vaccine lot.



2.Select "Add" as the action under "Modify Quantity on Hand."



3. From the drop-down menu, select "Transfer In" as the "Reason Type." Under the "Reason Notes," type in "additional doses per vial."



View Archived Messages

COVID-19 Vaccination Program Participation Requirements

Lesson 1

Your participation in the COVID-19 Vaccination Program is greatly appreciated as a vital service to public health. Immunization with a safe and effective COVID-19 vaccine is a critical component of the United States strategy to reduce COVID-19-related illnesses, hospitalizations, and deaths and to help restore societal functioning.

Phased Vaccination Efforts

The goal of the U.S. government is to have enough COVID-19 vaccine doses for all people in the United States who wish to be vaccinated. However, it is likely that early in the COVID-19 Vaccination Program, vaccine supply will likely be limited and vaccination efforts will be conducted in phases, focusing immunization efforts on critical populations defined nationally.

No-Cost Vaccines

Federally supplied COVID-19 vaccines, constituent products, and ancillary supplies will be procured and distributed by the federal government at no cost to enrolled COVID-19 vaccination providers. Vaccines will be made available to immunization providers working in partnership with state and local health departments to vaccinate individuals for whom the vaccine is recommended.

Enrollment at COVIDReadi

In order to receive and administer federally procured COVID-19 vaccines, healthcare providers must enroll and agree to participation conditions outlined in the CDC COVID-19 Vaccination Program Provider Agreement. Enrolled vaccination providers must have an active and valid license to possess and administer vaccines in the state of California.

The Provider Agreement must be signed electronically as part of the enrollment application process through California's enrollment portal at COVIDReadi. Once enrolled, organizations will receive an initial notification of approval and information to prepare the organization for vaccine receipt once vaccine supply becomes available.

Program Requirements

The organization must ensure staff involved in the COVID-19 Vaccination Program complete the required training and adhere to the following federal participation requirements:

1. Organization must administer COVID-19 vaccine in accordance with all requirements and recommendations of CDC and CDC's Advisory Committee on Immunization Practices (ACIP).

2. Within 24 hours of administering a dose of COVID-19 vaccine and adjuvant (if applicable), Organization must record in the vaccine recipient's record and report required information to the relevant state, local, or territorial public health authority. Details of required information (collectively, Vaccine Administration Data) for reporting can be found on CDC's website.

    a. Organization must submit Vaccine Administration Data through either

        i. the immunization information system (IIS) of the state and local or territorial jurisdiction or

        ii. another system designated by CDC according to CDC documentation and data requirements.

    b. Organization must preserve the record for at least 3 years following vaccination, or longer if required by state, local, or territorial law. Such records must be made available to any federal, state, local, or territorial public health department to the extent authorized by law.

3. Organization must not sell or seek reimbursement for COVID-19 vaccine and any adjuvant, syringes, needles, or other constituent products and ancillary supplies that the federal government provides without cost to Organization.

4. Organization must administer COVID-19 Vaccine regardless of the vaccine recipient's ability to pay COVID-19 Vaccine administration fees or coverage status. Organization may seek appropriate reimbursement from a program or plan that covers COVID-19 Vaccine administration fees for the vaccine recipient. Organization may not seek any reimbursement, including through balance billing, from the vaccine recipient.

5. Before administering COVID-19 vaccine, Organization must provide an approved Emergency Use Authorization (EUA) fact sheet or vaccine information statement (VIS), as required, to each vaccine recipient, the adult caregiver accompanying the recipient, or other legal representative.

6. Organization's COVID-19 vaccination services must be conducted in compliance with CDC's Guidance for Immunization Services During the COVID-19 Pandemic for safe delivery of vaccines.

7. Organization must comply with CDC requirements for COVID-19 vaccine management. Those requirements include the following:

    a. Organization must store and handle COVID-19 vaccine under proper conditions, including maintaining cold chain conditions and chain of custody at all times in accordance with the manufacturer's package insert and CDC guidance in CDC's Vaccine Storage and Handling Toolkit, which will be updated to include specific information related to COVID-19 vaccine;

b. Organization must monitor vaccine storage unit temperatures at all times using equipment and practices that comply with guidance in CDC's Vaccine Storage and Handling Toolkit;

c. Organization must comply with each relevant jurisdiction's immunization program guidance for dealing with temperature excursions;

d. Organization must monitor and comply with COVID-19 vaccine expiration dates; and

e. Organization must preserve all records related to COVID-19 vaccine management for a minimum of 3 years, or longer if required by state, local, or territorial law.

8. Organization must report the number of doses of COVID-19 vaccine and adjuvants that were unused, spoiled, expired, or wasted as required by the relevant jurisdiction.

9. Organization must comply with all federal instructions and timelines for disposing of COVID-19 vaccine and adjuvant, including unused doses.

10. Organization must report any adverse events following vaccination to the **Vaccine Adverse Event Reporting System** (VAERS) website or (1-800-822-7967).

11. Organization must provide a completed COVID-19 vaccination record card to every COVID-19 vaccine recipient, the adult caregiver accompanying the recipient, or other legal representative. Each COVID-19 vaccine shipment will include COVID-19 vaccination record cards.

12. a) Organization must comply with all applicable requirements as set forth by the U.S. Food and Drug Administration, including but not limited to requirements in any EUA that covers COVID-19 vaccine.

b) Organization must administer COVID-19 vaccine in compliance with all applicable state and territorial vaccination laws.

Reporting Inventory to Vaccine Finder

California COVID-19 Vaccination Program

All COVID-19 vaccination providers must report COVID-19 vaccine inventory daily into VaccineFinder. The organization identified during enrollment may choose to report inventory for all affiliated provider locations. Or the organization may choose to push reporting responsibility down to the provider locations. Inventory will be reported directly to VaccineFinder's COVID Health provider portal.

Program Requirements

Organization must report the number of doses of COVID-19 vaccine and adjuvants that were unused, spoiled, expired, or wasted as required by the relevant jurisdiction.

What is VaccineFinder?

The VaccineFinder platform helps the public find providers who offer select vaccines in communities across the United States. All information on Vaccine Finder is updated by participating vaccine providers. Initially providers will report their inventory to the platform. Once there is enough supply, providers may choose to make their location visible on VaccineFinder.

VaccineFinder's Role in the COVID-19 Response

- Inventory reporting: providers must report on-hand COVID-19 vaccine inventory each day
- Increase access to COVID-19 vaccines: providers may choose to make their location visible on VaccineFinder once there is enough supply

Reporting Options

- Upload a spreadsheet with inventory quantities
- Manually enter inventory quantities in VaccineFinder

When Inventory Is Reported to CDC

- Most recent inventory file will be reported to VaccineFinder at 5 am EST
- Files reported after 5 am will be reported the following day

Resources

- **VaccineFinder Fact Sheet**
- **VaccineFinder Provider Information**
- **VaccineFinder training video**
- **COVID-19 Vaccination Provider Data and Reporting Support**

Instructions for Initial Onboarding to VaccineFinder

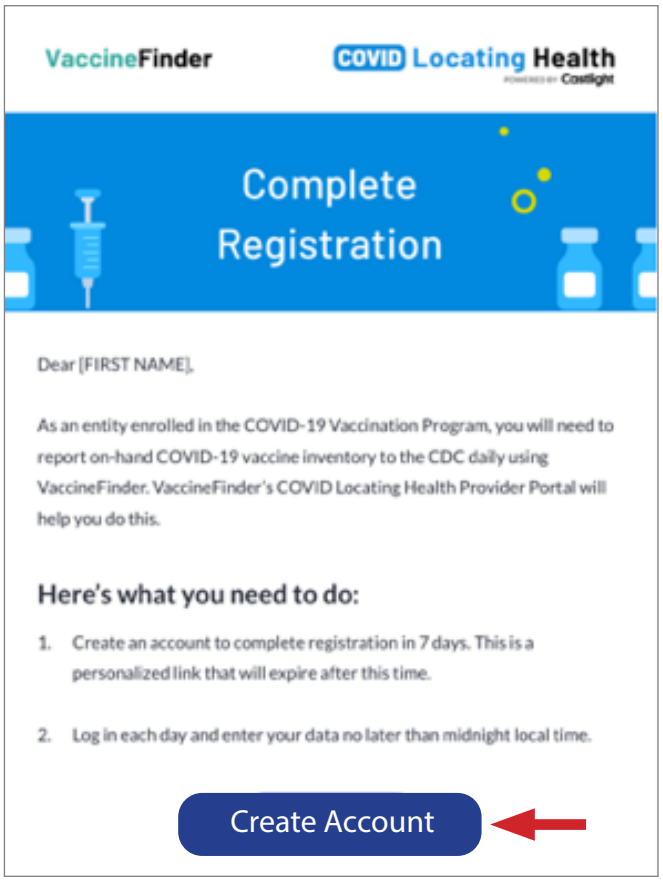
The organization identified during enrollment will automatically receive an invitation to register with VaccineFinder. Follow these instructions to complete initial onboarding to VaccineFinder.

Use Google Chrome or Safari browser when accessing the COVID Locating Health portal.

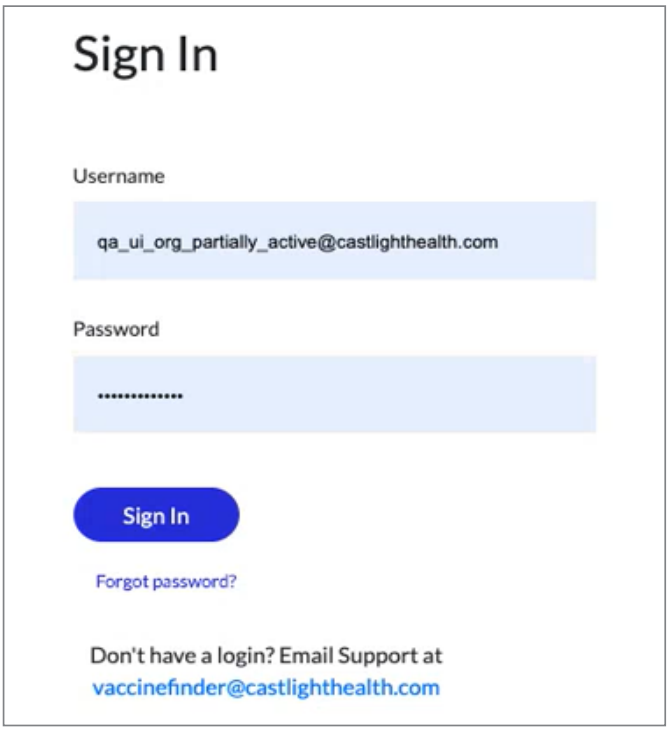
1. Retrieve your email sent from vaccinefinder@auth.castlighthealth.com and click **Create Account** to complete your registration.

   The invitation will be sent to the primary organization's email address submitted during enrollment. **Link will be active for about 7 days.**

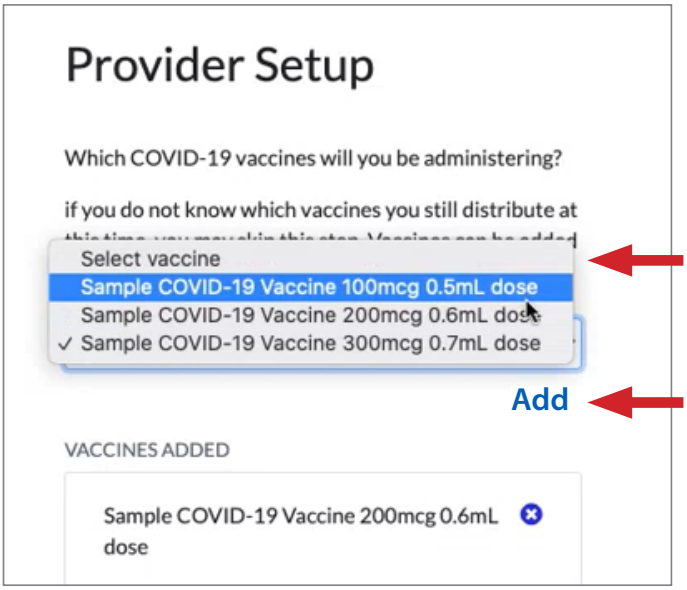
   Can't find your invitation email? Check the Spam and Junk folders for the organization's email identified during enrollment, or **email Support at (vaccinefinder@castlighthealth.com)**.



2. Sign in with your email and password.



3. **Select vaccine** you'll be administering from the dropdown menu and click **Add**. Repeat for additional vaccines. Selections appear under Vaccines Added. Click the **X** to remove vaccines.



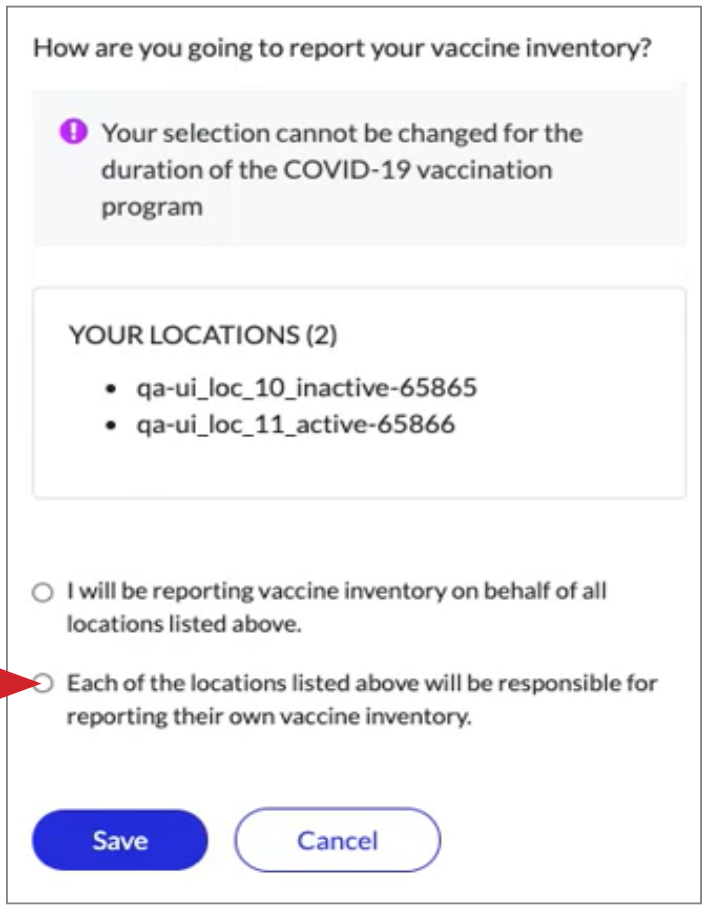
4. Click to indicate how your organization will be reporting inventory and click Save.

   All affiliated locations submitted during provider enrollment are listed as Your Locations.

   IMPORTANT: This option can't be changed for the duration of the COVID-19 Vaccination Program.

   First option: The organization will report daily inventory for all affiliated provider locations.

   Second option: The organization has the ability to push reporting responsibility down to the affiliated locations submitted during provider enrollment. A registration email will be sent to the vaccine coordinators identified for each location. Each location must go through this onboarding process and report inventory daily for their location.

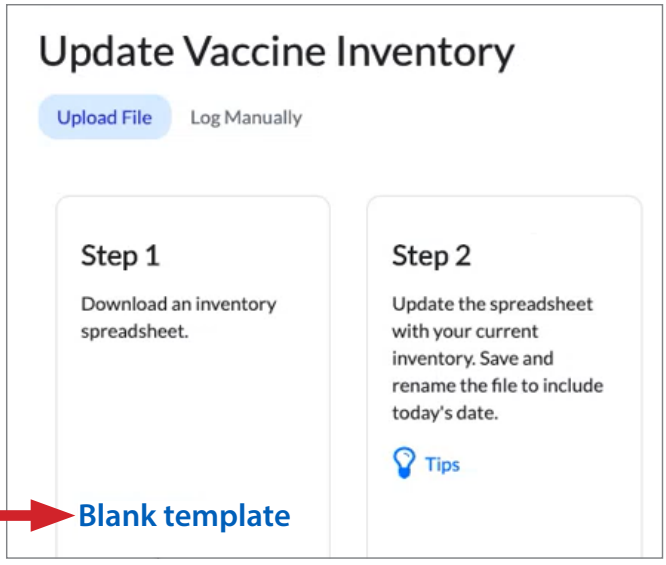


Instructions for Reporting Inventory Using Upload File

Follow these instructions to report daily inventory to Vaccine Finder by uploading a spreadsheet. Use Google Chrome or Safari browser when accessing the COVID Locating Health portal.

1. Click **Blank template** to open a spreadsheet. Spreadsheet will appear in lower left-hand corner of your browser.

   It will be prefilled with your organization and provider location details.



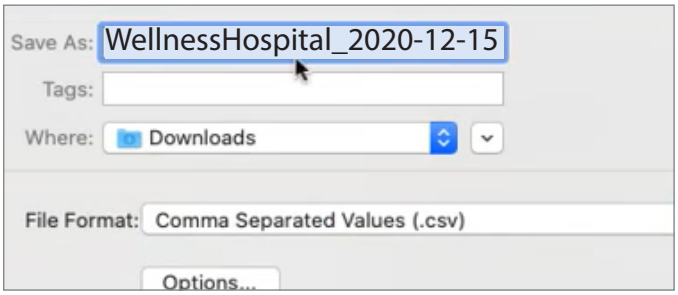
2. Open the spreadsheet. In this example, the organization has two affiliated provider locations each administering three vaccines. Three rows appear for each location so that inventory can be reported by vaccine.

Organization Name	Provider Location Name	Provider ID	Address	Medi-cation	NDC	Medi-cation	Quantity
Wellness Hospital	Clinic 1	abcd1234	123 South Lane	V	1000-0	COVID 1	Enter Quantity
Wellness Hospital	Clinic 1	abcd1234	123 South Lane	V	2000-0	COVID 2	Enter Quantity
Wellness Hospital	Clinic 1	abcd1234	123 South Lane	V	3000-0	COVID 3	Enter Quantity
Wellness Hospital	Clinic 2	jklm56789	456 North Lane	V	1000-0	COVID 1	Enter Quantity
Wellness Hospital	Clinic 2	jklm56789	456 North Lane	V	2000-0	COVID 2	Enter Quantity
Wellness Hospital	Clinic 2	jklm56789	456 North Lane	V	3000-0	COVID 3	Enter Quantity

3. Enter the vaccine **Quantity** for each vaccine and provider location

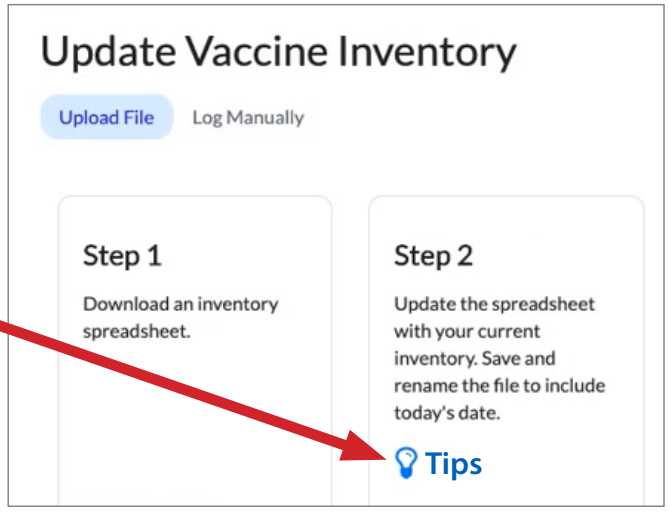
Medi-cation	Quantity
COVID 1	100
COVID 2	300
COVID 3	50
COVID 1	975
COVID 2	1000
COVID 3	1300

4. Save with filename that includes your **Organization Name** (first column in your spreadsheet) and **current date**. Store the file on your desktop or organize in folders.



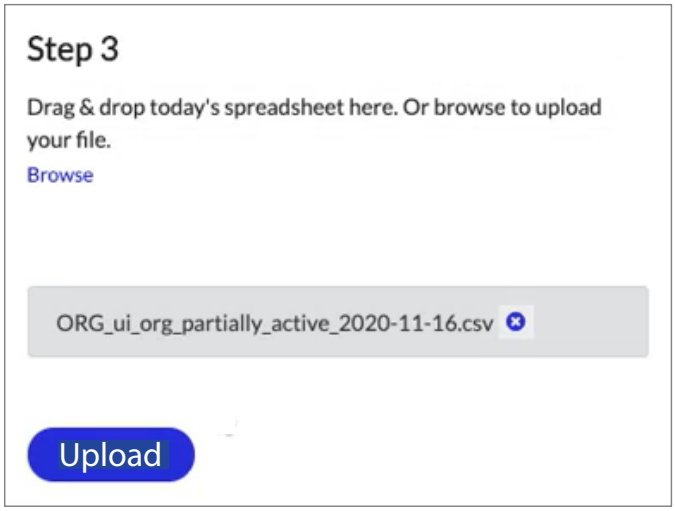
5. Click **Tips** under Step 2 for additional guidance: You may enter these values in the **Quantity** column of your spreadsheet:

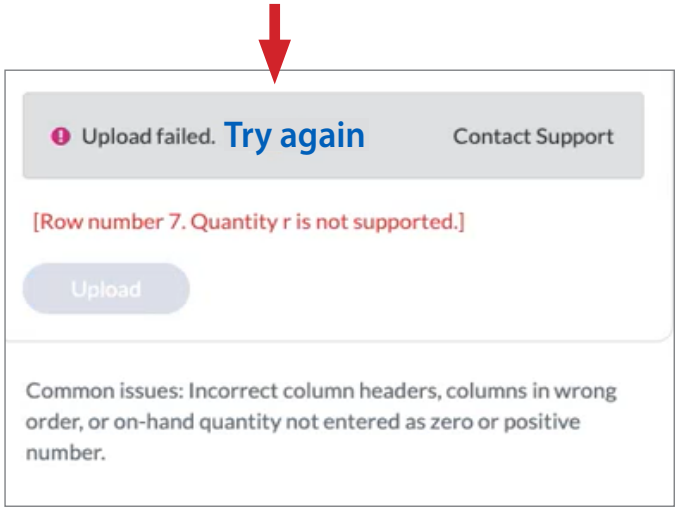
- **UNKNOWN** if quantity is unknown
- **REMOVE** to remove that row from your spreadsheet the next time you report if no longer stocking a vaccine
- **0** to report no doses left.



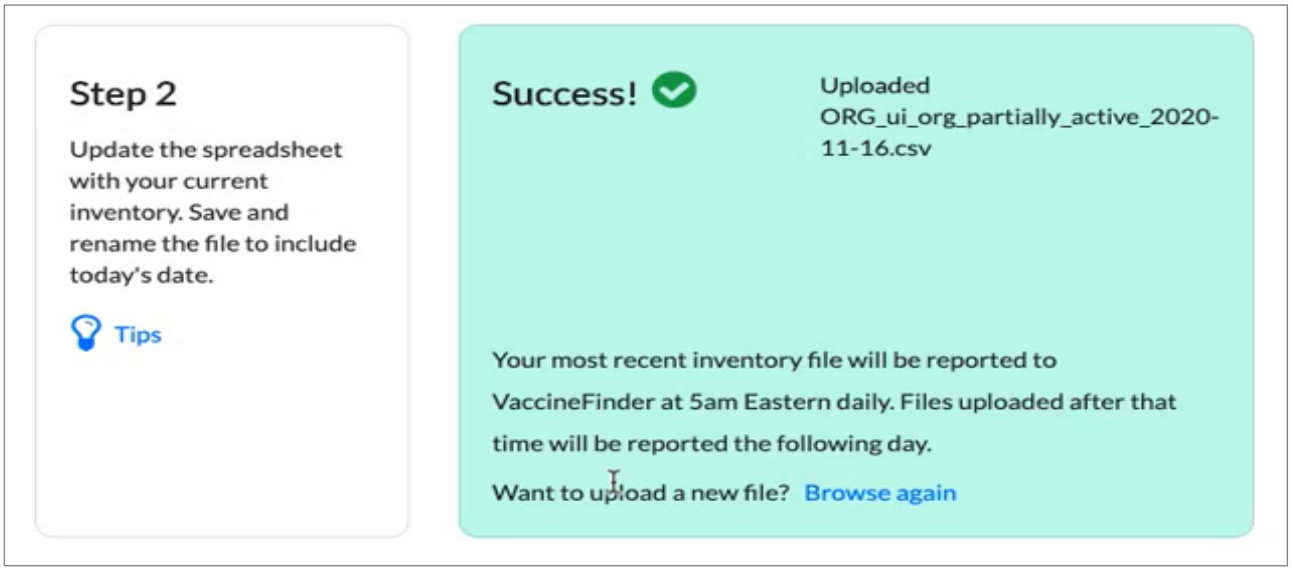
6. Drag/drop or browse to **Upload** today's spreadsheet.

   If upload fails due to errors, edit and save your spreadsheet then **Try again** to upload the corrected file.





7. Look for confirmation your inventory was successfully uploaded.
   - **Success message:** Your most recent inventory file will be reported to VaccineFinder at 5 am EST. Files reported after 5 am will be reported the following day.

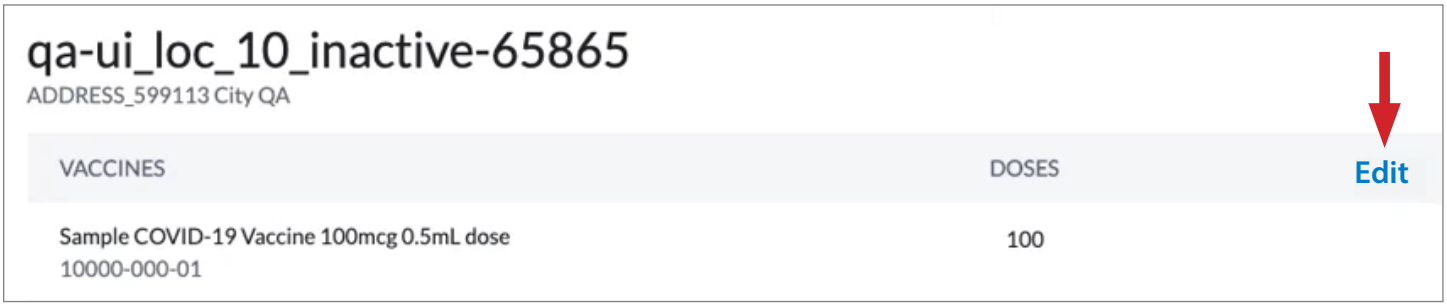


Questions? Click **Need Help** at the bottom of the page to email the VaccineFinder help desk.

Instructions for Reporting Inventory Through Manual Edits

Follow these instructions to report daily inventory to Vaccine Finder manually. Use Google Chrome or Safari browser when accessing the COVID Locating Health portal.

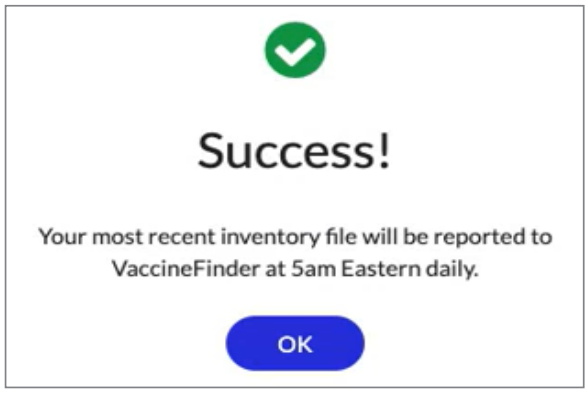
1. Click **Log Manually**.
2. Click **Edit** to report vaccine doses by location.



3. Type the current inventory for each vaccine for that location and click **Done**.

4. Repeat for each provider location and click Submit Inventory.

5. Look for confirmation your inventory was successfully reported.



Guidance for Existing VaccineFinder Accounts:

Q: What if I already report data for routine vaccines via my existing Locating Health account? Can I just use that account?

A: All COVID-19 vaccination providers will need to create a new account in the COVID Locating Health Provider Portal specifically for COVID-19 vaccine information.

There will initially be two Locating Health Provider Portals (plans are in place to integrate these provider portals into one platform in the coming months):

- **Locating Health Provider Portal** for reporting seasonal and routine vaccine availability
- **COVID Locating Health Provider Portal** for required daily reporting of on-hand COVID-19 vaccine inventory quantities

If you are reporting manually:

- Organizations will continue to access the existing Locating Health Provider Portal to update availability of influenza and other routine vaccines and medications.
- Organizations will log into the new COVID Locating Health Provider Portal to submit daily COVID-19 vaccine inventory reports for each participating provider location (online form or batch upload).

If you are using automated reporting:

- Organizations will continue to send data files to VaccineFinder to update availability of influenza vaccines and routine adult and child vaccines and medications at their provider locations.
- For COVID-19 reporting, organizations will add COVID-19 vaccination providers and COVID-19 vaccine quantities to their existing data file and send to VaccineFinder via the usual process.

COVID-19 Vaccine Transport Log

Instructions: Complete this log each time vaccines are transported.

Provider Name: _____ COVID-19 PIN: _____ Transport Date/Time:_____
Transported to: _____ COVID-19 PIN: _____

Vaccines transported due to:

☐ Redistribution ☐ Transfer ☐ Excess supply ☐ Power outage ☐ Unit malfunction ☐ Short-dated doses
☐ Repositioning (Temporary/satellite/off-site setting) ☐ Building maintenance ☐ Other _____

Vaccine Inventory Information

Manufacturer	Lot Number	Beyond Use or Expiration Date	Number of Doses	Doses Previously Transported	Refrigerated/Frozen/ULT	Thermal Shipper Last Re-iced

Temperature Monitoring Information:

Vaccine Storage	Temperature	Time	Vaccine Storage	Temperature	Time
Storage unit before departure:	°C/F		Cooler before departure:	°C/F	
Cooler upon arrival:	°C/F		Destination storage unit upon arrival:	°C/F	

Report all temperature excursions including the vaccine storage incident resolution. **Total Transport time (min/hours):_____**

Contact the COVID-19 Call Center for assistance at (833) 502-1245. Pfizer Vaccine: Transport time counts towards 120-hr refrigerator limit

Preparing for COVID-19 Vaccination Program Enrollment

Action Steps & Instructions for Provider Enrollment

In order to receive and administer COVID-19 vaccines, all California healthcare providers will enroll in the federal COVID-19 Vaccination Program electronically through CDPH's provider registration and enrollment system at https://ca.covidreadi.com/. Enrollment applications must be thoroughly and accurately completed by each enrolled organization and corresponding locations.

COVID-19 vaccines and ancillary supplies will be procured and distributed by the federal government at no cost to enrolled COVID-19 vaccination providers.

Enrollment Process

Each organization must enroll electronically through CDPH's provider registration and enrollment system. After completion of the Requirements and Legal Agreement portion of the enrollment form, the organization receives an invitation code. This code can be shared within the organization to access the organization's application and complete Section B to enroll their individual locations in the program.

- ✓ The Organization's Chief Medical Officer (CMO) and Chief Financial Officer (CFO) or Chief Executive Officer (CEO) completes the first portion of the enrollment process, Section A. Upon completion, they must sign and agree, on behalf of the organization, to the conditions of participation outlined in the COVID-19 Provider Agreement.
- ✓ If multiple locations within an organization plan to receive the COVID-19 vaccine, each location will complete Section B of the enrollment process. The locations must identify the Medical or Pharmacy Director that is responsible for their adherence to Provider Agreement terms, and attest to proper vaccine management for the site.
- ✓ Each enrolled organization location should designate a vaccine coordinator and a back-up vaccine coordinator serving as the site's point of contact for receiving vaccine shipments, monitoring storage unit temperatures, managing vaccine inventory, etc.

Upon submission of the registration through COVIDReadi, sites will receive a confirmation email confirming the request to enroll. Upon enrollment approval, registration information is sent to the Local Health Departments who will then be responsible for the allocation of available vaccine doses, pending supply availability. Information about vaccine ordering will be forthcoming.

For more detailed information on what is required during the enrollment process, please see below.

Preparing for COVID-19 Vaccination Program Enrollment

Sections and Information Needed

Section A: COVID-19 Vaccination Program Provider Requirements and Legal Agreement. For Section A you will need:

1. Identification of responsible organization officers' agreeing to the conditions specified in the federal COVID-19 Vaccination Program Provider Agreement:
   - Your Organization's Chief Medical Officer (CMO) and Chief Financial Officer (CFO) and Chief Executive Officer (CEO) agree to the conditions of participation outlined in the COVID-19 Provider Agreement and sign the Agreement on behalf of your Organization.
2. Identify the number of affiliated vaccination sites to the enrolling organization.

Section B: CDC COVID-19 Vaccination Program Provider Profile Information. Sites within your Organization that wish to receive the vaccine will complete Section B for each vaccination Location. Section B will require:

1. Identification of the individual location's Medical or Pharmacy Director or Vaccine Coordinator responsible for location's adherence to Provider Agreement terms. <u>Provider Identification Numbers if your organization's individual locations already participate in other publicly-purchased Vaccine Programs or State Immunization Information Systems.</u>
   - Vaccines for Children (VFC)/Vaccines for Adults (VFA)/State General Fund PIN (If Applicable)
   - Local Immunization Registry ID (e.g. CAIR2 Org Code)

Please note that Registry participation is required as part of COVID-19 Program Vaccination Enrollment. All enrolled organization individual locations will be required to report doses administered to your local registry within 24 hrs of vaccine administration.

2. <u>Information on affiliated Organization's individual Locations:</u>
   - Location Name
   - Location address
   - Times/days for vaccine shipment receipt
     - Locations should offer full-day receiving hours, to the extent possible, to facilitate shipment delivery
     - Minimally must be available during a 4-hour window on a weekday other than Monday to receive shipments.
   - If vaccines will be administered at location different from vaccine shipment, provide location information
   - Primary and Back up Vaccine Coordinator contact information
   - Approximate number of patients served at each location
   - Peak weekly flu doses administered during 2019-20 season
   - Population(s) served at each location including approximate number of patients under each population
   - Location vaccine storage capacity
     - Storage unit details
       - Cold storage unit type and capacity in three temperature ranges: 5-8^{o}C (refrigerator), -15 to -25^{o}C (freezer), and -60 to -80^{o}C (ultra-low temperature freezer)
       - Approximate capacity to store multi-dose vials of vaccines (approximate number of vials)
     - Temperature monitoring equipment
       - Thermometer details, including type, Model, and Calibration expiration date
3. <u>Information on Providers Practicing at this Facility who will be overseeing administering COVID-19 Vaccines</u>
   - Name of provider(s) with prescription privileges licensed in the State of California, title(s), and license number(s) must be provided as part of the COVID-19 Vaccination Provider Profile

Preparing for COVID-19 Vaccination Program Enrollment

Enrollment Requirements

Conditions for participation in the COVID-19 Vaccination Program are detailed in the participating agreement. Staff awareness, preparation and training are key to ensure adherence to all enrollment requirements, including:

- Enrolling/Participating in the state Immunization Information System (CAIR2, SDIR, RIDE)
- Completing required trainings upon content availability
- Reporting vaccine administration **within 24 hours** to CDPH
- Agreeing to automatic enrollment in Vaccine finder and **daily reporting of vaccine inventory**
- Sites redistributing vaccine must obtain approval from CDPH and complete a Vaccine Redistribution Agreement
- Reporting all vaccine repositioning (i.e. vaccine transfers)
- Immediately notifying CDPH in the event of any shipping incident

Members (CEOs, COOs, CMOs, CFOs),

Thanks to those that responded to the LADPH survey regarding your health care workers and vaccine capacity. Over 30 health centers indicated that they are able to vaccinate health center staff outside of their own. This is great! We are working with DPH to confirm those entities and get them lined up with vaccines ASAP.

Here is some basic info on what it means to be a Point of Dispensing (POD) for health center workers:

- You must be registered on COVIDReadi in order to be a vaccinator.
- After COVIDReadi registration, you must register for PrepMod, the tool for tracking the vaccine.
- Allotments will be direct shipped to health centers registered on COVIDReadi. Allotments come with the additional materials you'll need to vaccinate (syringes, vaccination cards, etc.)
- Health center staff must register on PrepMod prior to getting vaccinated (more info on this forthcoming). After they're vaccinated, the health center providing the vaccine will enter that information into PrepMod.
- Health centers can bill insurance for administering the vaccine - similar to community testing. Most insurers are following the CMS rate of $45 for the two shots.

If you're willing to vaccinate staff from other health centers, email the following **by COB Wednesday** to Laurie Hensley-Wojcieszyn, LHensley-Wojcieszyn@ph.lacounty.gov:

- The number of health center staff, outside of your own, you are able to vaccinate.
    - If you have multiple sites, identify which of your sites will be providing vaccines, and which will be open to outside staff.
- Whether you want to have outside staff come by appointment, or by walk in.
- Type of vaccine you are able to administer (Pfizer or Moderna).
- Confirm that you are registered on COVIDReadi.

Let me know if you have any questions about this information. CCALAC will be sending out a vaccine FAQ for members soon.

Vaccination Planning Guidance for Partners

In times of scarcity and uncertainty

COVID-19 Vaccine ICS team

1.25.21

Context

- Phase 1A near over
  - Minimal need to vaccinate own staff
- Phase 1B open to 65+ (1.5 million in LAC)
  - Vaccinate enrolled patients / eligible public
- Doses in shorter supply than believed
  - No expansion of supply likely until March/April
- Complexity of second doses planning, while maintaining a rapid, high administration/allocation ratio
  - State and federal dose accounting being enforced

Shift in goals

- Predictability
  - For partners, knowing doses will allow planning, first and second dose scheduling without shortfalls.
  - For LAC, knowing doses per partners simplifies accounting and allocations also minimizing shortfalls

- High burn rate
  - Week to week emphasis without accumulating reserves but enabled through reliable replenishment
  - Need to consistently aim to use >90% of inventory each week while completing 2nd doses
  - Must be able to demonstrate this in CAIR due to risk of State and Federal penalties

Need for weekly survey

- We recognize, unfortunate additional data collection

- However, current state/federal systems provide limited to no insight
  - LAC cannot access VaccineFinder inventory
  - Calvax orders only viewable
    (no context to determine priority during scarcity)
  - Cannot assess CAIR mismatch

- We hope to eliminate as soon as possible

Accountability

- LAC DPH sends weekly Doses Administered and Inventory Survey
  - Vaccinators must fill out weekly by deadline
  - Response informs allocations
- LAC DPH reviews weekly CAIR data
  - Compares to survey
- Vaccinators unable to consistently report into CAIR, will have allocations suspended.
  - Part of your CDC agreement
  - Let us know your bottlenecks

Weekly timeline

Monday
- Allocation and inventory survey sent to partners for data projection through following Monday
- New doses may arrive Monday or Tuesday

Tuesday
- Survey due
- Survey-based doses compared to CAIR reports
- Non-respondents will not receive vaccine

Wednesday
- LAC receives allocation notice and plans distribution
- Facilities with administration-CAIR mismatch notified
- Facilities with excess inventory notified

Thursday
- Allocations ordered if
  - Administration-CAIR mismatch resolved
  - Excess inventory plan communicated

Friday
- LAC notifies upcoming allocations for pickups
- CalVax notification for direct ship orders

Authorized vaccine capacity

- Allocate a fixed capacity
  - E.g. 1170 Pfizer doses per week
  - Can therefore plan ahead based on the same capacity
  - If supply increases, and your weekly maximum capacity is higher than the current authorized capacity, DPH may increase
- Will not allocate additional doses beyond the fixed amount
- Expectations
  - Manage first and second doses from this capacity alone
  - I.e. schedule appropriately
  - Use up >90% of doses before the next shipment arrives (usually Monday or Tuesday)

Scheduling using authorized capacity

- Note upcoming 2nd doses and prioritize
  - Schedule within the weekly authorized capacity only, space out accordingly
  - Use new CDC guidance of up to 6 weeks after dose #1 to schedule in the future

- Difference of (inventory+allocation)-2nd doses in the week
  - First doses possible
  - Schedule before next allocation arrives
  - Do not schedule first doses beyond one week at a time

Trouble-shooting

- Shortage of doses for the upcoming week
  - Facility must cancel 1st dose appointments made
  - Next, defer 2nd doses due to the subsequent week (using new CDC guidance of within 6 weeks after the first dose)
  - If not authorized for additional vaccine doses due to shortage, CAIR mismatch, or excess non-resolving inventory then refer patients to 2nd dose registration at PODs

- Excess inventory
  - Defer an allocation for one week (allocations will resume after)
  - Request decrease in authorized capacity
  - Additional special clinic – Must account for **future second dose implications** within the same authorized capacity OR notify individuals to register at POD sites for 2nd dose

Trouble-shooting, part 2

- CAIR data mismatch
  - Confirm registrants documented as vaccinated
  - Confirm walk-ins, etc registered
  - Confirm clinics closed to enable data transmission
  - Request DPH assistance

- TO DO
  - Clinic names in PrepMOD moving to MyTurn/Calvax/Accenture should match your registration name in CAIR and include your CAIR ID
  - Needed to match on the backend to credit you for doses
    - Example: Part A registration is FAMILY CLINIC SOUTH, and have 6 Part B registration of different clinic sites, and CAIR ID is: FCS6DATA
    - Name your clinics in the clinic management system:
      - FAMILY CLINIC SOUTH- Bellflower- CAIR FCS6DATA

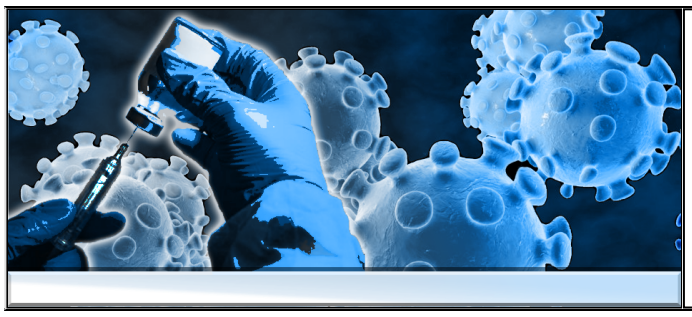
Scheduling example 1

- Authorized for 100 Moderna doses per week
  - Vaccinated 120 staff 3 weeks ago, then none, now due next week
  - Scheduled 30 patients next week
  - Zero inventory

- Example plan
  - Week 1: Cancel 30 first doses, plan 100 second doses
  - Week 2: Plan 20 second doses, 80 first doses
  - Week 3: Plan 100 first doses
  - Week 4: Plan 100 first doses
  - Week 5: Plan 100 first doses
  - Week 6: Plan 80 second doses, 20 first doses
  - Week 7: Plan 100 second doses

Patients versus PODs

- If vaccinating publicly, i.e. PODs or allowing new enrollments
  - Authorized capacity can continue indefinitely
- If vaccinating empaneled patients
  - Need to estimate numbers and track completion
  - Communicate cessation in advance to avoid excess inventory



COVID-19 Vaccine

Checklist & Guidance for Health Facilities

COVID-19 Hub

COVID-19 Provider Vaccine Hub

- Vaccine - New & Noteworthy
- Vaccine Summary
- Vaccine Prioritization
- Facility Checklist
- Becoming a Vaccine Provider
- Webinars
- Clinical Considerations

Vaccine Quicklinks

- CDC Provider Website
- CDC Provider Communications
- CDPH Vaccination Program
- ACIP
- Immunization Registry (CAIR)
- Reporting

General Public

Contact us about Vaccine

LAHAN Alerts

This webpage is specifically intended for the medical community.

Click here to visit DPH's COVID-19 webpage for the general public.

On this Page

12-23-20

General Education & Resources
Reporting Systems
Receiving & Transporting Vaccine
Vaccine Administration Preparation
Vaccine Administration
Post-Vaccination

Introduction

Dear Colleagues,

As part of Phase 1A under priority allocation of COVID-19 vaccine, healthcare personnel and Long-Term Care Facilities (LTCF) staff and residents have been designated to receive the first available vaccine.

For health facilities conducting onsite vaccinations, the Los Angeles County Department of Public Health (LACDPH) has developed a list of necessary planning and training steps in preparation for the delivery of COVID-19 vaccine. This guidance checklist will prepare you to implement the required steps to providing the vaccine safely and efficiently to staff and/or residents.

We greatly appreciate your partnership in this critical effort and thank you for all you do to protect the health and well-being of the people you care for.

If you have any questions or concerns, please contact the Vaccine Preventable Disease Control Program at LACIPInfo@ph.lacounty.gov

DPH will also be providing “office hours” to answer any questions you may have.

Sincerely,

COVID-19 Vaccine Provider Outreach Team
Los Angeles County Department of Public Health

General Education & Resources

All staff designated to participate in the administration of COVID-19 vaccine should gain an understanding of the storage, handing and other practices specific to COVID-19 vaccine and immunization. Please view the following training and guidance.

☐ **California Department of Public Health (CDPH)**

- California COVID-19 Vaccination Program
- CDPH - Required Trainings & Resources

☐ **Centers for Disease Control (CDC)**

- Add “CDC Immunization Courses: webcasts and self-study
- COVID-19 Vaccination Training Programs and Reference Materials for Healthcare Professionals
- Vaccine Storage and Handling Toolkit
- COVID-19 Vaccine Training: General Overview of Immunization Best Practices for Healthcare Providers

Reporting Systems

Enrollment in the State Immunization Information System (IIS) or California Immunization Registry (CAIR) is a condition of participation in the state’s COVID – 19 vaccine programs. In addition, facilities administering COVID – 19 vaccine will be required to document COVID – 19 vaccines in PrepMod.

☐ **Enroll in CAIR**

Those who require CAIR enrollment: http://cairweb.org/enroll-now/.

- Instructions for Enrolling in CAIR
  - For additional assistance, contact the CAIR Help Desk
    - By phone: 1-800-578-7889
    - By Email: CAIRHelpDesk@cdph.ca.gov
- Some facilities may already be enrolled in CAIR; organizations that are uncertain of their enrollment status should contact their Local CAIR Representative or the CAIR Help Desk, both of which are noted on the CAIR enrollment webpage.
  - Please see attached specific instructions for enrolling in CAIR; it is important to follow the instructions to prevent substantial delays in CAIR access approval. If your facility accidentally submitted an application for regular CAIR access or if you requested CAIR user accounts, please follow up with your Local CAIR Representative to indicate your plans to use PrepMod.
  - If your COVIDReadi registration is pending, please check your storage and temperature device If this is a barrier to your registration, there are many relatively inexpensive options available on shopping platforms that can be delivered quickly. You can update the details in your registration immediately before unit arrival

Attachments:

- Guidance on IIS Participation

☐ **Enroll in COVIDReadi**

Review the CDPH Training and Resources noted above. If you have questions, contact: COVIDVaccineReq@ph.lacounty.gov

Attachments:

- COVIDReadi Provider Enrollment: Before You Enroll
- COVIDReadi Provider Enrollment Quick Start Guide
- PrepMod Training Module

☐ Clinic Registration and Management in PrepMod

PrepMod is a secure, online application also has useful features for running mass Covid-19 vaccination clinics, including clinic set-up, vaccine inventory management, and the ability for patients to schedule appointments and consent online. PrepMod FAQs and PrepMod User Manual . **No training required.**

Vaccinator staff will require access to CAIR with a CAIR User ID and training to use PrepMod.

Have designated staff prepared and ready to use PrepMod by viewing the demonstration site and recorded PrepMod trainings.

- Maryland PrepMod demo site: https://demo.vaccineconsent.com/clinics
  - Username: causer@test.com
  - Password: password

Recorded links to prior PrepMod live trainings:*(For staff who will be setting up in advance of vaccine administration, the details of the clinic/vaccination event, vaccine inventory, lead clinic staffing and other event details):*

Admin Training:

- Recorded Webinar
- Password: $57bX#M6

Staff Training:

- Recorded Webinar
- Password: +qh?%2XU

For issues with the platform, the PrepModHelp Desk is available 8 a.m. to 8 p.m. EST Monday thru Friday

- **Phone**: 888-503-0515
- **Email**: techsupport@vaccineconsent.com

For California specific questions, contact Prepmod@cdph.ca.gov

LAC DPH PrepMod Recorded Trainings

- Training for Healthcare Facilities
  - **Play recording** (1 hr 5 mins)
  - Recording password: Gr6iJ8SR
- Training for Skilled Nursing Facilities
  - **Play recording** (1 hr 5 mins)
  - Recording password: Gr6iJ8SR

Receiving & Transporting Vaccine

☐ Identify a designated vaccine storage site and appropriate temperature monitoring unit.

Attachments:

- Guidance on Storage & Handling
- Guidance on Temperature Monitoring
- Guidance of Transporting Refrigerated Vaccine

☐ Create protocol to monitor storage unit temperatures twice a day and create a log to document AM and PM temperatures.

Attachments:

- Moderna Storage and Handing Resources, including Temp Logs
- Pfizer Storage and Handling Resources, including Temp Logs

Steps for Receiving Vaccine

- ☐ Verify number of doses/vials received.
- ☐ Make sure vaccine was transported at the appropriate temperature.
- ☐ Store vaccine in designated storage unit.
- ☐ Complete sign – off sheet

Attachments:

- COVID-19 Vaccine Receiving Log

DPH Pickup Checklist

Skilled nursing facilities that are receiving vaccine from DPH will be notifed when their allocation is ready for pick – up. DPH will distribute vaccine from our main warehouse at 313 N. Figueroa, LA 90012. Please follow these steps when picking – up your vaccine:

- ☐ Enter the parking garage from the Figueroa Street entrance and check in with the attendant.
- ☐ Inform the attendant you are picking up vaccine and sign – in. Parking is free.
- ☐ Proceed down the structure to the basement loading dock and park in the 20-minute parking spots. DO NOT park at the loading dock.
- ☐ Walk to the loading dock. Please make sure to bring your cooler and boxes to receive your vaccine.

Attachments:

- **COVID – 19 Temperature Log**
- **COVID – 19 Vaccine Transport Log**
- **Data Logger Set-up and Use**
- **Vaccine Expiration Date Tracker**

☐ Enter vaccine inventory in PrepMod and VaccineFinder.

Attachments:

- Reporting Vaccine Inventory to VaccineFinder
- VaccineFinder Provider Information Sheet
- Quick Start Guide for Vaccine Finder
- Quick Start Guide Vaccine Finder Inventory
- Quick Start Guide Vaccine Finder Inventory Reporting - Log
- Vaccine Finder Provider Onboarding
- COVID Locating Health Provider Portal - Training for IIS Level Reporting
- COVID Locating Health Provider Portal – Training for Provider Reporting

Vaccine Administration - Preparation

Create list of all staff and/or residents who will be vaccinated and register them in PrepMod when creating the clinic/vaccination event.

☐ Create a schedule for staff vaccination including staggering

Attachment:

- Guidance for the Allocation of Phase 1A Tier 1 COVID-19 Vaccine (12-16-20)

☐ Develop standing orders/standardized procedures for vaccine administration.

Attachment:

- Standardized Procedure (Template)
- Moderna Standing Order
- Pfizer Standing Order

☐ Develop or use internal procedures to obtain assent or consent for staff and/or residents

Every recipient must receive a EUA fact sheet (Pfizer and Moderna fact sheets available in 20 languages). Persons receiving the vaccine must assent to vaccination. Consent is neither required nor prohibited.

☐ **Create procedure to document declinations for staff**

Attachment:
- COVID Vaccination Declination (Template)

☐ **Separate and store PPE and vaccine administration supplies**

Ensure additional vaccine administration supplies are available: PPE, sharps containers, alcohol wipes, cotton balls, and additional safety syringes.

Attachment:
- Product Information Guide – (Ancillary supply section)

☐ **Plan for adverse reactions**

Attachment:
- Preparing for Anaphylaxis Preparing for the Potential Management of Anaphylaxis at COVID-19 Vaccination Sites. From CDC
- Medical Management of Vaccine Reactions in Adults in a Community Setting From IAC

☐ **Create return to work and testing protocol**

Attachments:
- Post Vaccination Assessment of Symptomatic Healthcare Personnel

☐ **Ensure emergency cart supplies**

Ensure emergency cart supplies are sufficient for treating adverse reactions. (i.e. Benadryl, Epinephrine)

☐ **Familiarize staff with the VAERS reporting system and reportable events.**

☐ **Identify fixed site(s) within your facility to administer vaccine for staff and/or residents**

☐ **Identify a mobile mechanism within your facility to administer vaccine for staff and/or residents who are mobile**

☐ **Identify team compositions**

Attachment:
- Field Operations Guide (FOG) (pending)

☐ **Review best practices for immunizations with staff and train staff in advance or use just in time training.**

Skills Checklist for Vaccine Administration

☐ **Ensure staff are appropriately trained to identify age**

Ensure staff are appropriately trained to identify age – appropriate anatomical sites for intramuscular (IM) injections.

☐ **Ensure staff is using proper hand hygiene**

Ensure staff is using proper hand hygiene (e.g. wash hands for 20 seconds before administering vaccines, change gloves between patients, and anytime they become soiled). (See CDC hand hygiene recommendations)

☐ **Begin engaging and provide COVID-19 vaccine resources for staff and residents**

Frequently Asked Questions LAC DPH

Talking to Patients About COVID – 19 Vaccines CDC

V-Safe: Get Vaccinated Flyer - 2-Page Flyer , 1-Page Summary

☐ **Develop system to generate reminders to administer second dose at the designated interval.**

☐ **Create a process to reconcile vaccination with your facility's MAR.**

Vaccine Administration

☐ **Download Registration List from PrepMod**

☐ **Confirm recipient eligibility**

Confirm registration

Verify contraindications and precautions to vaccination.

- Pre-Vaccination Screening Form (for Pfizer-BioNTech and Moderna COVID-19 Vaccines)

☐ **Prepare vaccine prior to administration**

Attachments:

- Product Information Guide – (instructions for thawing vaccine)
- Reconstitution instructions (pending)

☐ **Ensure staff administering vaccine are following the Seven (7) Rights of vaccine administration:**

- ☐ Right patient
- ☐ Right time
- ☐ Right medication
- ☐ Right dose
- ☐ Right route and technique
- ☐ Right site
- ☐ Right documentation

☐ **Reporting**

Report all administration errors per facility protocol and take corrective action immediately. Report vaccine errors to the Vaccine

Report all administration errors per facility protocol and take corrective action immediately. Report vaccine errors to the Vaccine Error Reporting Program (VERP)

Report any adverse reactions to VAERS and document per your facilities protocol.

Report any needlestick injuries per facility protocol and refer for medical treatment and evaluation if needed.

Encourage staff and residents to enroll in v-safe

Attachments:

V-Safe: Get Vaccinated Flyer - 2-Page Flyer , 1-Page Summary

☐ **Dispose of used needles and syringes in sharps containers immediately after vaccination**

☐ **Document vaccines administered in PrepMod and update Vaccine Finder**

- Reporting Vaccine Inventory to Vaccine Finder

☐ **Monitor residents and staff for 15 minutes after vaccination for adverse reactions**

Post-Vaccination

☐ **Close clinic in PrepMod within 24 hours. (See PrepMod Training video and module for instructions)**

☐ **Reconcile vaccination records with your facility's MAR and begin 2nd dose administration planning**

Gmail

Jerry P Abraham, MD MPH <abraham.jerry@gmail.com>

FW: Vaccine distribution to health care clinics in Los Angeles

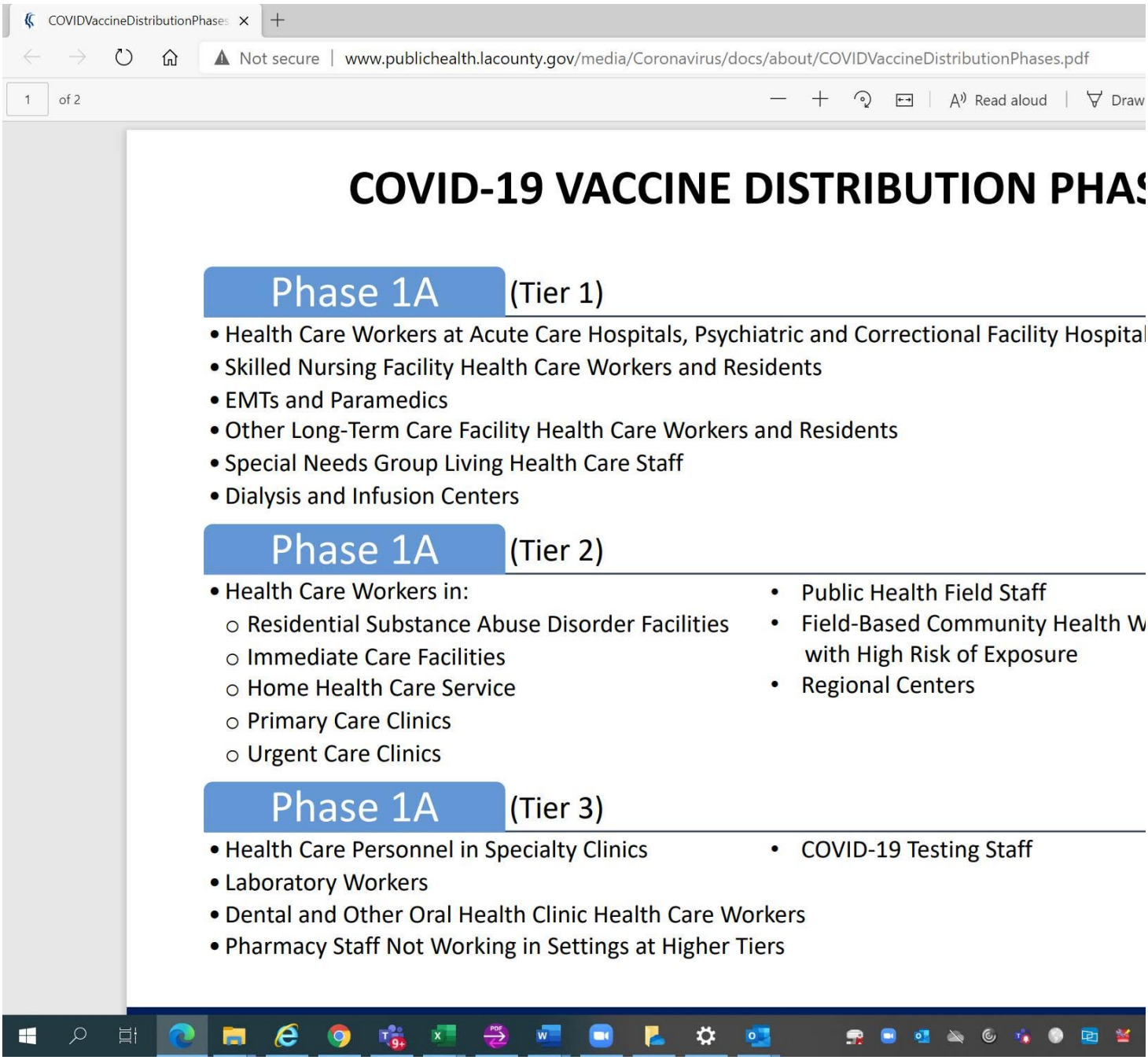
Diana R. Shiba <Diana.R.Shiba@kp.org>
To: "Omer J Deen, MD" <ojdeen@gmail.com>
Cc: Jeffrey Lee <JeLee@facey.com>, "Jerry P Abraham, MD MPH" <abraham.jerry@gmail.com>, Gustavo Friederichsen <gustavo@lacmanet.org>, "hector.flores@ah.org" <hector.flores@ah.c

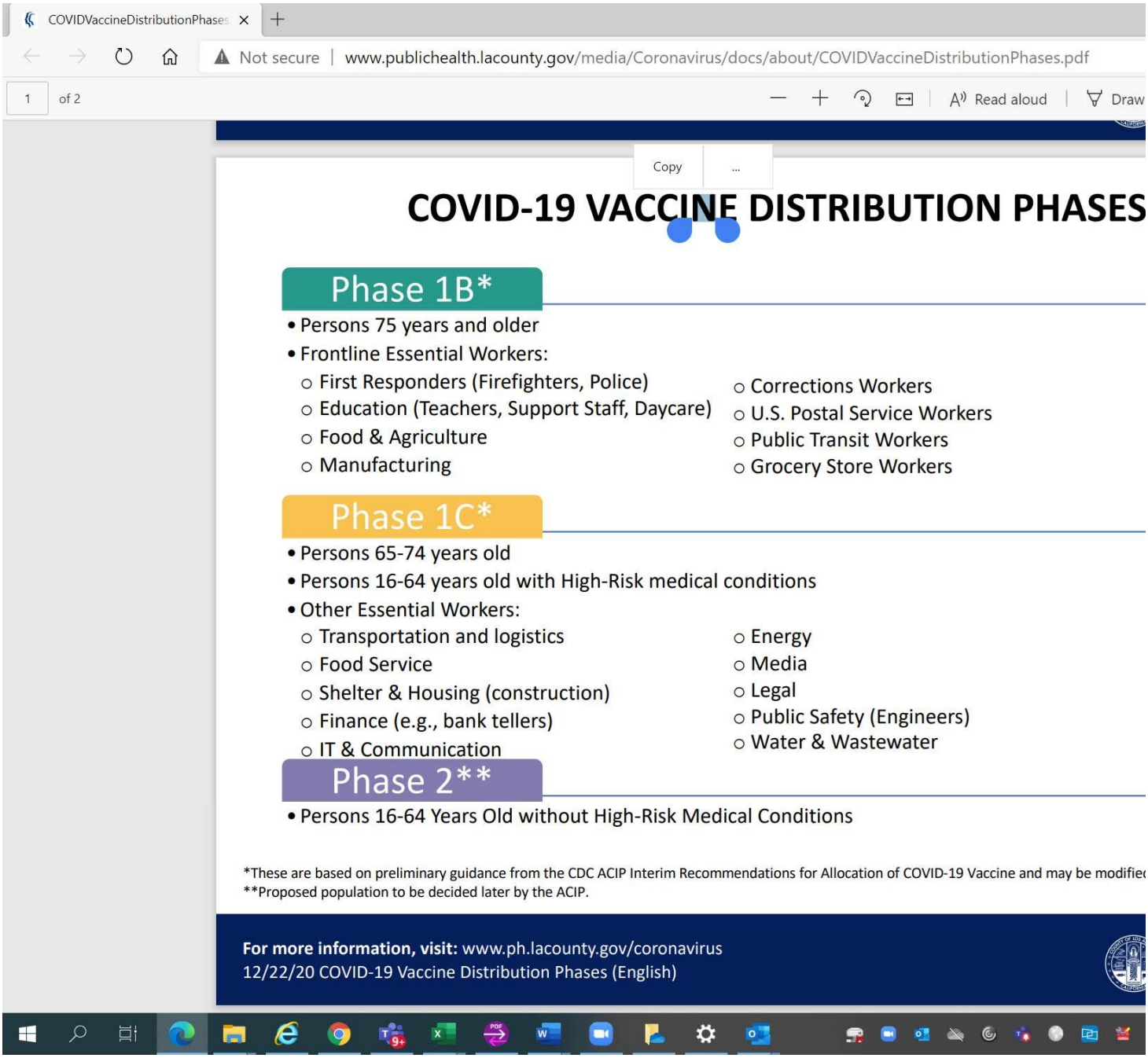
Agree new members would be great – but there truly is a larger problem for the community-based private physicians, and I'm sure there is some not-so-ideal behavior out there too.

When Gustavo and I spoke to Muntu, he mentioned that the goal was to get it to the hospitals first (makes sense where the sick are) and then mentioned that "they don't have enough vaccine million doses sitting in LA, I'm sure DPH or even CDPH would send out a directive for all community docs to proceed to your local hospital. I am guessing that may be their plan with the POD and running, as they'll be using those for the essential workers too. As Dr. Zachary Rubin mentioned, they "are trying to fly the plane while building it" for the largest county in the nation…

I also asked Dr. Rubin specifically if a clinic could register on CovidReadi/CPDH to receive vaccine but he answered it wouldn't work as it's built for hospital receipt of vaccine now.

I would share that we're hearing the goal is to amplify Tier 2, phase 1a (outpatient primary care clinics), followed by Tier 3 (specialty clinics), as they are planning for phase 1b by ideally mid-J the phases and tiers start to blend. Diana





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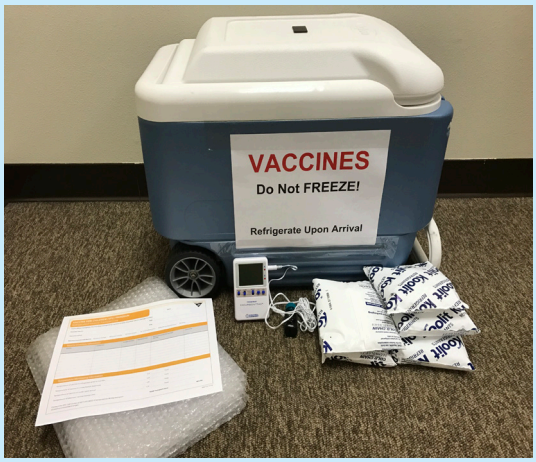
TRANSPORTING REFRIGERATED VACCINE

GUIDELINES FOR EMERGENCY VACCINE TRANSPORT AND SHORT-TERM STORAGE

CDC discourages any vaccine transport. Vaccines should only be transported when absolutely necessary. In an emergency situation, this procedure will keep refrigerated vaccines within the required temperature range for up to eight hours—depending on transport conditions. Call the vaccine manufacturer if you have concerns.

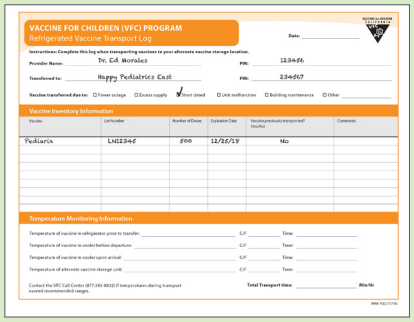
ASSEMBLE PACKING SUPPLIES AND DOCUMENTS

1. **Hard-sided cooler**
2. **Conditioned cold packs or conditioned frozen water bottles**
   Leave cold packs at room temperature until they perspire (1-2 hours). Frozen water bottles can be placed in lukewarm water until the ice block inside spins freely (fewer than 5 minutes).
3. **Insulating cushioning material**
   Use 2-inch layers of bubble wrap to prevent vaccines from freezing. Do NOT use packing peanuts or other loose material that might shift during transport.
4. **Data logger**
   Retrieve your backup device's buffered probe from the vaccine refrigerator and its digital display.
5. **Transport Log**
   Print a copy of the VFC "Refrigerated Vaccine Transport Log" (IMM-1132).
6. **Vaccine management plan**
   Find the alternate vaccine storage location in your practice's vaccine management plan.



PREPARE FOR TRANSPORT

1. Contact the VFC Call Center or your VFC Field Representative for approval to transport vaccine.
2. Verify that the alternate vaccine storage location can store all of your vaccines.
3. Fill out the top portion of the transport log.
4. Remove vaccines from the refrigerator.
5. Fill out "Vaccine Inventory Information" on the transport log before proceeding.


VACCINE FOR CHILDREN (VFC) PROGRAM
Refrigerated Vaccine Transport Log

Date:

Instructions: Complete this log when transporting vaccines to your alternate vaccine storage location.

Provider Name: Dr. Ed Morales PIN: 123456

Transferred to: Happy Pediatrics East PIN: 234567

Vaccine transferred due to: ☐ Power outage ☐ Excess supply ☑ Short dated ☐ Unit malfunction ☐ Building maintenance ☐ Other

Vaccine Inventory Information

Vaccine	Lot Number	Number of Doses	Expiration Date	Vaccine previously transported? (Yes/No)	Comments
Pediarix	LN12345	500	12/25/13	No	

Temperature Monitoring Information

Temperature of vaccine in refrigerator prior to transfer: ____ °C/°F ____ Time: ____

Temperature of vaccine in cooler before departure: ____ °C/°F ____ Time: ____

Temperature of vaccine in cooler upon arrival: ____ °C/°F ____ Time: ____

Temperature of alternate vaccine storage unit: ____ °C/°F ____ Time: ____

Contact the VFC Call Center (877-243-8832) if temperatures during transport exceed recommended ranges.

Total Transport time: ____ Min/Hr

IMM-1132 (7/14)

Continued on next page

PACK VACCINE AND PREPARE FOR TRANSPORT

1 Conditioned cold packs or conditioned frozen water bottles

Place the conditioned items to cover only half of the bottom of the cooler.

2 Bubble wrap & buffered probe

Completely cover the cold packs/frozen water bottles and cooler bottom with a 2-inch layer of bubble wrap.

Place the buffered probe on top of the bubble wrap—directly above a cold pack.

3 Vaccines

Layer vaccine boxes on the bubble wrap and probe. Do NOT let vaccine boxes touch the conditioned items.

4 Bubble wrap

Completely cover vaccines with another 2-inch layer of bubble wrap.

5 Conditioned cold packs or conditioned frozen water bottles

Place conditioned cold packs or frozen water bottles to cover only half of the bubble wrap. Do NOT let any vaccine boxes touch the conditioned items.

6 Bubble wrap, transport log, display

Layer bubble wrap to the top of the cooler. Close the cooler.

Record the temperatures before departure on the transport log.

Carefully attach the digital display and log to the top of the cooler.

UNPACK VACCINE

When you reach the alternate storage location, confirm the vaccine storage unit temperatures are within recommended ranges. Record the cooler temperature on the transport log before removing the vaccines.

If the cooler temperature is:

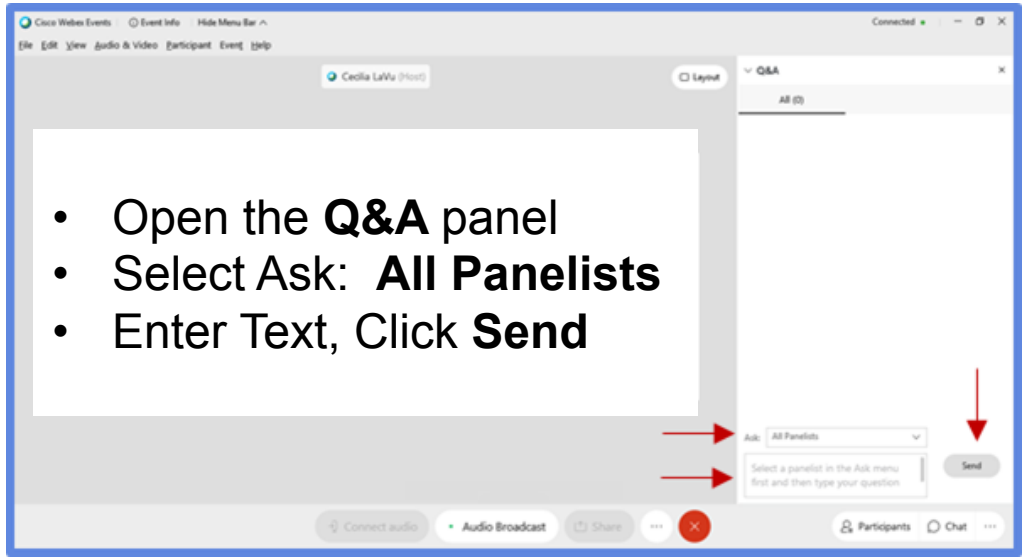
OK (36.0–46.0°F or 2.0–8.0°C): unpack and store vaccines in the alternate vaccine refrigerator.

Out of range (Below 36.0°F/2.0C or above 46.0°F/8.0C): label the vaccines "Do Not Use" and store them in the vaccine refrigerator; alert your supervisor; immediately report the excursion to SHOTS at MyVFCvaccines.org.

Welcome to Provider Office Hours

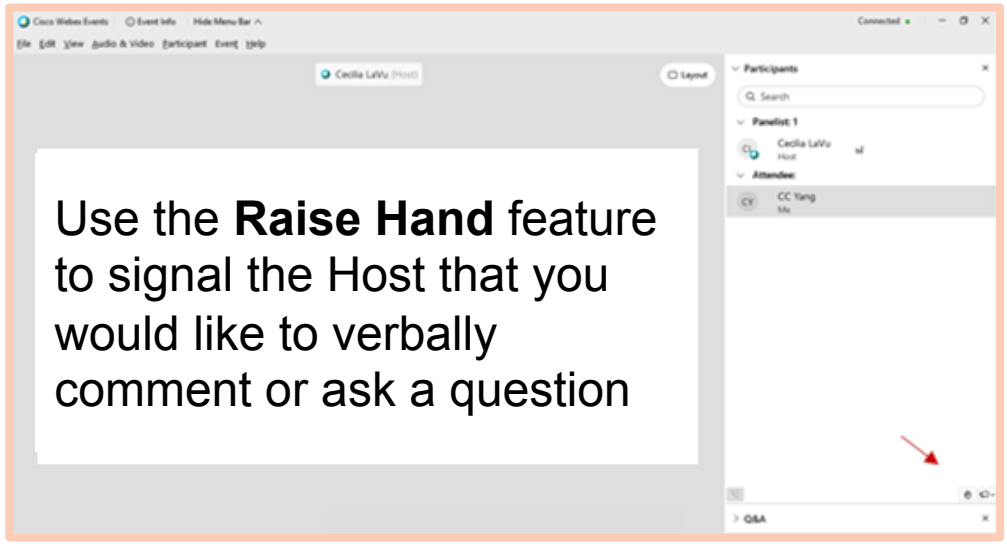
During the session, please use one of these methods to comment or ask a question:

OPTION #1: Q&A Panel



- Open the **Q&A** panel
- Select Ask: **All Panelists**
- Enter Text, Click **Send**

OPTION #2: Request to Join Audio



Use the **Raise Hand** feature to signal the Host that you would like to verbally comment or ask a question

Poll

In a few words, what is the biggest challenge you continue to face with COVID-19 vaccine administration?

Examples:

- Allocation
- Reporting
- Eligibility
- Supply
- Storage and handling
- Vaccine hesitancy

Agenda

Announcements

- Third Party Administrator – Kathleen Billingsley
- Shipping Delays – Claudia Aguiluz
- FEMA Sites – Kate McHugh

Vaccine Updates

- Allocations – Amy Pine
- Systems Overview – Claudia Aguiluz
- VaccineFinder – Troy Parrish
- myCAvax – Claudia Aguiluz
- Vaccinate All 58 Campaign – Edgar Ednacot
- Storage & Handling – Kate McHugh
- Temperature Monitoring – Claudia Aguiluz
- Provider Call Center – Brenton Louie

Q&A

Announcements

Third Party Administrator – Kathleen Billingsley

California is committed to equitable, efficient, & safe distribution of COVID-19 vaccines.

- To help reach those goals, it has contracted with a Third Party Administrator (TPA) to create, manage, and oversee a statewide network of vaccine providers.
- Key functions of the TPA include:
  - Contracts
  - Communications & education
  - Implementation
  - Reporting

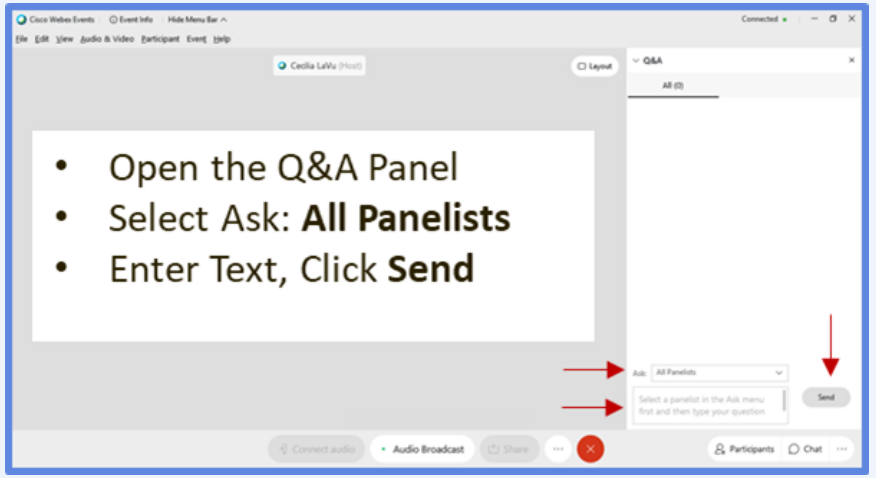
The state released its contract with Blue Shield of California to be its Third-Party Administrator on February 15, fulfilling a commitment by the Governor.

What questions do you have for the TPA?

Please start your question with "TPA"

SAMPLE:
"TPA: As a provider, how will my dose allocations change under the TPA?"

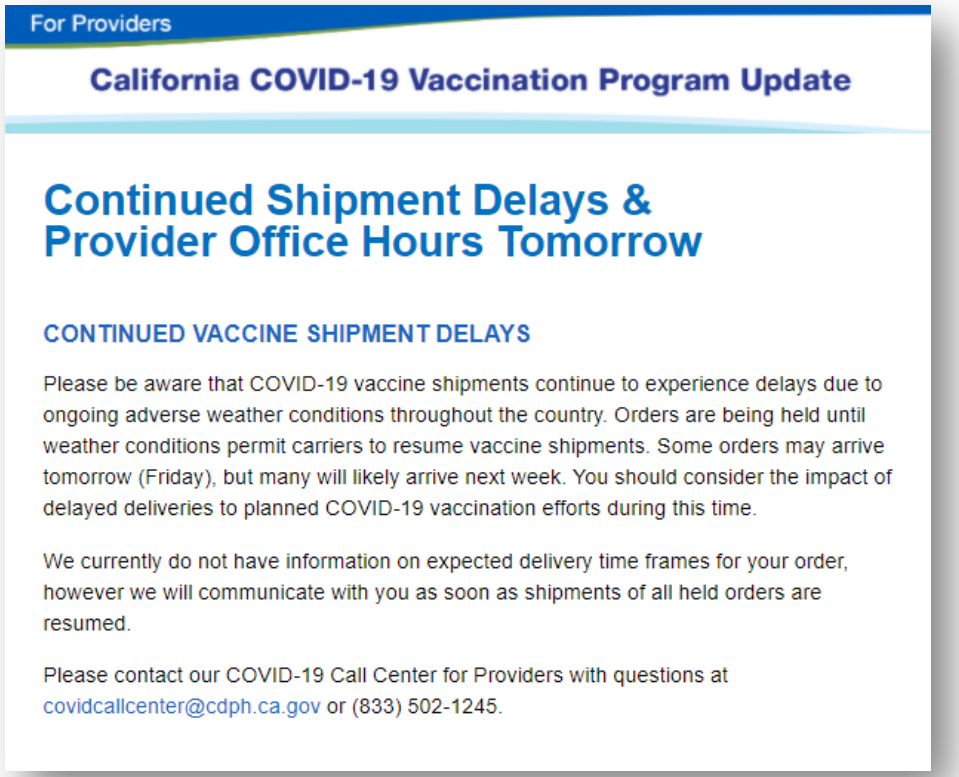
Submit your question into the Q&A panel



Shipping Delays – Claudia Aguiluz

Update: vaccine shipments delays

- Adverse weather has impacted vaccine distribution and shipment across the US
- Impact on the ground at distribution hubs and commercial carriers
- **Pfizer** had limited shipping this week; most pending vaccine orders have were delivered this week
- **Moderna** orders placed since mid-late last week have not yet shipped
- Limited vaccine packing and shipment preparation have created a back log of orders that will need to get out once weather conditions improve
- It is likely that all orders arrive next week- waiting for confirmation on estimated shipping day
  - May need to be prepared to receive all pending orders
- Consider the impact of delayed deliveries to planned COVID-19 vaccination efforts & ability to store multiple shipments
- Shipment delay notifications have been issued to all providers and posted on eziz.org/COVID.



For Providers

California COVID-19 Vaccination Program Update

Continued Shipment Delays & Provider Office Hours Tomorrow

CONTINUED VACCINE SHIPMENT DELAYS

Please be aware that COVID-19 vaccine shipments continue to experience delays due to ongoing adverse weather conditions throughout the country. Orders are being held until weather conditions permit carriers to resume vaccine shipments. Some orders may arrive tomorrow (Friday), but many will likely arrive next week. You should consider the impact of delayed deliveries to planned COVID-19 vaccination efforts during this time.

We currently do not have information on expected delivery time frames for your order, however we will communicate with you as soon as shipments of all held orders are resumed.

Please contact our COVID-19 Call Center for Providers with questions at covidcallcenter@cdph.ca.gov or (833) 502-1245.

FEMA Sites – Kate McHugh

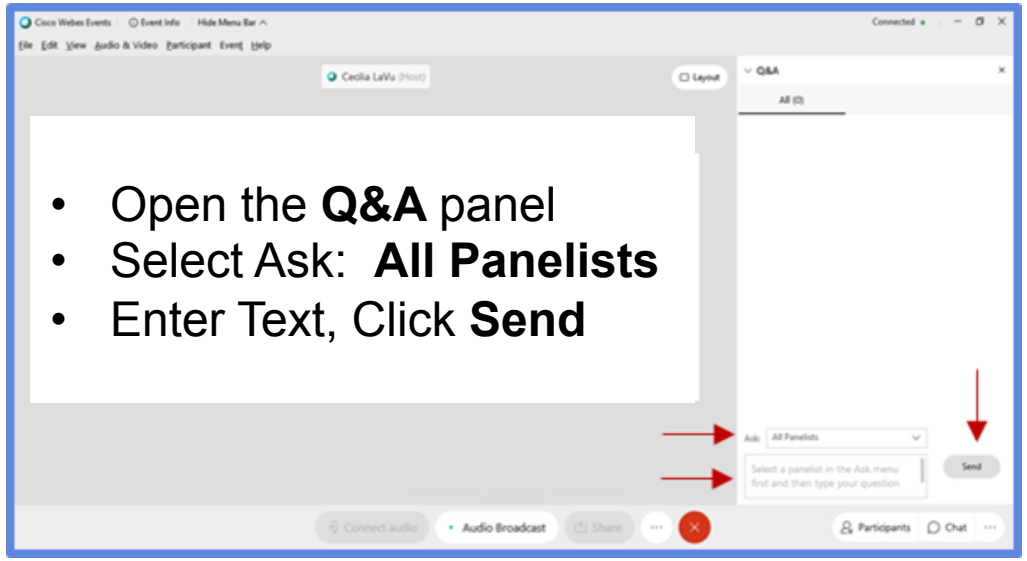
- Oakland Coliseum and Cal State University, Long Beach
- Federally staffed and allocated
- Capacity of up to 6,000 people/day
- Appointments made at www.myturn.ca.gov

Provider Q&A

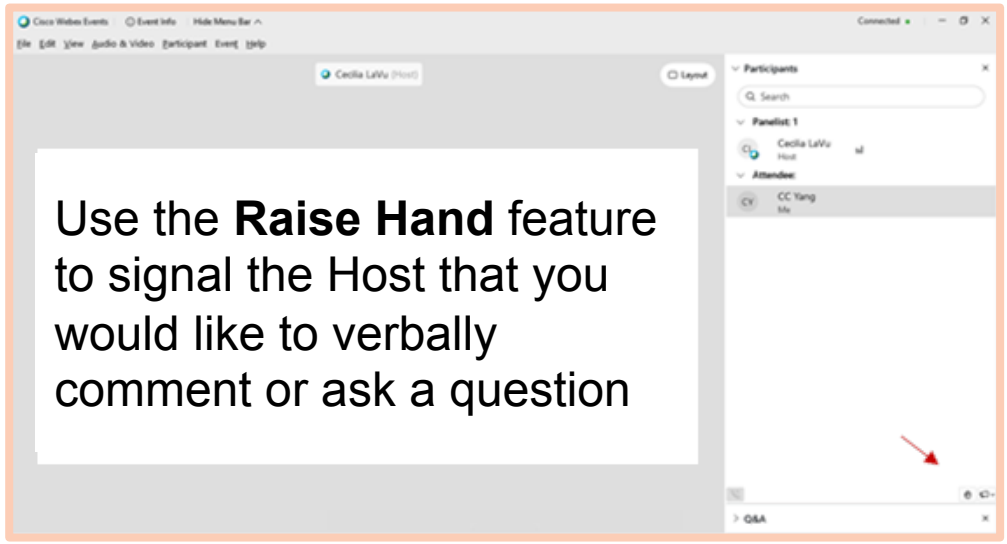
How to Ask a Question

During the webinar, please use one of the following methods to ask a question or make a comment.

OPTION #1: Q&A Panel



OPTION #2: Request to Join Audio



Vaccine Updates

Allocations – Amy Pine

Food/Ag, Education/Child Care and Emergency Responders added to denominator

CA's allocation this week from CDC:

- 380,300 Moderna doses (3803 boxes)
- 382,590 Pfizer doses (327 boxes)
- **762,890 total doses**

Systems Overview –
Claudia Aguiluz

Keep this Job aid near you!

Access Systems Overview at:

https://eziz.org/assets/docs/COVID19/IMM-1354-Provider.pdf

VaccineFinder – Troy Parrish

VF's Role in COVID-19 Response

Daily inventory reporting of COVID-19 vaccines (required)

- Providers agree to report doses on hand daily to provide visibility into vaccine uptake

Increase access to COVID-19 vaccines (optional, launch TBD)

- Providers may choose to make their location(s) visible on the public-facing website when vaccine is more widely available
- COVID Locating Health portal was **updated in February** to allow providers to populate data in advance of the public launch

VaccineFinder

Topics

- Completing registration
- Reporting inventory

https://eziz.org/covid/reporting/

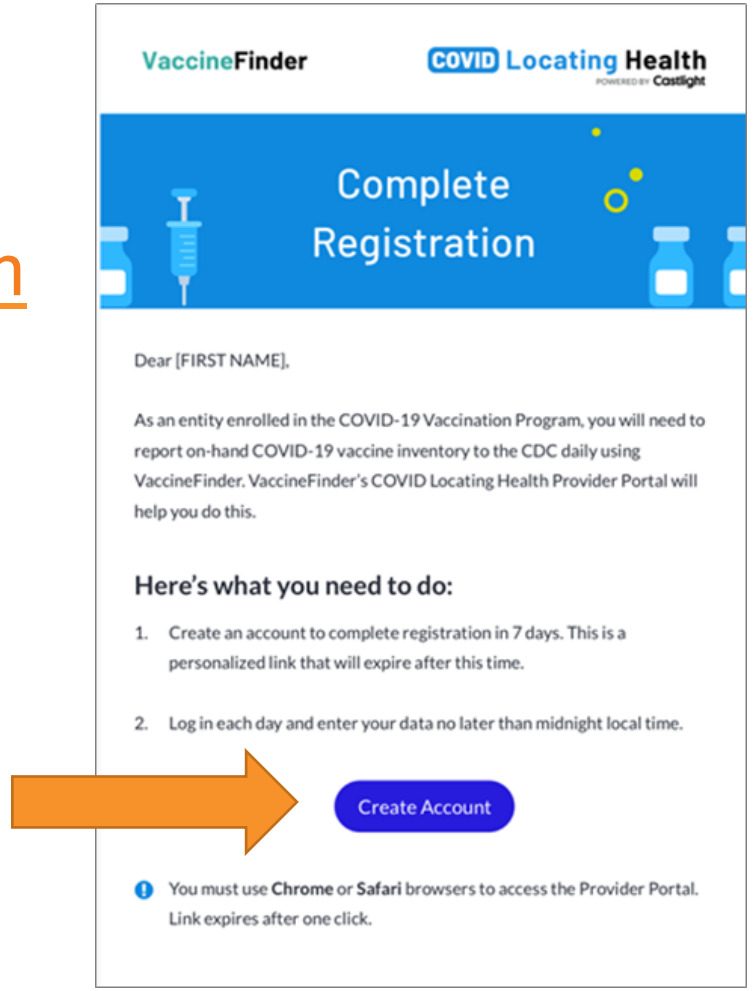
1. Request Invitation Email

If your facility is expecting vaccine:

- Email the VaccineFinder Help Desk at eocevent522@cdc.gov
- Provide organization name, address, email (Section A in myCAvax)
- Invitation sent within 12-24 hrs. if CDC can identify the organization; for new enrollees, takes a few days

1. Request Invitation Email

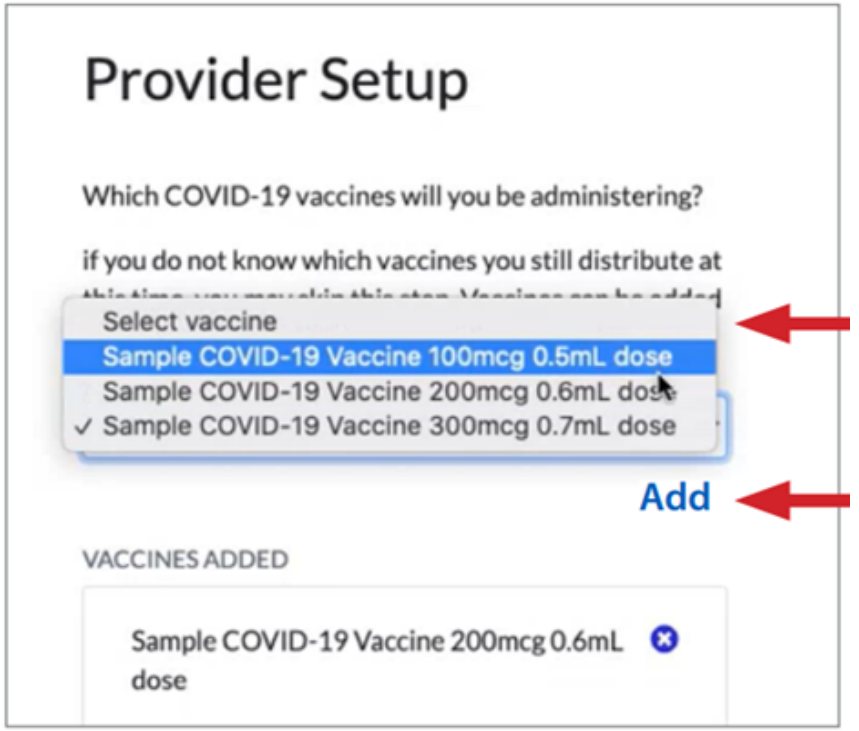
- **Organization Email** (Section A) will receive the email; email must be monitored
- Sender: vaccinefinder@auth.castlighthealth.com
- Click **Create Account** to complete registration
- Use Edge, Chrome, or Safari browsers
- Link expires after 7 days
- **Can't find it?** Check Spam/Junk folders, or have IT list VaccineFinder as a safe sender



2. Complete Registration

Which vaccines will you administer?

- Select vaccine from dropdown menu and click **Add**
- Repeat for additional vaccines
- Selections appear under **Vaccines Added**
- Vaccines can be added later

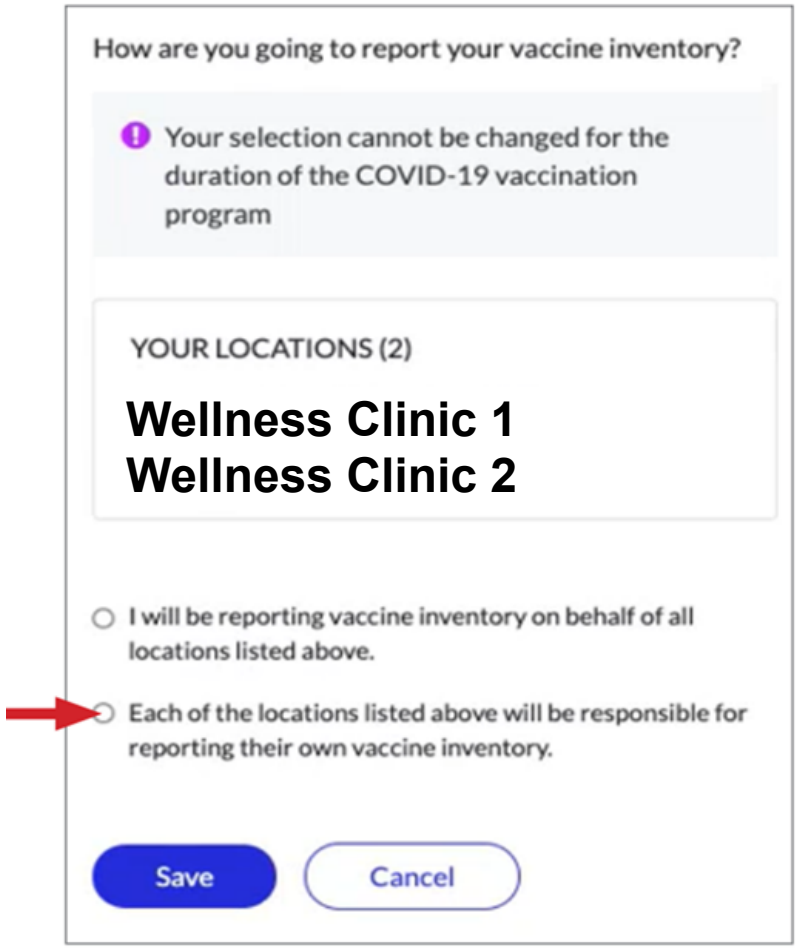


2. Complete Registration

How will you report vaccine inventory?

- Organization may report aggregate doses on hand for all affiliated provider locations
- Or locations may report their inventory

Registration email sent to Section B **Location Contacts**; each location goes through this onboarding process to begin inventory reporting



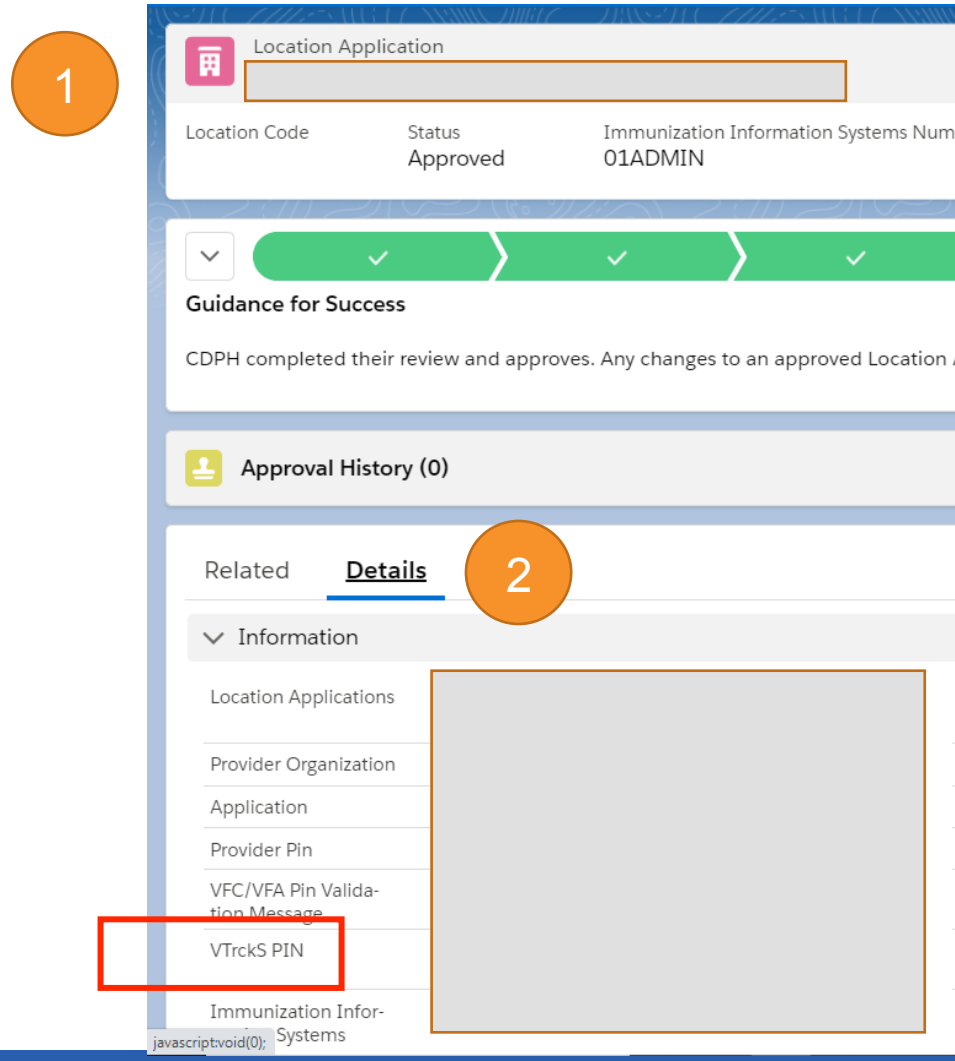
2. Complete Registration

For location-level reporting:

- At least one location emailed invitation
- Uninvited locations processed within 3-4 days

To expedite all affiliated locations:

- Email eocevent522@cdc.gov
- Provide location name, address, and primary & backup location coordinators (Section B)
- Or **VTrkS PIN** (visible in myCAvax)

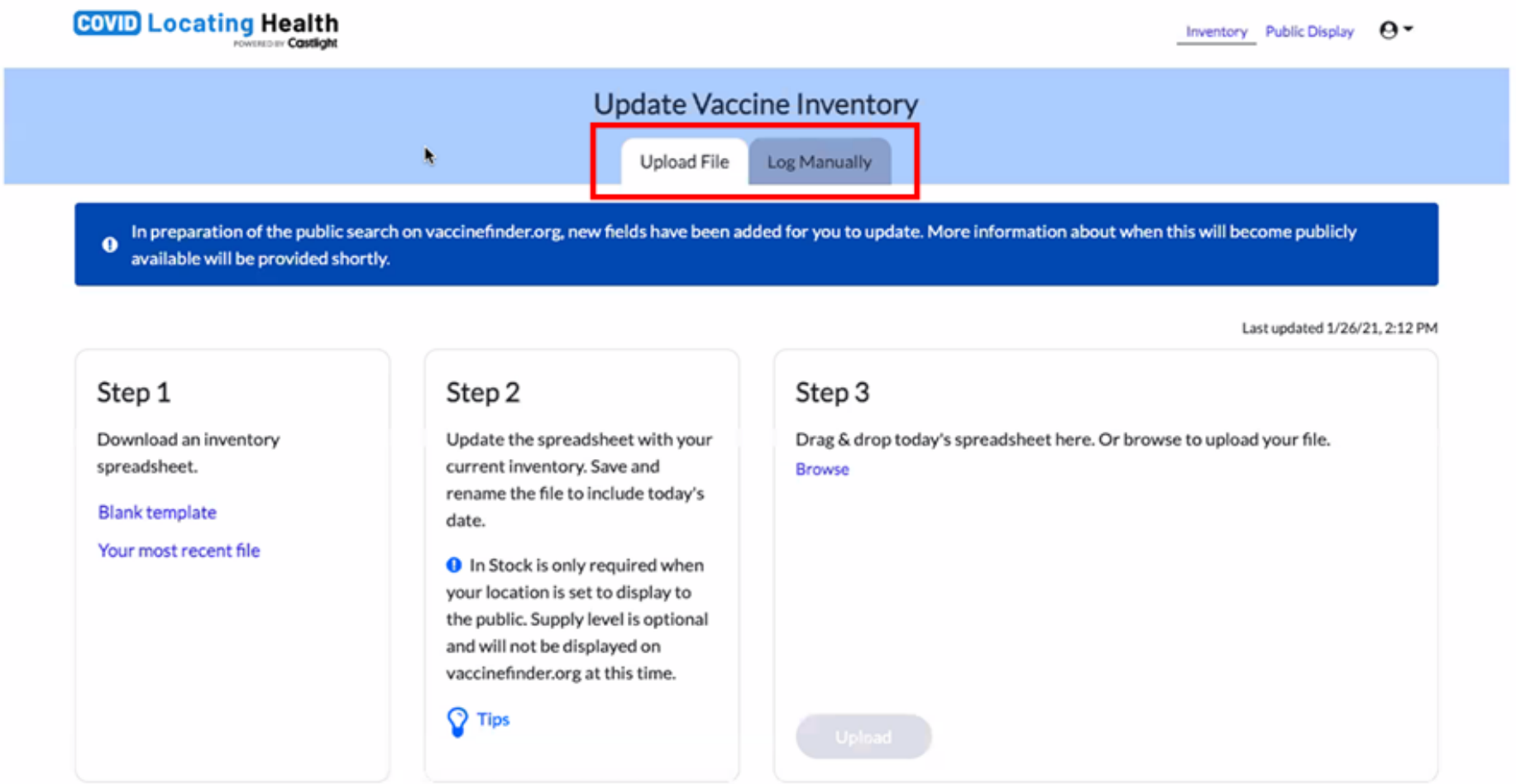


2. Complete Registration

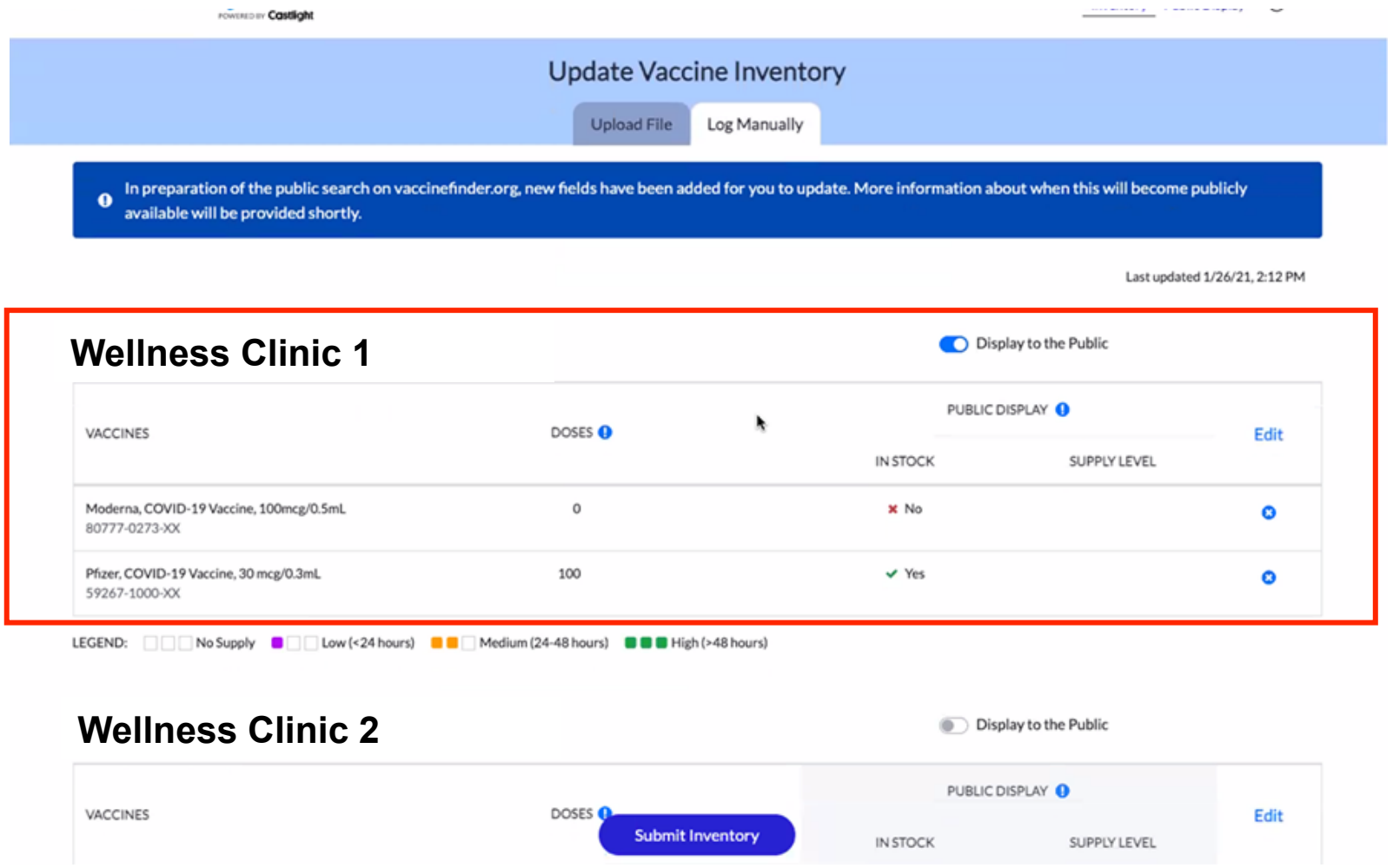
VF user accounts are synchronized with myCAvax

- Organization Reporting: Organization email will be the only user account (Section A)
- Location Reporting: Primary & Backup Location Coordinator emails each have accounts (Section B)
- No other user accounts can be added at this time
- Role must have visibility into inventory
- Changes to accounts require updates to Section A and/or B; contact COVID Call Center for assistance

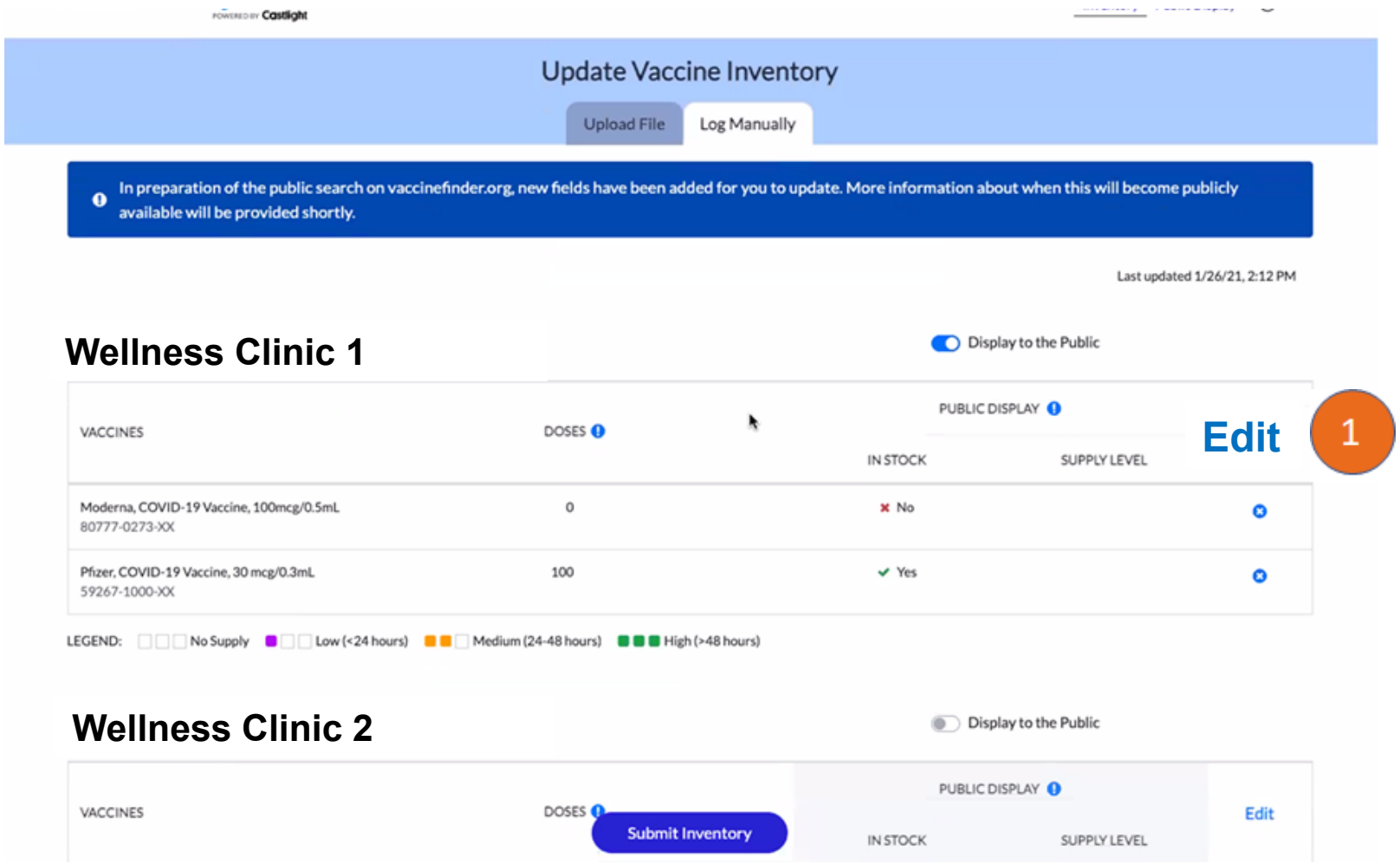
Report Inventory Daily- Provider Portal



Report Inventory: **Log Manually**

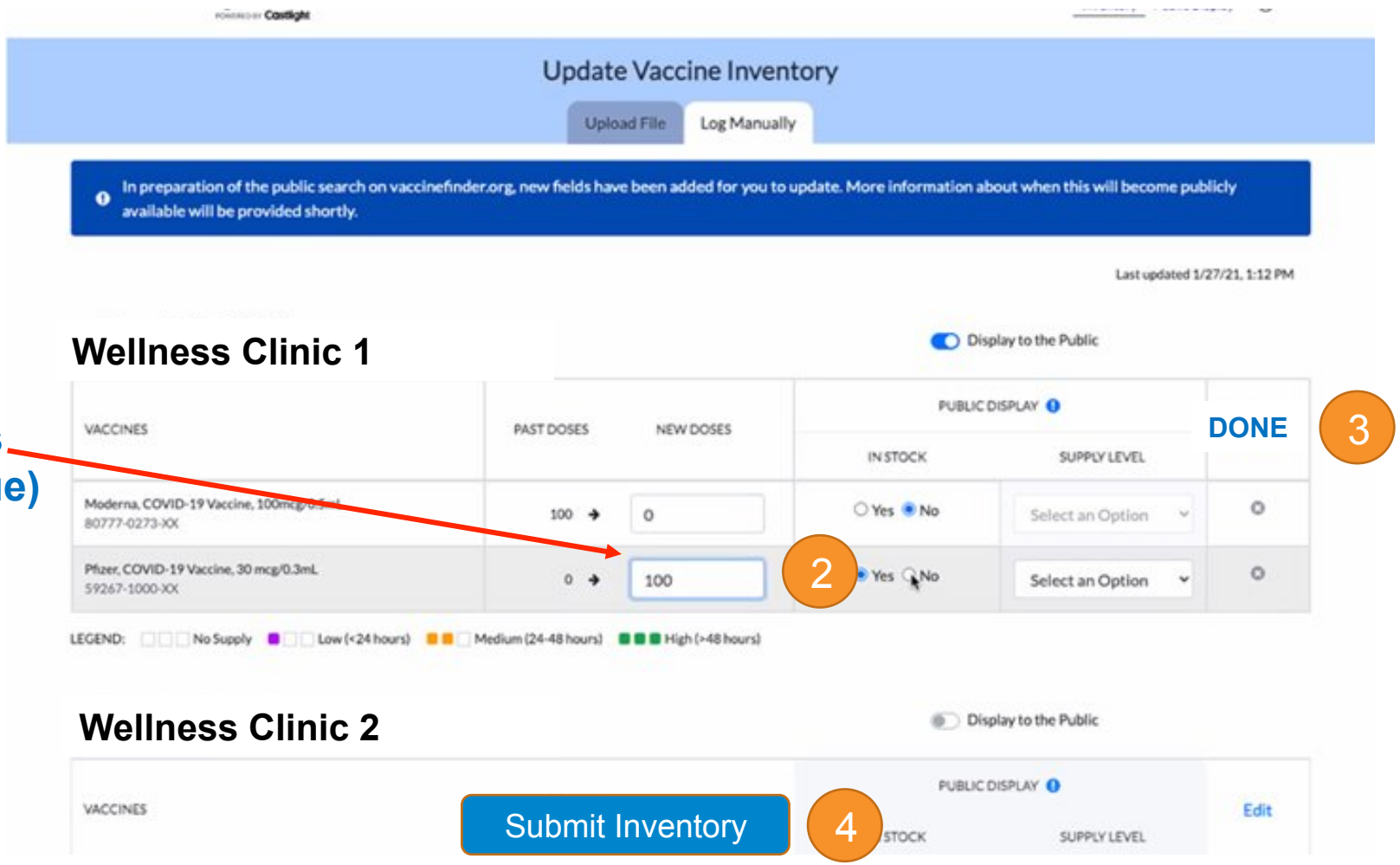


Report Inventory: **Log Manually**



4 steps to report even if inventory hasn't changed

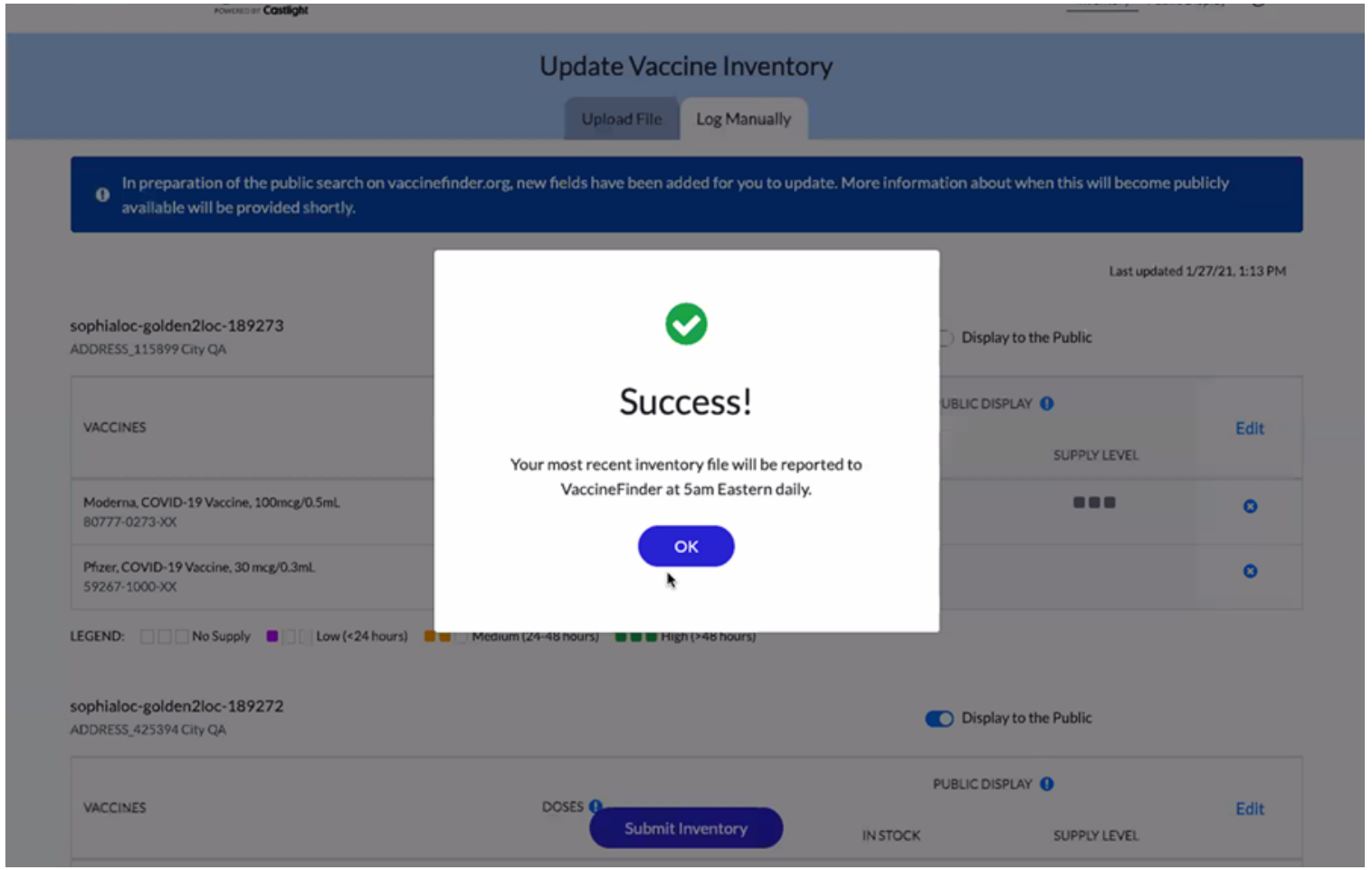
Report Inventory: **Log Manually**



Enter new doses (overwrite old value)

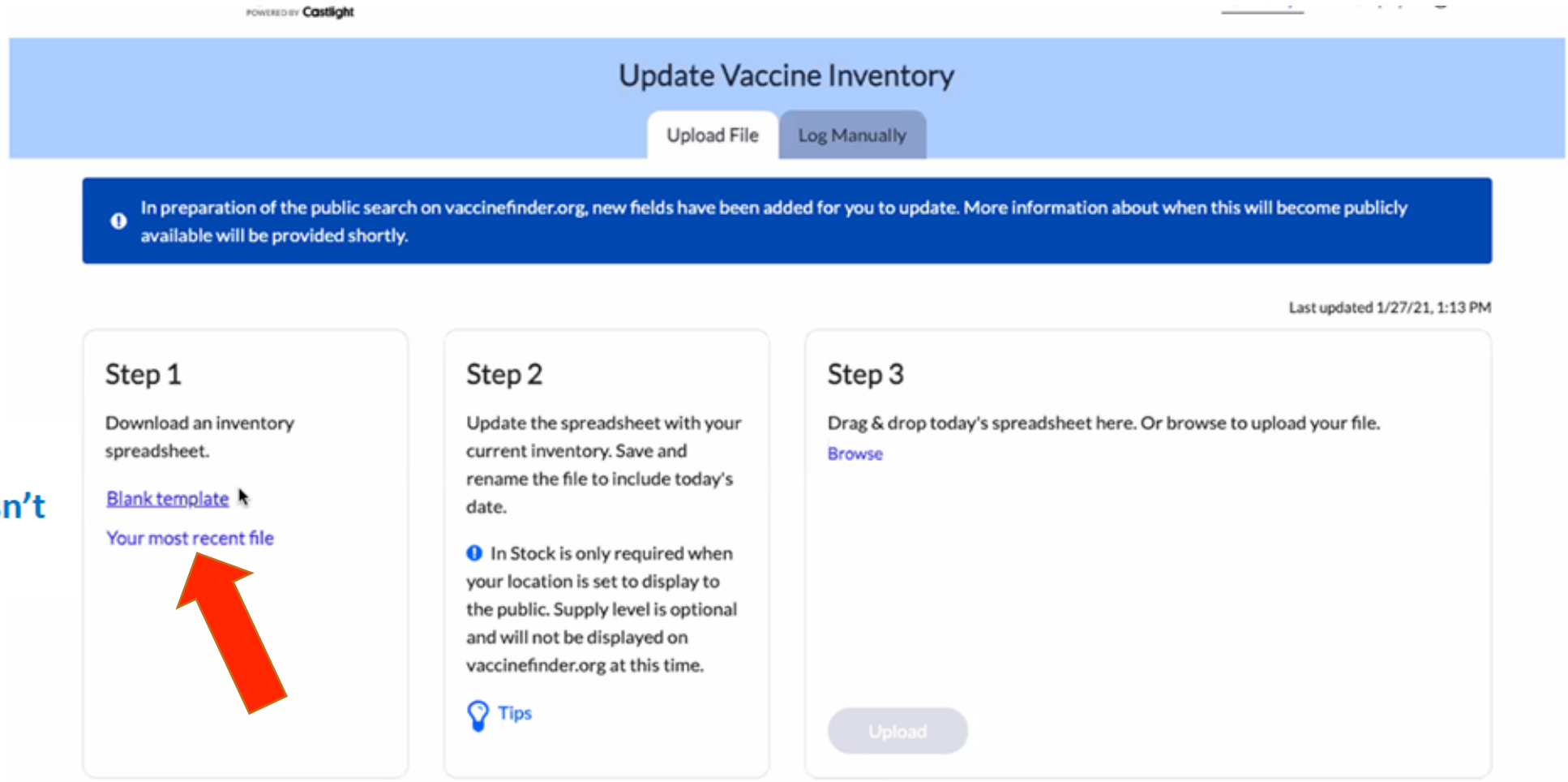
4 steps to report

Report Inventory: **Log Manually**



Report Inventory: **Upload File**

Helpful if inventory hasn't changed



Report Inventory: **Upload File**

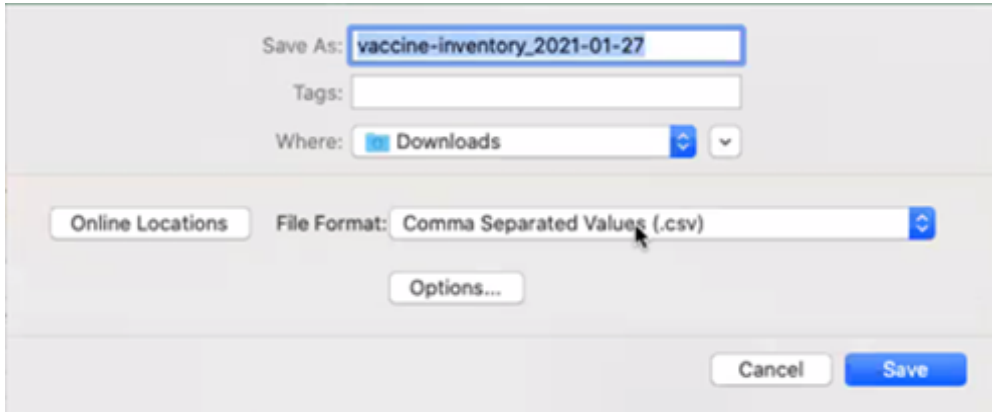
Organization Name	Provider Location Name	Provider ID	Address	Medi-cation	NDC	Medi-cation	Quantity
Wellness Hospital	Clinic 1	abcd1234	123 South Lane	V	1000-0	Pfizer	Enter Quantity
Wellness Hospital	Clinic 1	abcd1234	123 South Lane	V	2000-0	Moderna	Enter Quantity
Wellness Hospital	Clinic 2	jklm56789	456 North Lane	V	1000-0	Pfizer	Enter Quantity
Wellness Hospital	Clinic 2	jklm56789	456 North Lane	V	2000-0	Moderna	Enter Quantity

prepopulated with your locations
one row for each vaccine stocked

Report Inventory: **Upload File**

Organization Name	Provider Location Name	Provider ID	Address	Medi-cation	NDC	Medi-cation	Quantity
Wellness Hospital	Clinic 1	abcd1234	123 South Lane	V	1000-0	Pfizer	Enter Quantity
Wellness Hospital	Clinic 1	abcd1234	123 South Lane	V	2000-0	Moderna	Enter Quantity
Wellness Hospital	Clinic 2	jklm56789	456 North Lane	V	1000-0	Pfizer	Enter Quantity
Wellness Hospital	Clinic 2	jklm56789	456 North Lane	V	2000-0	Moderna	Enter Quantity

1



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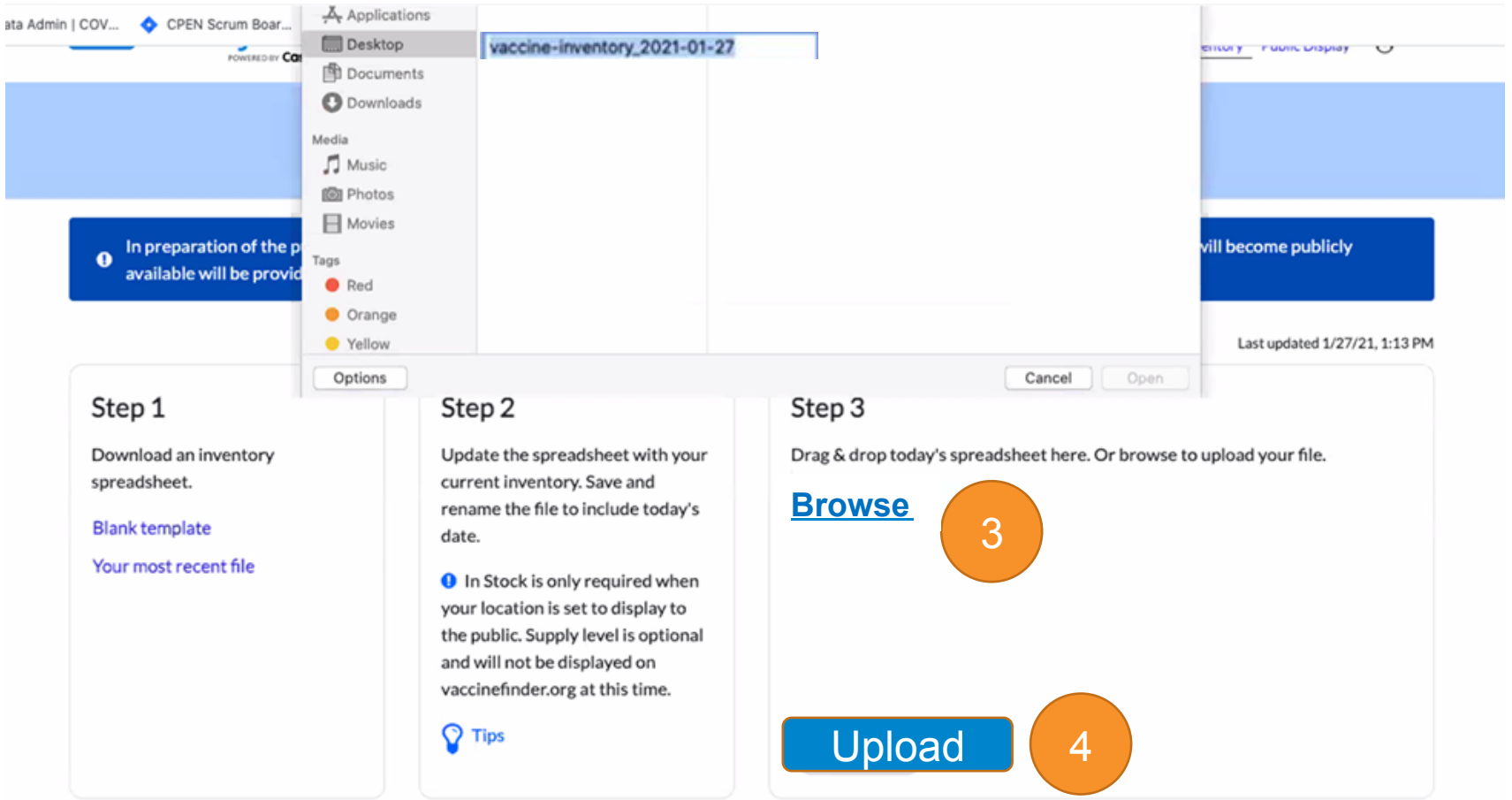
Report Inventory: **Upload File**



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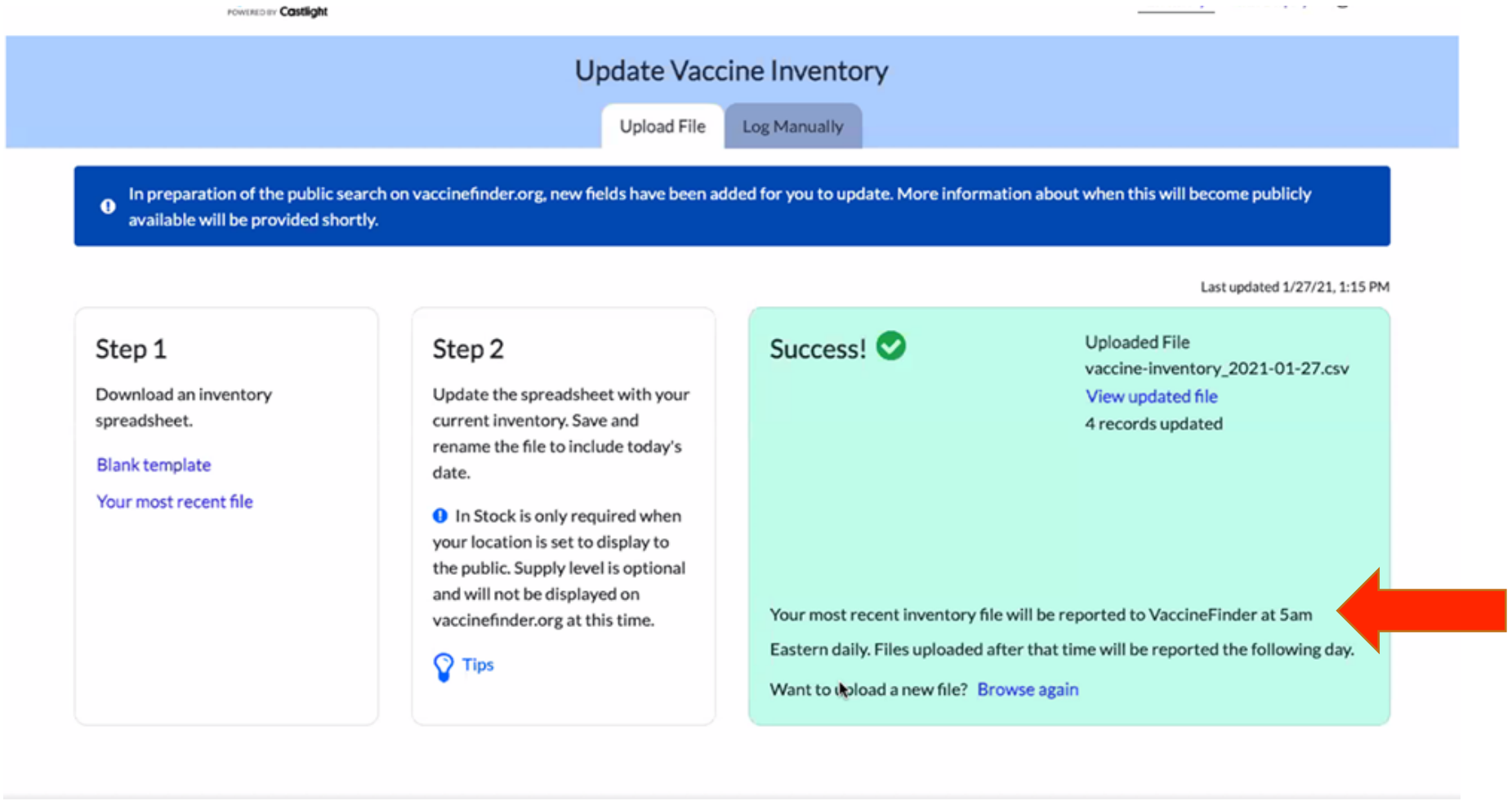

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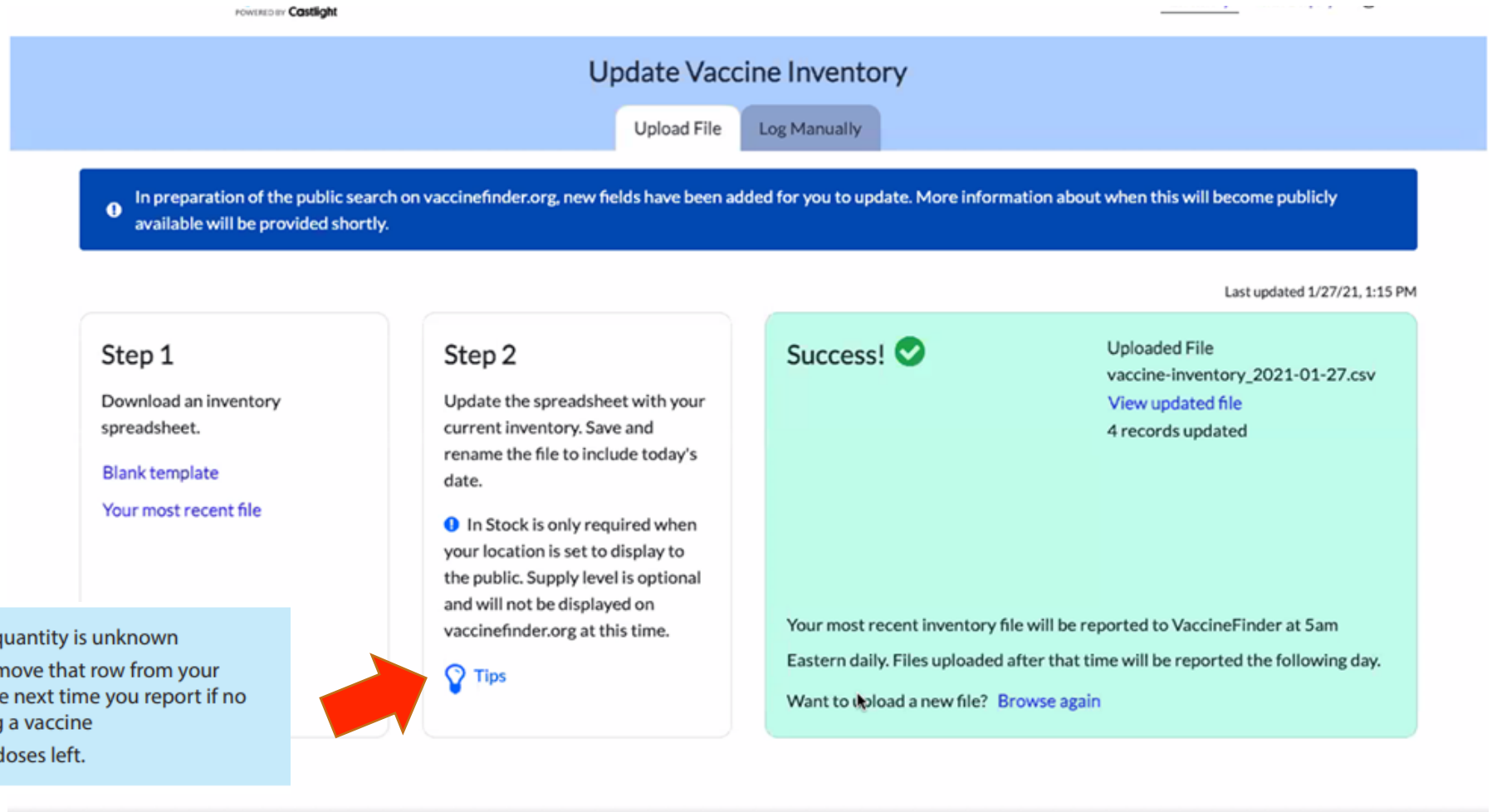


VaccineFinder Updates & Reminders

Providers agree to report doses on hand daily—except excluded holidays—to support nationwide scrutiny of on-hand doses

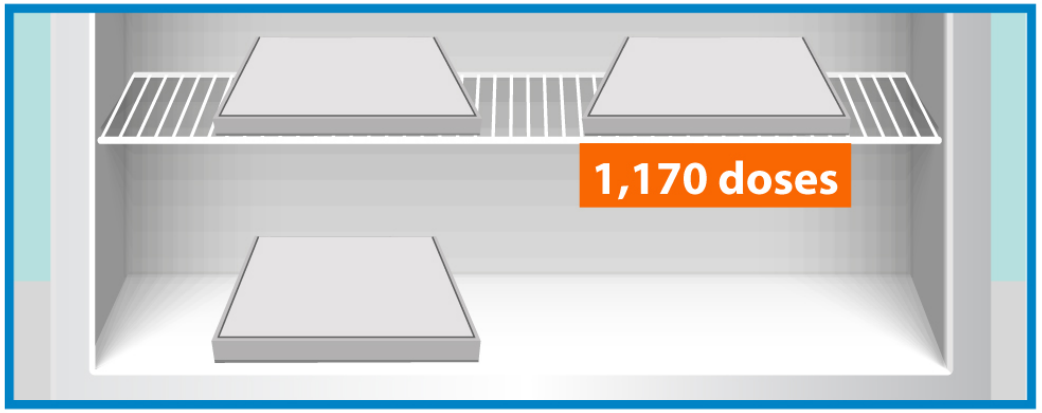
- Reporting begins once doses are received
- Uploads can be performed remotely at COVID Locating Health

Inventory hasn't changed?

- Browse & upload Your most recent file, or
- Manually **edit**, **overwrite** old value, click **done** and **submit inventory** (do not skip or data will not be transmitted to VF)

VaccineFinder Updates & Reminders

- Report Moderna as 10-dose vials
- For Pfizer orders **submitted on or after February 16,** report as 6-dose vials; separate inventory to track these doses



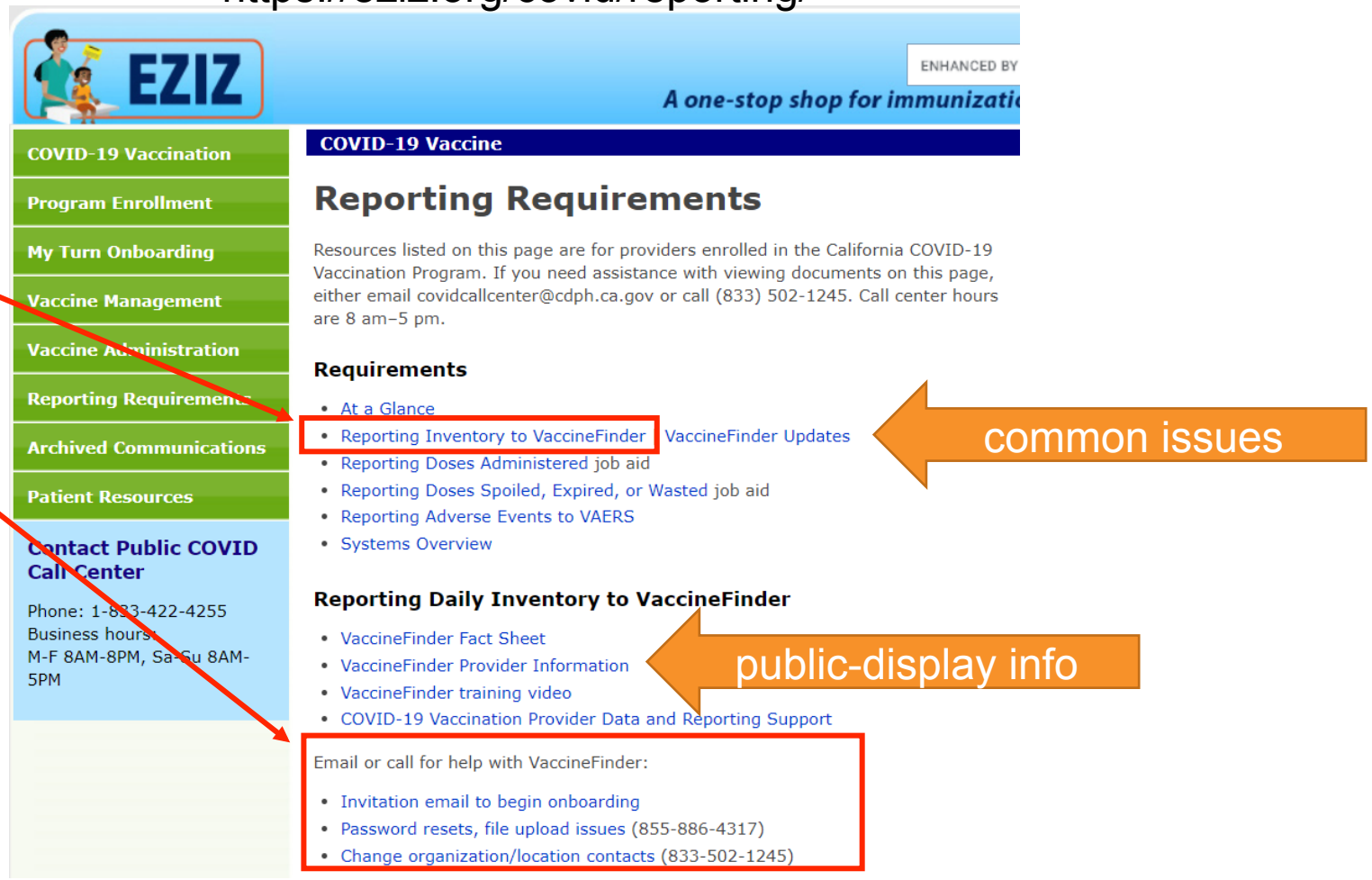
975 + 975 + 1,170 = **3,120**

VACCINES	PAST DOSES	NEW DOSES
Moderna, COVID-19 Vaccine, 100mcg/0.5mL 80777-0273-XX	100 →	0
Pfizer, COVID-19 Vaccine, 30 mcg/0.3mL 59267-1000-XX	0 →	3120

VaccineFinder Resources

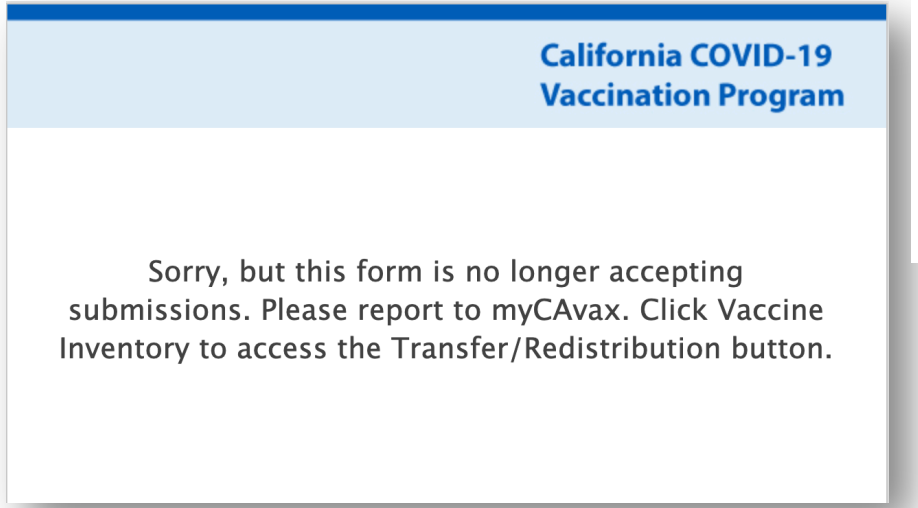
https://eziz.org/covid/reporting/

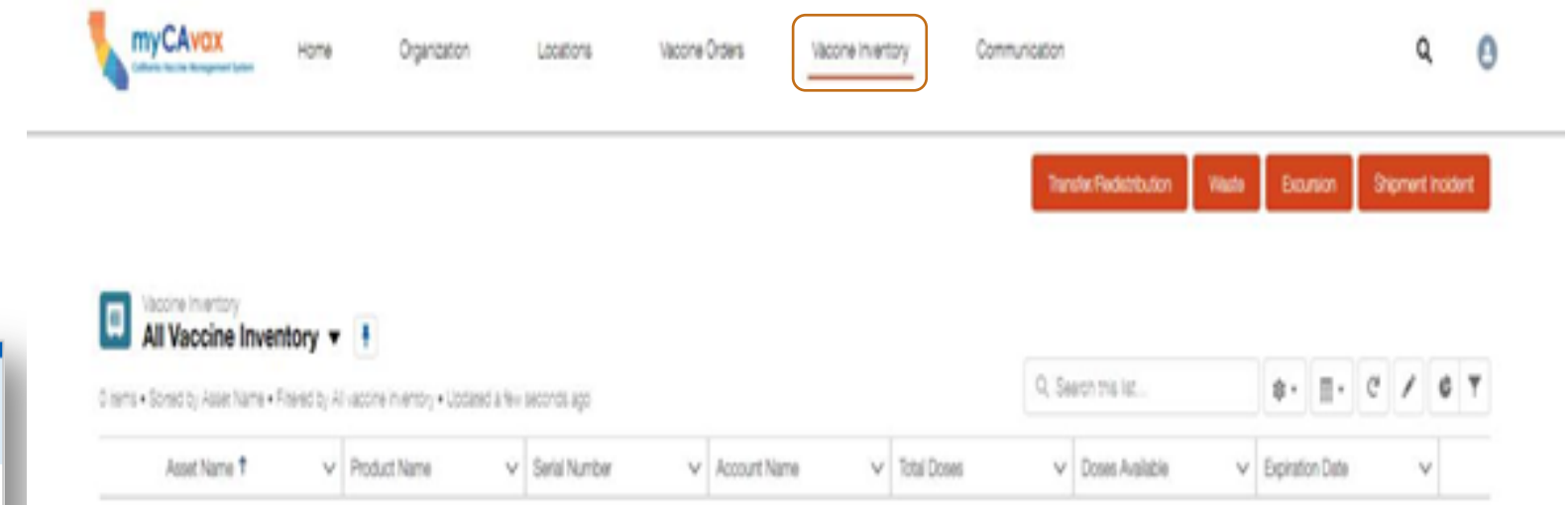
Support options



myCAvax – Claudia Aguiluz

- Please submit all vaccine management related reports in myCAVax



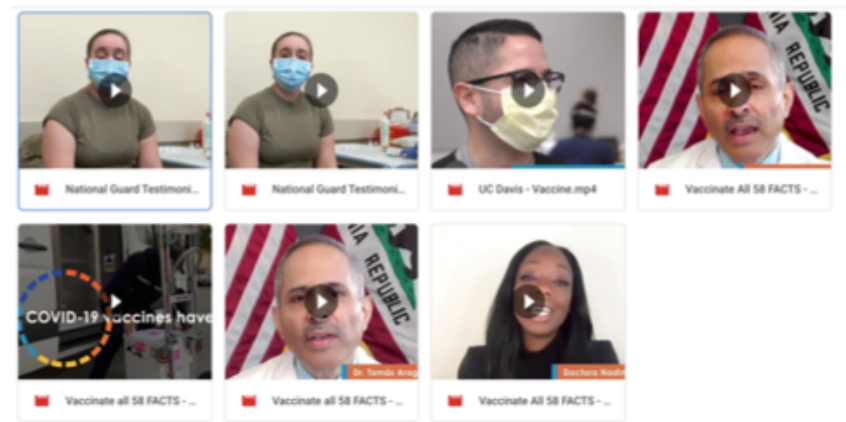


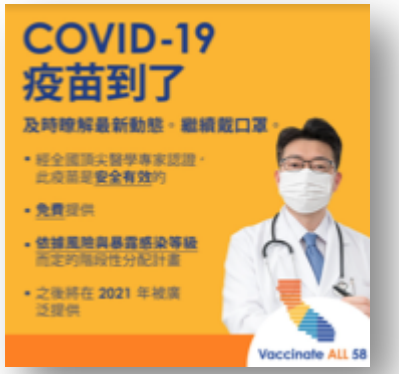
Vaccinate ALL 58 Campaign Toolkit – Edgar Ednacot

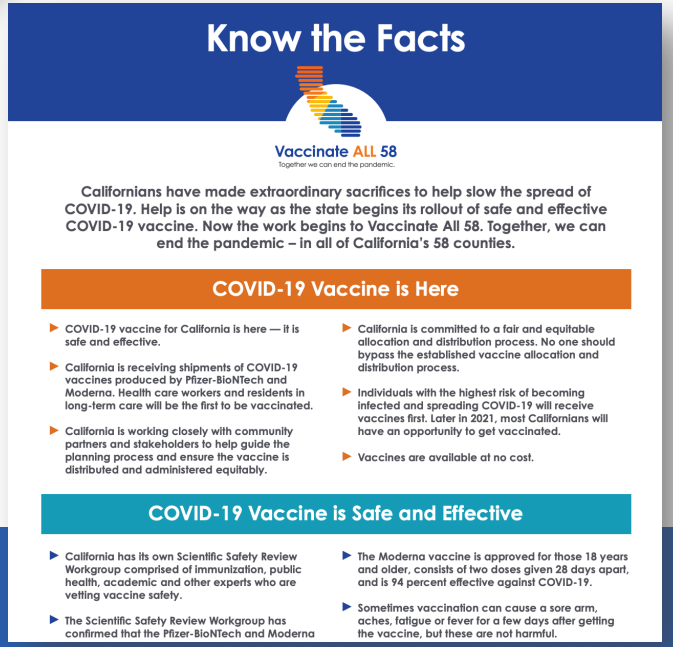
- Fact Sheets in 18 languages
- Video PSAs
  - English and Spanish (feature Drs. Aragon and Burke-Harris)
  - Testimonials from HCWs and National Guard
- Social media posts
  - To build vaccine confidence in English, Spanish, Chinese
  - My Turn
- Web buttons, logos
- More tools being added, along with statewide campaign
- CDC/Ad Council to release campaign and resources soon
- Toolkit: https://toolkit.covid19.ca.gov/partners/

https://youtu.be/4PXRkfoF7_c
https://youtu.be/NI-IUZ86K8Y (Spanish)

Vaccinate ALL 58 Campaign – Edgar Ednacot







https://eziz.org/covid/patient-resources/

Storage & Handling – Kate McHugh

Moderna Transport

- Moderna has stated you can transport at refrigerated/thaws temperatures multiple times
- It is still a general best practice to minimize the transport of any type of vaccine as much as possible

Punctured Vial Transport

- Recommended over transporting pre-drawn syringes
- Do this sparingly (e.g., for homebound patients, for homeless patients, etc.)
- Transport punctured vials between 2°C and 8°C
- Must be used within 6 hours after puncture/reconstitution or discarded

Storage & Handling – Kate McHugh

General Transport Guidance

- Use a digital data logger!
- Record the time and min/max temperatures at the start of transport, every time the storage container is opened, and when transport is completed
  - If using the transport container to store during clinic, recommended to record temperatures every hour
- Protect vaccines as much as possible from drops, shocks, or vibration
- Transport in the carton whenever possible
- Use dunnage (bubble wrap or other padding, make sure to pre-condition)
- Secure storage containers in the vehicle
- Try to ensure vaccine vials stay upright

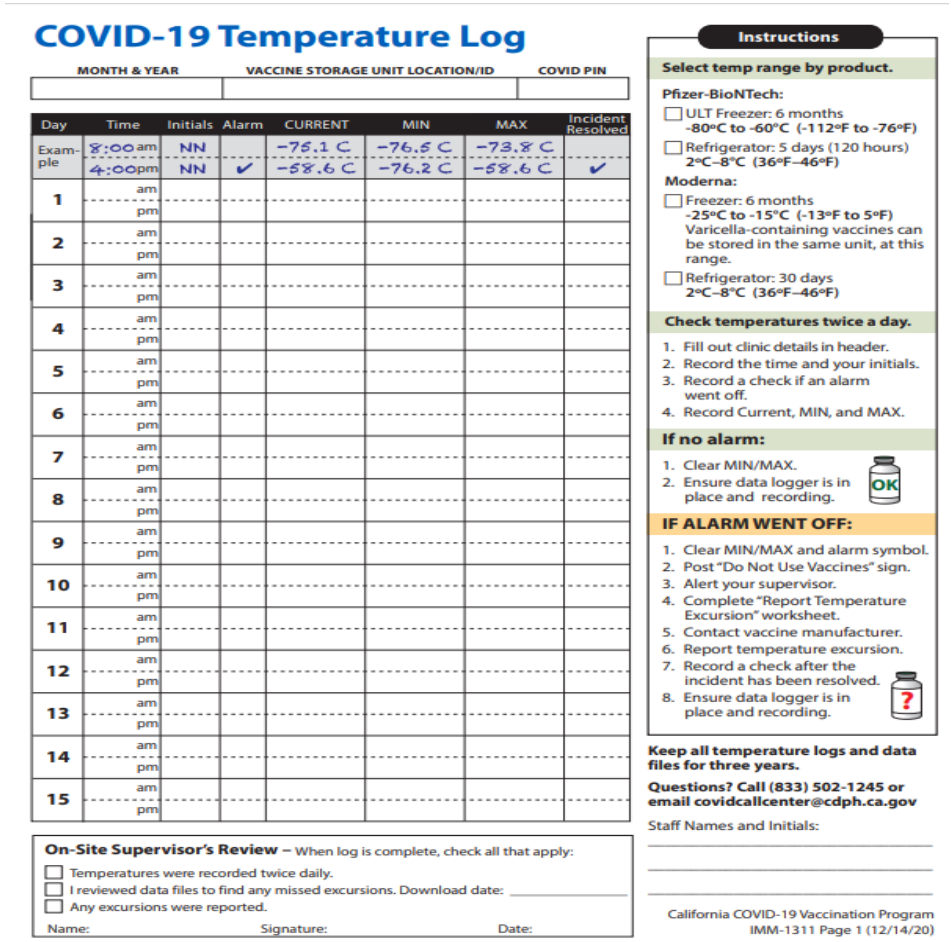
Storage & Handling – Kate McHugh

Pfizer Ancillary Kits

- Reconfigured to support 6 doses per multidose vial
- Kits include enough supplies to administer 1,170 vaccinations
- 1-inch needles and syringes in the kit are low dead-volume
- Use low dead-volume syringes/needles to withdraw 6 doses
  - If sufficient quantities of low dead-volume syringes are not available or a 1.5-inch needle is needed, withdraw vaccine using combination of low dead-volume syringes and non-low dead-volume syringes per vial (e.g., 3 low dead-volume syringes and 3 non-low dead-volume syringes)
  - Slowly inject the diluent to prevent excess foaming or bubbling
  - When mixing and withdrawing vaccine, insert the needle into different places on the vial septum

Temperature Monitoring – Claudia Aguiluz

- One of the most important activities of vaccine management
- Use the correct temperature monitoring device (DDL)
- Monitor temperatures at all times!
- Use the right log
- Document Min, Max, and current temperatures
- Review data logger files
- If a temperature is out of range, take actions & document and report them



COVID-19 Temperature Log

MONTH & YEAR | VACCINE STORAGE UNIT LOCATION/ID | COVID PIN

Day	Time	Initials	Alarm	CURRENT	MIN	MAX	Incident Resolved
Example	8:00 am	NN		-75.1 C	-76.5 C	-73.8 C	
	4:00 pm	NN	✔	-58.6 C	-76.2 C	-58.6 C	✔
1	am / pm						
2	am / pm						
3	am / pm						
4	am / pm						
5	am / pm						
6	am / pm						
7	am / pm						
8	am / pm						
9	am / pm						
10	am / pm						
11	am / pm						
12	am / pm						
13	am / pm						
14	am / pm						
15	am / pm						

On-Site Supervisor's Review – When log is complete, check all that apply:
- ☐ Temperatures were recorded twice daily.
- ☐ I reviewed data files to find any missed excursions. Download date: _____
- ☐ Any excursions were reported.

Name: Signature: Date:

Instructions

Select temp range by product.

Pfizer-BioNTech:
- ☐ ULT Freezer: 6 months -80°C to -60°C (-112°F to -76°F)
- ☐ Refrigerator: 5 days (120 hours) 2°C–8°C (36°F–46°F)

Moderna:
- ☐ Freezer: 6 months -25°C to -15°C (-13°F to 5°F) Varicella-containing vaccines can be stored in the same unit, at this range.
- ☐ Refrigerator: 30 days 2°C–8°C (36°F–46°F)

Check temperatures twice a day.

1. Fill out clinic details in header.
2. Record the time and your initials.
3. Record a check if an alarm went off.
4. Record Current, MIN, and MAX.

If no alarm:

1. Clear MIN/MAX.
2. Ensure data logger is in place and recording.

IF ALARM WENT OFF:

1. Clear MIN/MAX and alarm symbol.
2. Post "Do Not Use Vaccines" sign.
3. Alert your supervisor.
4. Complete "Report Temperature Excursion" worksheet.
5. Contact vaccine manufacturer.
6. Report temperature excursion.
7. Record a check after the incident has been resolved.
8. Ensure data logger is in place and recording.

Keep all temperature logs and data files for three years.

Questions? Call (833) 502-1245 or email covidcallcenter@cdph.ca.gov

Staff Names and Initials:

_____

_____

_____

California COVID-19 Vaccination Program
IMM-1311 Page 1 (12/14/20)

Temperature Monitoring

- How to Record Temperatures job aid
- COVID-19 Temperature Log
- Hourly Temperature Log
- Data Logger Setup & Use job aid
- Reporting Temperature Excursions: Job Aid | Worksheet

Provider Call Center – Brenton Louie

When will I receive my vaccine order?

- Due to inclement weather, McKesson and Pfizer were unable to deliver vaccines this past week. Once weather improves, carriers will resume vaccine shipments.

Why is my application stuck in E-signature requested?

- There may be issues with DocuSign linking to the correct accounts causing this error. Please contact the Accenture Helpdesk at myCAvax.HD@accenture.com for assistance.

Updated Hours starting Monday, February 22

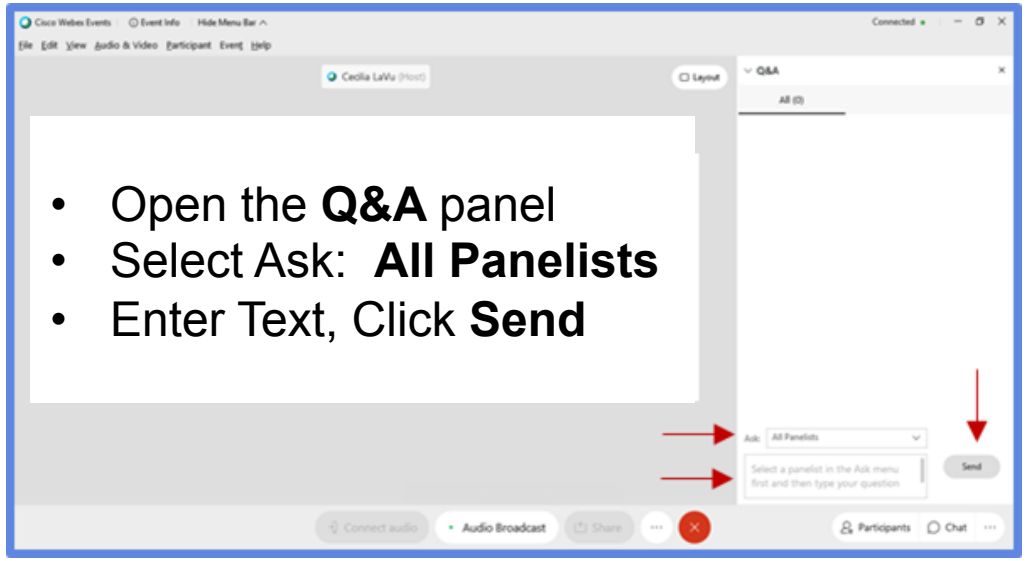
- Monday through Friday, 8AM - 8PM

Provider Q&A

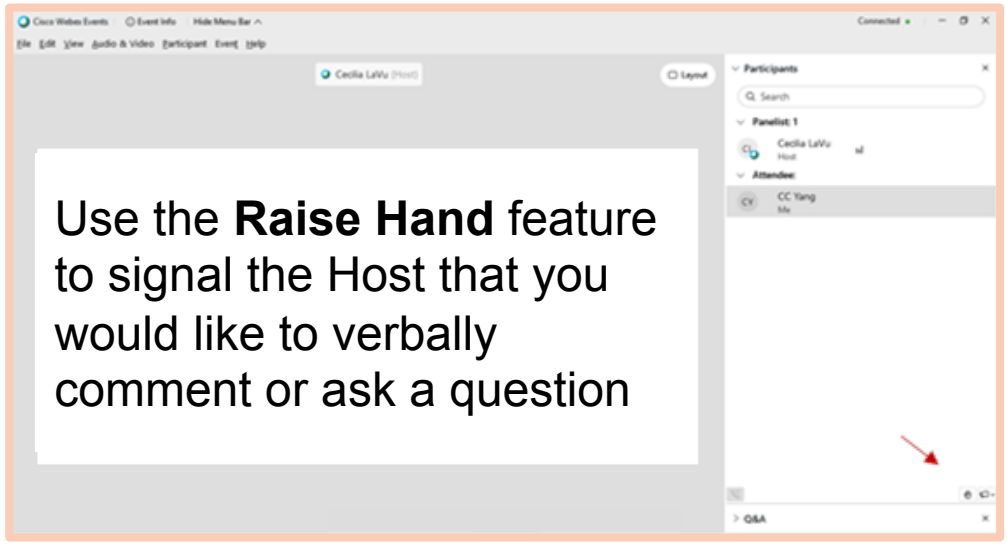
How to Ask a Question

During the webinar, please use one of the following methods to ask a question or make a comment.

OPTION #1: Q&A Panel



OPTION #2: Request to Join Audio



Summary Slide

- For Pfizer orders **submitted on or after February 16,** report doses on hand to VF as 6-dose vials; separate inventory to track these doses
- Monitor temperatures at all time
- Report inventory in VaccineFinder daily

Provider Resources

COVID-19 Call Center – for questions regarding the COVID-19 Vaccine Program

- Email: covidcallcenter@cdph.ca.gov
- Phone: (833) 502-1245
  Monday through Friday from 8 AM – 5 PM

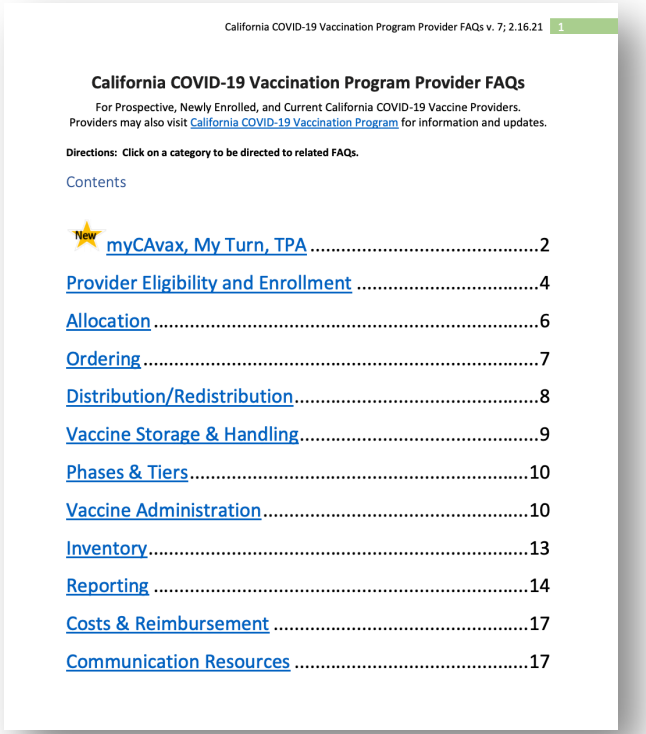
myCAvax Technical Help – for technical questions relating to CalVax

- Email: myCAvax.HD@accenture.com

My Turn – for questions regarding My Turn application

- Email about onboarding questions: myturnonboarding@cdph.ca.gov
- Email about general questions: myturninfo@cdph.ca.gov

Provider FAQs



California COVID-19 Vaccination Program Provider FAQs v. 7; 2.16.21 1

California COVID-19 Vaccination Program Provider FAQs

For Prospective, Newly Enrolled, and Current California COVID-19 Vaccine Providers.
Providers may also visit California COVID-19 Vaccination Program for information and updates.

Directions: Click on a category to be directed to related FAQs.

Contents

New myCAvax, My Turn, TPA 2
Provider Eligibility and Enrollment 4
Allocation 6
Ordering 7
Distribution/Redistribution 8
Vaccine Storage & Handling 9
Phases & Tiers 10
Vaccine Administration 10
Inventory 13
Reporting 14
Costs & Reimbursement 17
Communication Resources 17

https://eziz.org/assets/docs/COVID19/Vax58ProviderFAQs.pdf

Thank You

for our next weekly

Provider Office Hours

Friday, February 26th

9:00 – 10:00 AM

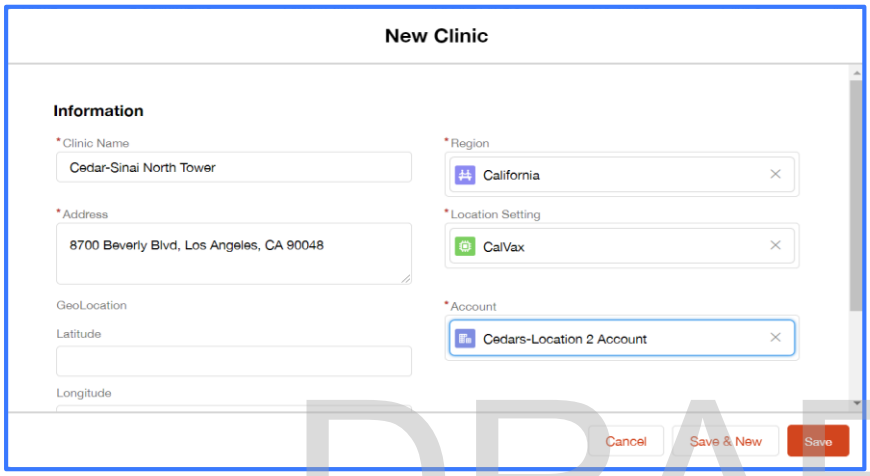
What You Need to Know as a Provider Coordinator

Target Users: Care Coordinator, Clinic Managers

Purpose: This document is a quick reference guide on what provider coordinators can perform in the Provider Portal.

1 Create a Clinic under a Provider (Location)

Select "**Clinics**" tab → "**New**" → Fill out ALL fields → Hit "**Save**"



Important: Fill out the following for the fields:

- **"Regions"** = "California"
- "**Location Setting**" = "CalVax"
- "**Account**" = Provider Account Location
  - Account will be auto-populated – if it is not, select the provider's location name you want)

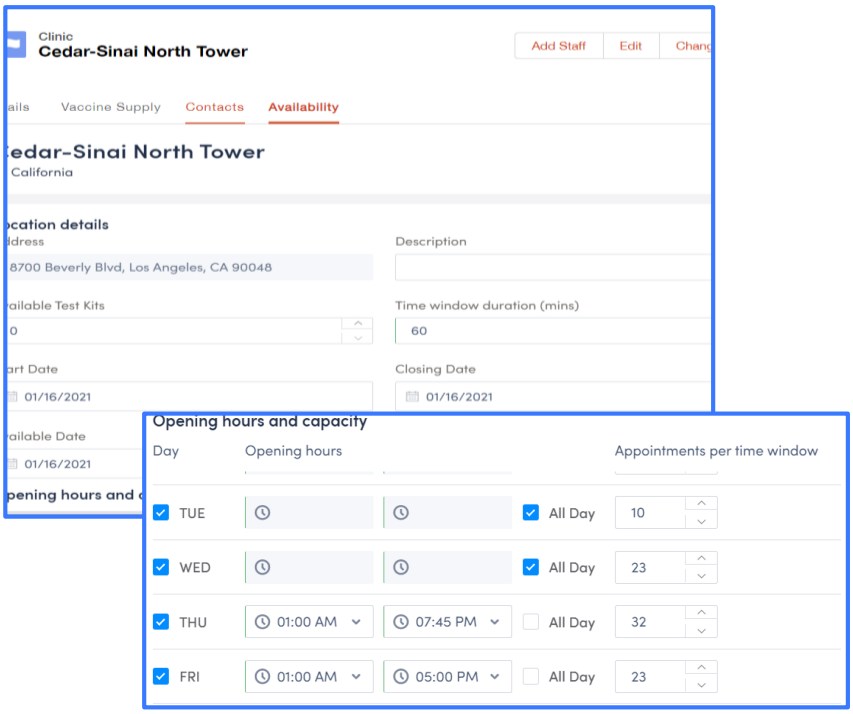
DRAFT

2 Schedule Clinic Hours of Operations

1. Select "**Clinics**" tab → Click on the clinic you wish to view.
2. Select "**Availability**" → Fill out all fields

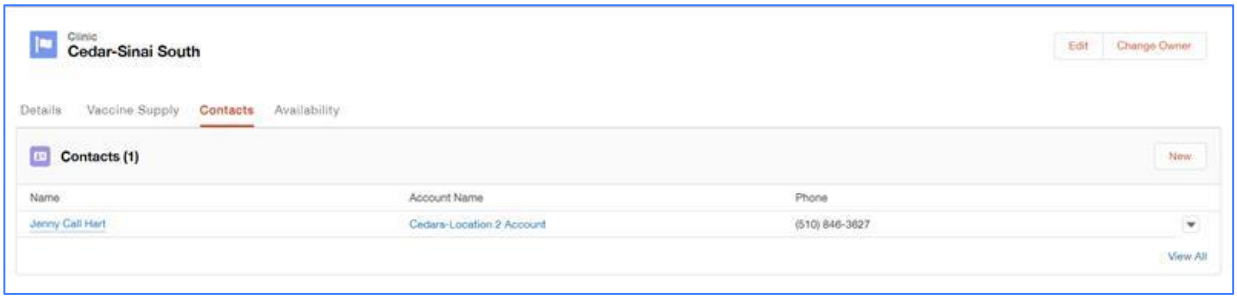
Fill out the following for the fields:

- "**Start Date**" = first date when clinic will start
- "**Closing Date**" = last date of clinic

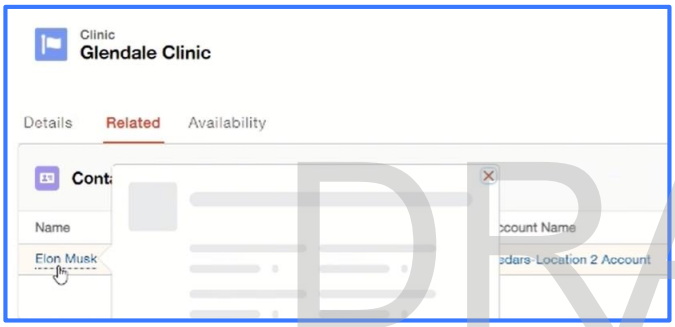


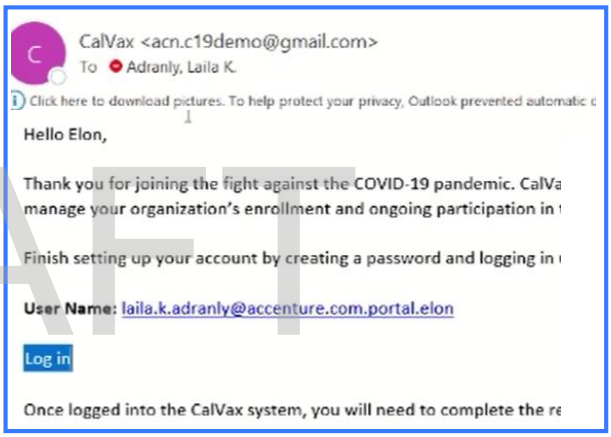
3 Add Staff to Clinic

1. Select “**Clinics**” tab → Click on a clinic → Select “**New**”
2. Fill out staff information in necessary fields → Hit “**Next**”



3. You should see the new staff listed in “**Related**” under the clinic you’ve assigned them to.
4. An email will be sent to the staff member’s inbox. The email will contain their account information.





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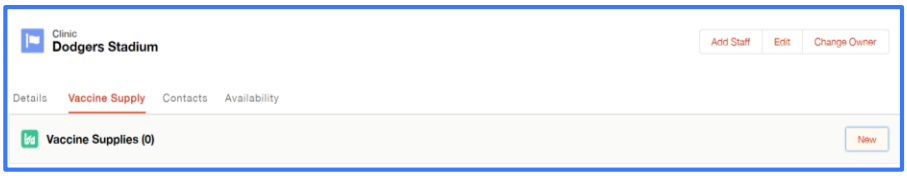
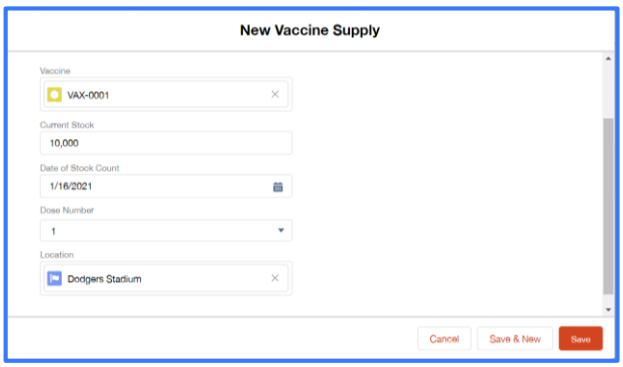
5 Add Vaccination Administration & Supply

1. Select “**Clinics**’ tab → click on the clinic you want to view → Click “**Vaccine Supply**”





2. Fill out fields → “**Save**”

Important:
- **VAX-0000 =** Pfizer
- **VAX-0001** = Moderna

What You Need to Know as a System Administrator

Target Users: CDPH / LADPH IT System Administrators

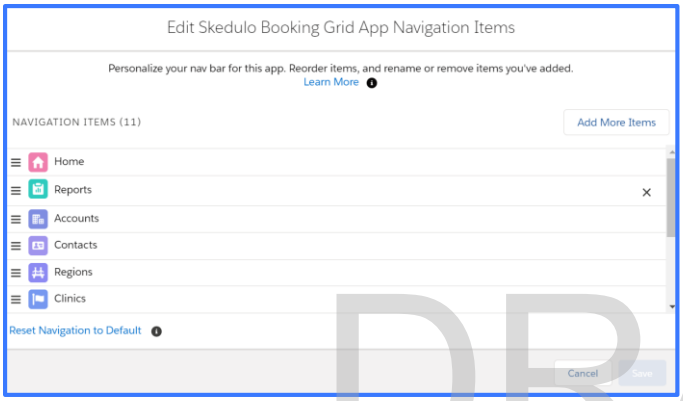
Purpose: This document is a quick reference guide on what tasks System Administrators can perform in the Salesforce CalVax system.

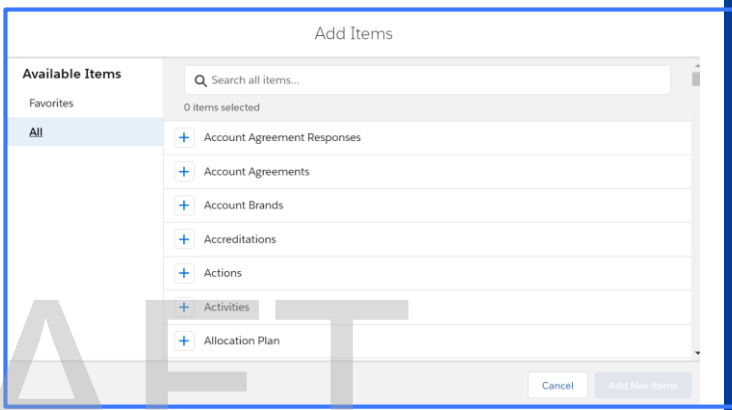
Functional Permissions:

- Manage the Salesforce system
- Manage vaccine inventory
- Create reports and dashboards

1 Configure Navigation for Skedulo

1. Select the pencil icon (top right corner) -> **Edit Skedulo Booking Grid App Navigation Items**
2. Click "**Add More Items**" → "**All**" → Select the + to add a tab
3. Click "X" next to the Navigation Item to delete a tab
4. Slide the ☰ to change the order of navigation Items





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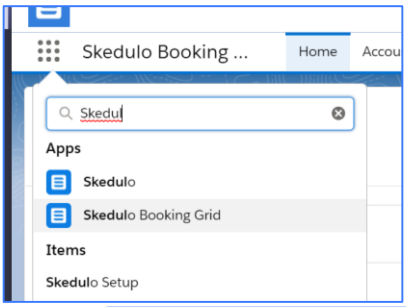
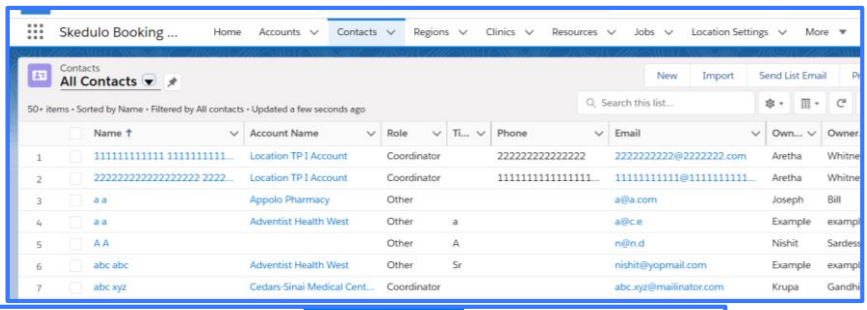
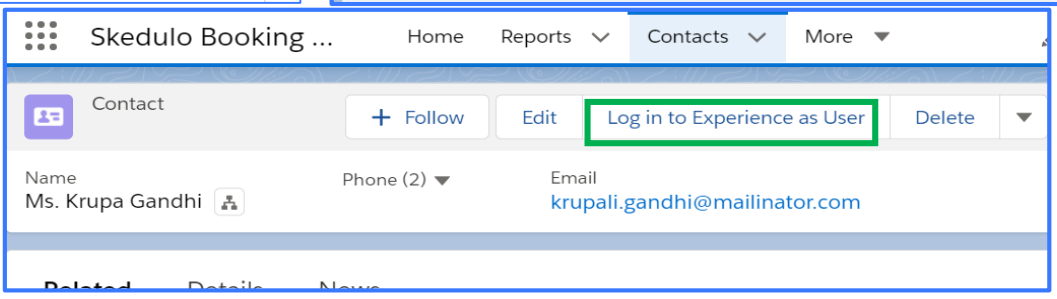
2 Troubleshooting Users

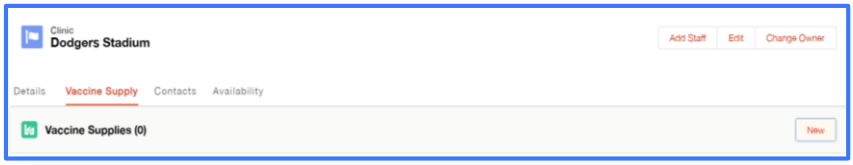
1. Click on the grid in the upper left portion of the screen
2. Type "**Skedulo Booking Grid**" into the search bar → Select option
3. Select **"Contacts"** → "**All Contacts**" → Select user (example, Krupa Ghandi)
4. Select "**Log in to Experience as User**"

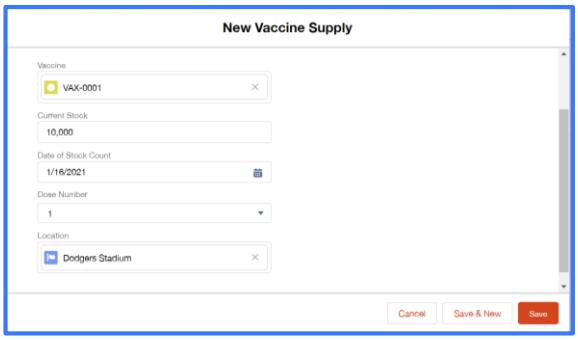






3 Track Vaccine Supply & Inventory Decrement



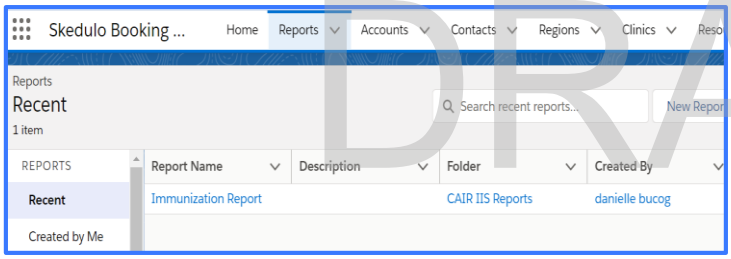


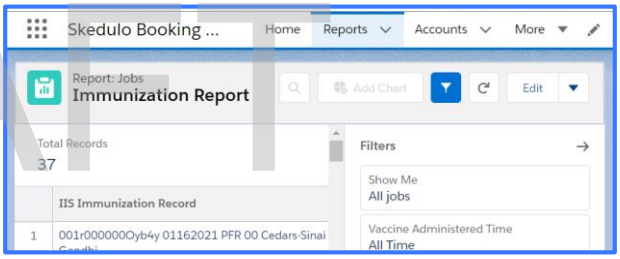
1. Select "**Clinics**' tab → click on clinic to view → Click "**Vaccine Supply**"
2. Select **"New"**
3. Fill in New Vaccine Supply details and click **"Save"**

Important:
- **VAX-0000 =** Pfizer
- **VAX-0001** = Moderna

4 Transfer Immunization Files into IIS

1. Click "**Reports**" → "**All Folders**" → "**CAIRS ISS Reports**" → "**Immunization Report**"





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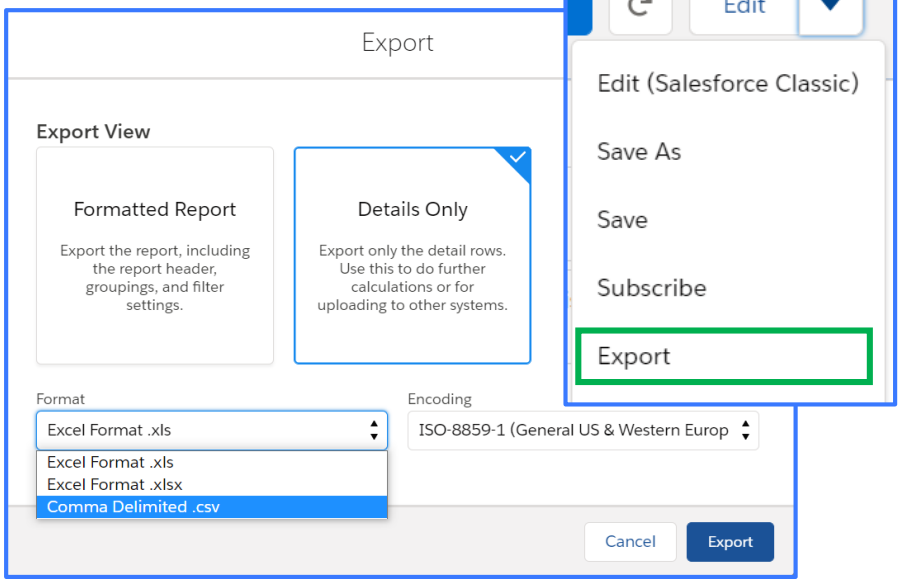
2. Select the down arrow next to "**Edit**" → "**Export**"
3. Select "**Details Only**" → Click "**Format**" → "**Comma Delimited.csv**" → Hit "**Export**"
4. The report file will begin downloading.



Note: The file format should contain the following:
- Vaccine allocation
- Providers
- Provider Location

What You Need to Know as a Vaccine Administrator

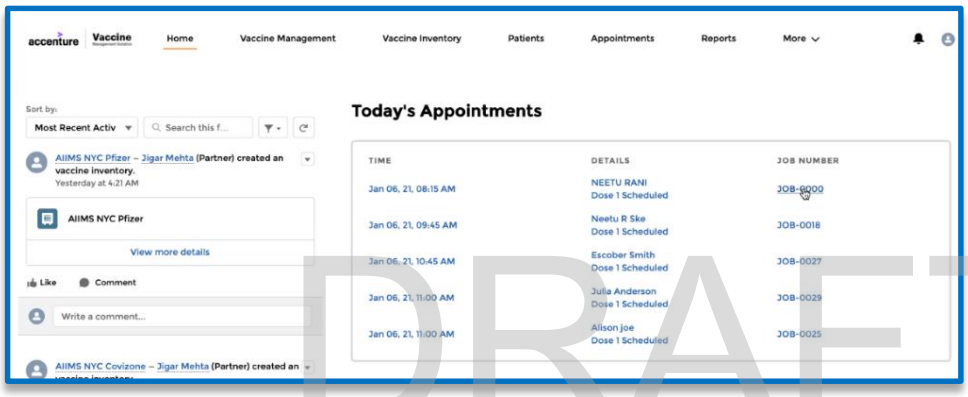
Purpose: This document is a quick reference guide for Vaccine Administrators on how to use CalVax for the Vaccine Management process.

Ensure you are logged into the CalVax Provider Portal as a Vaccine Administrator.

Target Users: Nurses, Physicians/Physicians Assistants, Dentists, Pharmacists

1 Check-In Patient for Vaccination (Walk-Ins & Appointments)

1. Select the **Appointments** tab, select the appropriate patient's name from **"Today's Appointments"**
2. If patient is a walk-in, direct the patient to the Registration Portal.



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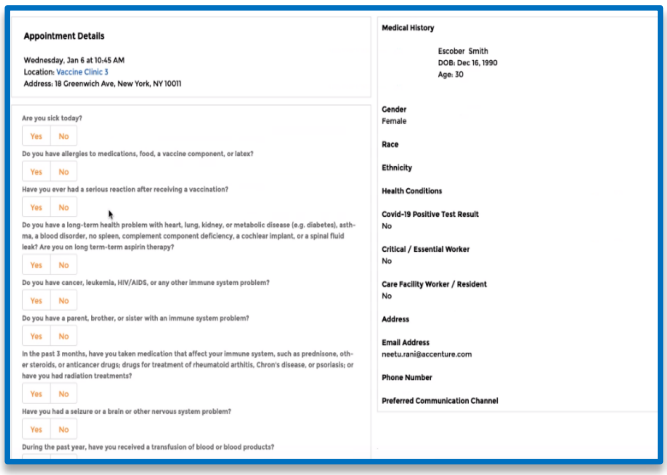
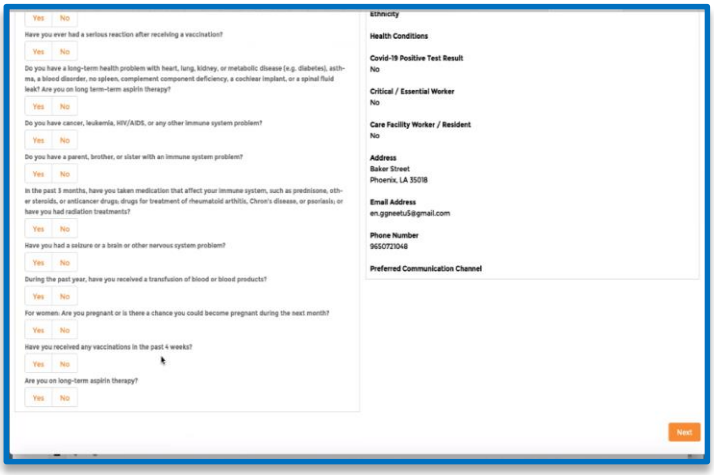
2 Patient Verification & Screening

1. Verify patient's identity (**Name DOB**, etc).
2. Confirm patient's **Medical History** and **Contact Information**
3. Note patient's responses to the screening questions and click **"Next"**
4. Obtain patient's consent to administer the vaccine and click **"Next"**



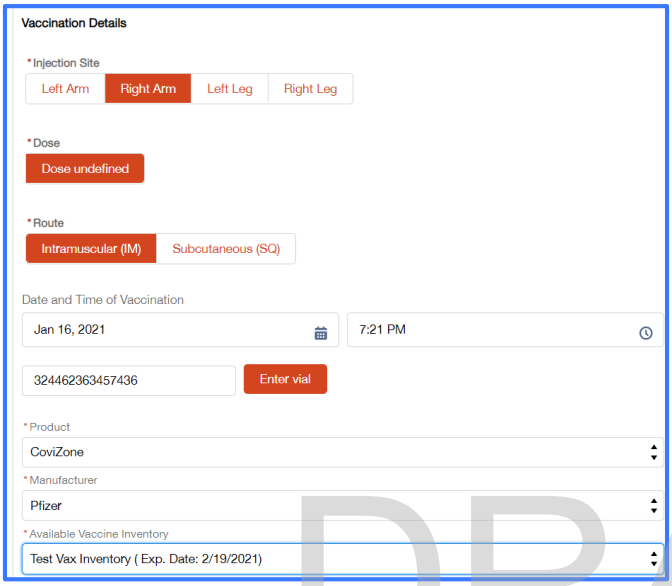


3 Vaccine Administration

1. Enter information about vaccine injection (injection site, dose, date, time).
2. Enter the vial number for the vial being given to the patient

Note: Vaccine product, manufacturer, and available vaccine inventory is pre-populated.

3. Document any **Immediate Adverse Reactions** and click **"Next"**



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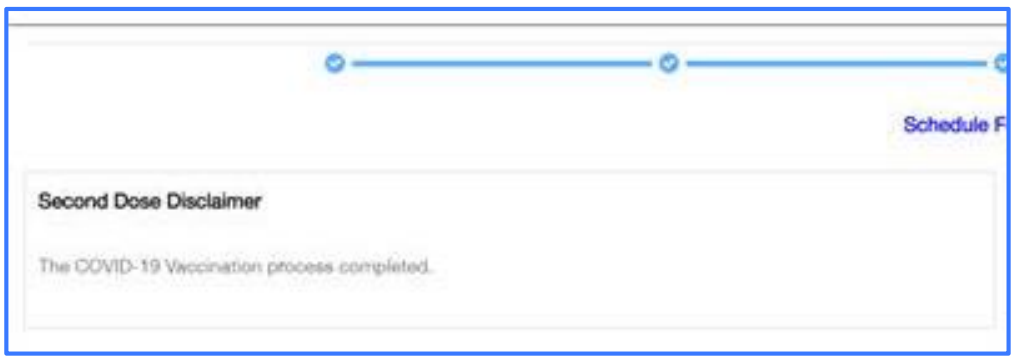
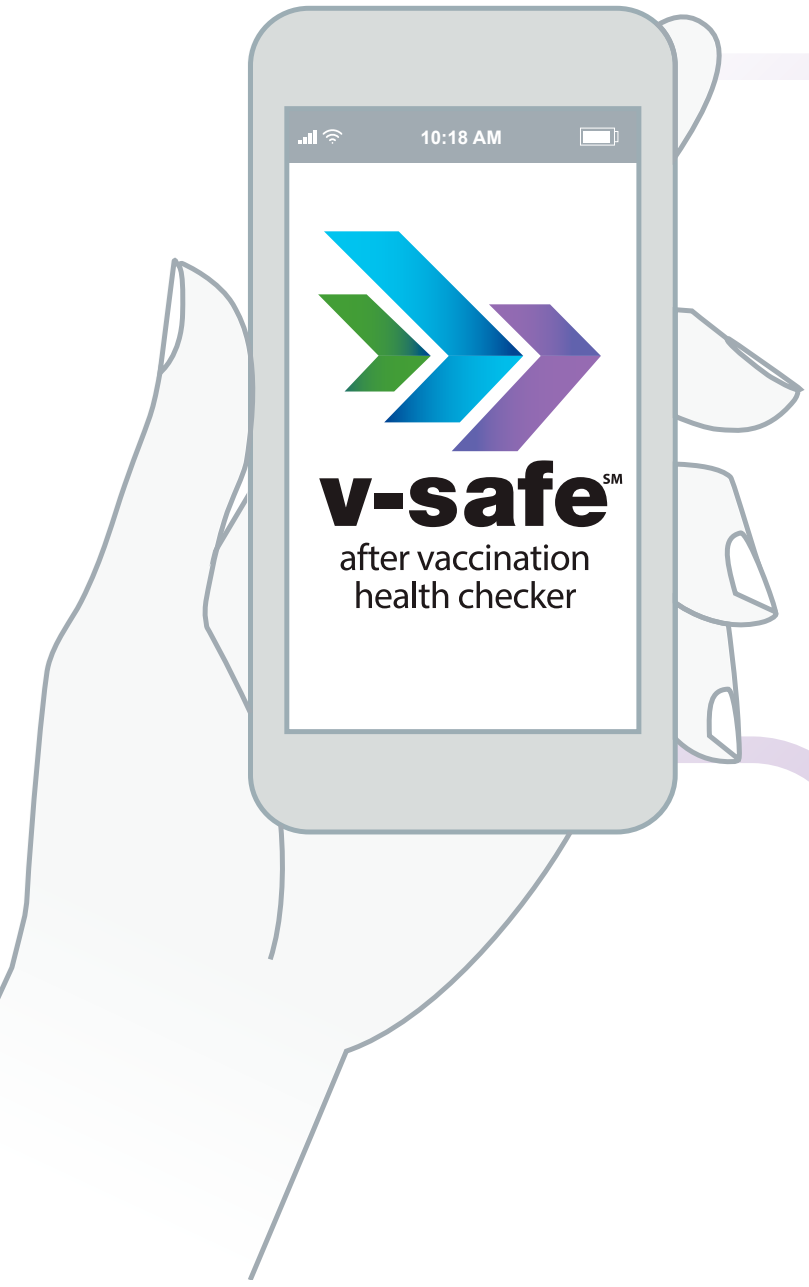
4 Second Dose Reminder

1. After the vaccination process is complete, you will see the **"Second Dose Disclaimer"**.
2. Remind patients to set up their second appointment on the Registration Portal.



Vaccinate ALL 58
CDPH
CalVax
California Vaccine Management System

Get vaccinated.
Get your smartphone.
Get started with v-safe.

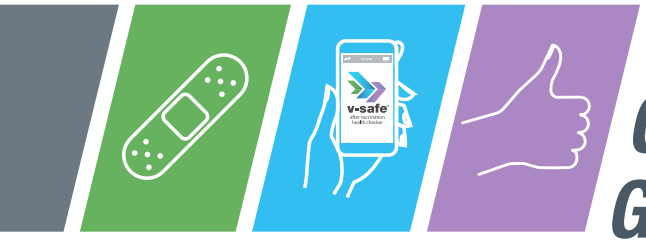


Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second vaccine dose.

When you get your COVID-19 vaccination, ask your healthcare provider about getting started with v-safe

Learn more about **v-safe**
www.cdc.gov/vsafe

12/01/20



Get vaccinated. Get your smartphone. Get started with v-safe.

What is v-safe?

V-safe is a smartphone-based tool that uses text messaging and web surveys to provide personalized health check-ins after you receive a COVID-19 vaccination. Through ***v-safe***, you can quickly tell CDC if you have any side effects after getting the COVID-19 vaccine. Depending on your answers, someone from CDC may call to check on you. And ***v-safe*** will remind you to get your second COVID-19 vaccine dose if you need one.

Your participation in CDC's ***v-safe*** makes a difference—it helps keep COVID-19 vaccines safe.

How can I participate?

Once you get a COVID-19 vaccine, you can enroll in ***v-safe*** using your smartphone. Participation is voluntary and you can opt out at any time. You will receive text messages from ***v-safe*** around 2pm local time. To opt out, simply text "STOP" when ***v-safe*** sends you a text message. You can also start ***v-safe*** again by texting "START."

How long do v-safe check-ins last?

During the first week after you get your vaccine, ***v-safe*** will send you a text message each day to ask how you are doing. Then you will get check-in messages once a week for up to 5 weeks. The questions ***v-safe*** asks should take less than 5 minutes to answer. If you need a second dose of vaccine, ***v-safe*** will provide a new 6-week check-in process so you can share your second-dose vaccine experience as well. You'll also receive check-ins 3, 6, and 12 months after your final dose of vaccine.

Is my health information safe?

Yes. Your personal information in ***v-safe*** is protected so that it stays confidential and private.*

*To the extent ***v-safe*** uses existing information systems managed by CDC, FDA, and other federal agencies, the systems employ strict security measures appropriate for the data's level of sensitivity. These measures comply, where applicable, with the following federal laws, including the Privacy Act of 1974; standards enacted that are consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Federal Information Security Management Act, and the Freedom of Information Act.

v-safe℠
after vaccination health checker

Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second vaccine dose.

Sign up with your smartphone's browser at vsafe.cdc.gov

OR

Aim your smartphone's camera at this code

12/01/20

How to register and use v-safe

You will need your smartphone and information about the COVID-19 vaccine you received. This information can be found on your vaccination record card; if you cannot find your card, please contact your healthcare provider.

Register

1. Go to the ***v-safe*** website using one of the two options below:

Use your smartphone's browser to go to

vsafe.cdc.gov

OR

Aim your smartphone's camera at this code

2. Read the instructions. Click **Get Started**.
3. Enter your name, mobile number, and other requested information. Click **Register**.
4. You will receive a text message with a verification code on your smartphone. Enter the code in ***v-safe*** and click **Verify**.
5. At the top of the screen, click **Enter your COVID-19 vaccine information**.
6. Select which COVID-19 vaccine you received (found on your vaccination record card; if you cannot find your card, please contact your healthcare provider). Then enter the date you were vaccinated. Click **Next**.
7. Review your vaccine information. If correct, click **Submit**. If not, click **Go Back**.
8. **Congrats! You're all set!** If you complete your registration before 2pm local time, ***v-safe*** will start your initial health check-in around 2pm that day. If you register after 2pm, ***v-safe*** will start your initial health check-in immediately after you register—just follow the instructions.

   You will receive a reminder text message from ***v-safe*** when it's time for the next check-in—around 2pm local time. Just click the link in the text message to start the check-in.

Complete a v-safe health check-in

1. When you receive a ***v-safe*** check-in text message on your smartphone, click the link when ready.
2. Follow the instructions to complete the check-in.

Troubleshooting

How can I come back and finish a check-in later if I'm interrupted?

- Click the link in the text message reminder to restart and complete your check-in.

How do I update my vaccine information after my second COVID-19 vaccine dose?

- ***V-safe*** will automatically ask you to update your second dose information. Just follow the instructions.

Need help with *v-safe*?
Call 800-CDC-INFO (800-232-4636)
TTY 888-232-6348
Open 24 hours, 7 days a week
Visit www.cdc.gov/vsafe

MEMORANDUM OF UNDERSTANDING

BETWEEN

INTERNATIONAL MEDICAL CORPS (IMC)

AND

[INSERT FULL NAME OF OTHER PARTY]

1. PREAMBLE

1 This Memorandum of Understanding ("**MOU**") is entered into this 12th day of February 2020, by and between **International Medical Corps** (hereinafter "**IMC**"), a non-profit, non-political international organization that provides medical relief, nutrition, health care training, and development programs, and having a principal office at **12400 Wilshire Boulevard, 15th Floor, Los Angeles, California 90025**, and **Kedren Community Health Center** (hereinafter **"[KEDREN HEALTH]" or "Healthcare Facility")**, a non-profit FQHC community health center and an acute psychiatric hospital with outpatient mental health outfit, and having its principal office at 4211 South Avalon Blvd, Los Angeles, CA 90011, in recognition of their respective mandates, responsibilities, strategic objectives and mission statements. IMC and Hospital may each be individually referred to herein as a "**Party**," or collectively as the "**Parties**."

2. PURPOSE

The purpose of this MOU is to provide a framework for cooperation and coordination between the Parties concerning: (1) to source clinical volunteers from our roster during the COVID-19 Pandemic for the purpose of vaccination, and (2) address the possibility of additional tents, equipments, or PPE should these become available.

3. COSTS

3.1 Each Party shall bear its own costs and expenses of whatever nature incurred as a result of or relating to (i) the entering into of this MOU and (ii) any agreements or any activities carried out under this MOU including, but not limited to, travel and living expenses and expenses of negotiation. Neither Party shall be obligated to provide funds for the operational needs of the other Party, including but not limited to funds for the salaries of the other Party's personnel, the purchase of equipment and supplies, medications, drugs, or food.

3.2 Either Party may, subject to the availability of funds, and at its sole discretion, provide training or other support to the other Party.

4. TERM

This MOU shall be effective from the date first written above until **December 31, 2021**, unless terminated earlier pursuant to Article 9 herein.

5. OBLIGATIONS OF IMC

5.1 IMC will, at the request of the healthcare facility, organize volunteer nurses, doctors, and appropriate level medical technicians that are licensed healthcare staff (hereinafter "Staff") in response to COVID-19 needs for the purpose of staffing Vaccination Sites at your facility.

5.1.1 Staff will be screened to ensure they possess a valid medical license and a clear background check.

5.1.2 IMC will provide electronic copies of credentials and identification documents prior to deployment for hospital review and acceptance.

5.2 IMC will be responsible for Staff costs, including travel, lodging, and per diem.

5.3 IMC will provide a Staff point of contact in Los Angeles to provide administrative support to the volunteers at the health care facility.

5.4 IMC does not guarantee availability or quantity of Staff. However, IMC will focus initially on organizing 6 volunteers Monday through Friday (8 hour day) for an intial period of 4 weeks subject to renewal/mutual modification.

5.5 If additional resources become available, IMC will explore the provision of medical tents suitable for patient care with sizes and locations to be mutually determined between IMC and the Healthcare facility.

6. OBLIGATIONS OF HEALTHCARE FACILITY

6.1 Healthcare facility shall work with the IMC to facilitate suitable assignments for IMC sponsored vaccinators.

6.2 Healthcare facility will assist IMC in ensuring they complete necessary orientation, access, forms, and badging as needed to fulfill their duties. Health Center shall provide forms and documentation in advance to the extent possible.

6.3 If possible, the Healthcare Facility shall arrange for IMC Staff to be covered under their malpractice insurance and to ensure Staff medical credentials and licensure are appropriate for the purpose they will be serving at healthcare facility and jurisdiction in which facility is located. Regardless, IMC will also provide insurance to its employees.

6.4 Healthcare facility shall provide an orientation to IMC Staff prior to any assignments, which shall include facility layout, security, safety, safeguarding, and key policies and procedures required for onboarding.

6.5 Facility shall provide a Staff point of contact to IMC and volunteers so that assignments can be coordinated properly.

6.6 Once facility no longer requires Staff deployed under this arrangement, the healthcare facility shall notify IMC. IMC will notify Staff and coordinate with hospital to conclude the Staff's deployment at the healthcare facility

6.7 Healthcare facility is responsible for adhering to CDC's *Information for Healthcare Professionals.* This Guidance is subject to change and Parties are responsible for following CDC update announcements.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

6.8 Healthcare facility is will provide appropriate Personal Protective Equipment (PPE) for Staff per CDC's guidance. If Healthcare facility is unable to provide sufficient quantiites of PPE, they must notify IMC immediately. Staff will be unable to provide patient care services without PPE. This will generally include the following items: Face shields and/or goggles Eye protection, gloves, gowns, N95 or appropriate Mask, along with fit testing if needed.

6.9 Healthcare facility will provide IMC with a method to quantify overall response data (ex. # of patients vaccinated)

6.10 Healthcare facility will work with IMC to field media requests and provide designated spokesperson(s) to participate in media interviews.

6.11 Healthcare facility will work with IMC to support the collection of video, photo and story assets.

6.12 Facility agrees to work with IMC on promotion and publicity for activities under this agreement, which may be necessary in order to maximize potential volunteer sourcing. Specific details regarding logo use and publicity are referenced in Article 8 and may be further decided in writing agreement between the two Parties.

7. JOINT RESPONSIBILITIES OF IMC AND HOSPITAL

7.1 The Parties acknowledge that there are risks and dangers associated with the activities contemplated under this MOU, including but not limited to operating in an environment with a known COVID-19 presence.

7.2 The Parties shall each appoint a Point of Contact responsible for managing Agreement needs. Any change to the Point of Contact must be notified in writing.

For IMC:

- Administrative –Jonah Sargent
  - . jsargent@internationalmedicalcorps.org
- Medical Coordinator – John Roberts, MD, MPH
  - Jroberts@internationalmedicalcorps.org
- Media - Todd Bernhardt, Director, Global Communications
  - Tbernhardt@internationalmedicalcorps.org
- Staff - Staci Parelman, Senior Recruiter
  - Sparelman@internationalmedicalcorps.org

For KEDREN HEALTH:

- Administrative – Jerry P Abraham, MD MPH CMQ
  - Family & Community Medicine
  - Global Injury Epidemiologist
  - Director, KEDREN VACCINES
  - abraham.jerry@gmail.com
- Administrative – Sonny Tran, MBA
  - Chief Operating Officer COO, KEDREN HEALTH
  - stran@kedrenhealth.org
  - sonnyde@gmail.com
- Administrative – Irene Wilson
  - Business Manager, KEDREN HEALTH
  - iwilson@kedrenhealth.org
- Media – n/a
- Staff – n/a

8. PUBLICITY

8.1. The Parties hereby grant each other a non-exclusive, royalty-free right to use the other Party's logo for the purposes of volunteer recruitment and/or promotion of the collaboration across all communication and media channels. The presence of the logo should not be portrayed as an

endorsement or recommendation of any of Hospital or IMC products or services. Hospital and IMC are required to notify each other of any potential infringement of the other Party's logo of which they are aware, or reasonably should be aware. Each Party agrees to reference the other in its promotional materials when promoting services being providing under this Agreement.

8.2. Any permission to use the other Party's name, logo, or marks, may be terminated immediately upon written notice if there are breaches any of the terms of this agreement, engagement in any conduct which is criminal, or engagement in conduct that would tend to damage the reputation of the other Party.

8.3. Notwithstanding the foregoing grant to use the other Party's logo for specific purposes identified in 8.1, advance written approval is required for any and all uses of the other Party's name or the other Party's Mark. Both Parties will endeavour to provide review and feedback within one business day.

9. TERMINATION; FORCE MAJEURE

9.1 This MOU may be terminated by either Party without cause upon thirty (30) days advance written notice. Either Party may terminate this MOU with cause immediately upon written notice to the other Party. Termination shall be "with cause" in the event of the other Party's gross negligence or malfeasance, including any incidence of fraud in the performance of its duties hereunder, or in the event the non-terminating Party fails to comply with its material obligations under this MOU and fails to cure such failure within ten (10) days of its receipt of written notice thereof.

9.2 The Parties are released from any penalty in case of force majeure. "Force majeure" is any circumstance beyond a Party's reasonable control including, but not limited to, acts of God, fire, flood or other natural disaster, changes in the law, adverse government actions, industrial disturbances, war, unrest, explosions and any other similar circumstances.

9.3 As a condition to the claim of non-liability, the Party experiencing the force majeure event shall immediately provide written notice to the other Party with full details of such force majeure event and its effects on the Party's ability to perform its obligations under this MOU. If such force majeure circumstance results in the suspension of performance by one of the Parties for a period exceeding thirty (30) days, then the other Party may terminate this MOU by sending prior written notice of such termination, effective upon delivery. In the event of such termination, each Party shall bear its own costs.

10. LEGAL LIABILITY; INDEMNIFICATION

10.1. The Parties shall each be responsible for their own employees, representatives, subcontractors, affiliates, and agents, and shall defend, indemnify and hold each other harmless from and against all liability, damage, loss, claim, demand, action and expense (including legal fees and disbursements) to the extent resulting from, arising out of or in connection with their respective activities hereunder, or any claims brought by third parties as a result of any act or omission hereunder by their respective employees, representatives, subcontractors, affiliates, and agents.

10.2. Healthcare facility shall release IMC from any liability arising out of the actions or inactions of the Staff provided to the Healthcare facility under this Agreement.

10.3. Neither Party, nor its respective employees, representatives, subcontractors, affiliates, or agents, shall be liable to the other or its affiliates, in whole or in part, for any consequential, incidental, special, multiple, exemplary or punitive damages of any kind whatsoever, whether in an action that is the subject of a contract or in tort, including negligence, malpractice, or otherwise, arising out of or in connection with this grant agreement, whether or not the indemnified party has been advised of the possibility of any such damages.

10.4. IMC does not manufacture the products it may donate or set up at Healthcare facility under this Agreement. No claims, representations or warranties, whether expressed or implied, are made

by IMC as to the safety, reliability, durability and performance of any of the products. Furthermore, IMC accepts no liability whatsoever for the safety, reliability, durability and performance of the products. IMC will conduct reasonable due diligence to ensure that personal protective equipment donated to Hospital comply with US standards laid out by the US FDA and CDC."

11. DISPUTE RESOLUTION; GOVERNING LAW

11.1 The Parties agree to attempt to settle any and all disputes, controversies or claims directly or indirectly arising out of or relating to this MOU ("Disputes"), or the interpretation, construction, enforceability, breach, termination or invalidity thereof, by mutual consent and in the spirit of good business relationships. In the event that settlement of a Dispute is not reached within thirty (30) days, such Dispute shall be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association in effect at the time such arbitration is initiated. The discovery period related to a particular claim shall be limited to sixty (60) days for both parties. The dispute shall be settled by one (1) mutually agreed arbitrator, whose decision shall be final and binding against both parties. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The arbitration shall be conducted in Los Angeles, California or in such other location mutually agreed to by the parties.

11.2 This MOU shall be interpreted, construed and governed by the laws of the State of California, excluding any choice of law rules which may direct the application of the laws of another jurisdiction.

12. ANTI-TERRORISM; ANTI-FRAUD

12.1. By entering into this MOU, the Healthcare facility certifies it has not and will not promote or engage in violence or terrorism and is in full compliance with all U.S. Executive Orders, laws and regulations that prohibit transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the Hospital to ensure compliance with all U.S. Executive Orders, laws and regulations.

12.2. In accordance with guidelines issued by the U.S. Treasury Department, the Hospital certifies that none of its employees, representatives, sub-grantees or sub-contractors appear on the U.S. Government lists of persons or entities associated with terrorist activities or support, or whose assets are otherwise blocked by the U.S. Department of the Treasury's Office of Foreign Assets Control.

12.3. This anti-terrorism provision must be included in any agreements that the Hospital may enter into in fulfilling its obligations under this Agreement. For further information, see http://www.treas.gov/ofac.

12.4. International Medical Corps has zero tolerance for fraud, bribery, waste, corruption, sexual misconduct, theft, and other forms of malfeasance. By entering into this MOU, the Hospital certifies it will take reasonable measures to prevent misconduct under this agreement, including fraud, bribery, waste, sexual misconduct, theft, and other misconduct while executing and performing under this agreement. Failure to take reasonable measures may result in termination of this agreement.

13. COMPLIANCE WITH LAWS

The Healthcare facility warrants that it shall, at its own expense and at all times, comply with all laws, rules, regulations, decrees or official government orders that may be at the time of this MOU or become in the future applicable to the Healthcare facility's business, equipment, and personnel, including without limitation, any registration and other administrative requirements. The Healthcare facility shall not engage in any activities that would violate any law, rule, regulation or official order. The Healthcare facility shall not take any action on behalf of IMC that would result in inadequate or inaccurate reporting of assets, liabilities, or any other transaction or which would violate any applicable laws. In the event of breach of the Healthcare facilities obligation to comply with the laws, regulations and requirements set

forth in this section, the Healthcare facility shall release, defend and hold harmless IMC from and against any claims, including reasonable attorney's fees, arising out of or resulting from the Healthcare facility's failure to comply with all applicable laws, rules and regulations, decrees or official government orders.

14. GENERAL

14.1 Nothing in this MOU shall affect the contractual relationship and administrative supervision of IMC's operational partners, donors or constituents overseas, nor the relationship between Healthcare Facility and its corresponding entities, including governmental and non-governmental organizations.

14.2 Nothing in this MOU shall be deemed to create a joint venture, agency or partnership between the Parties, and neither Party shall have the power to obligate or bind the other in any manner whatsoever, except as specifically provided herein.

14.3 This MOU shall not affect the identity or core values of either Party. Nothing in or relating to this MOU shall be deemed a waiver, express or implied, of any of the privileges and immunities granted to either Party by any governmental body, nor be construed to confer upon either Party, or any of its personnel or agents, any immunities or privileges that may be granted to the other Party or its personnel by any governmental body.

14.4 Unless otherwise required by law, neither Party, nor any of their employees, representatives, subcontractors, affiliates, or agents, shall disclose any matters of a confidential nature relating to the other Party to which it may be or become privy as a result of this MOU, unless such disclosure is authorized by the other Party's prior written consent. Except as required by law, any public disclosure of the existence or terms of this MOU shall only be made by the Parties on a joint basis.

14.5 This MOU may be renewed in writing upon mutual agreement of the Parties.

14.6 This MOU, including all documents listed under Article 2.2 (if any), may be amended only by written agreement of the Parties.

14.7 Failure of IMC to enforce at any time any of the provisions of this MOU, or to exercise any option that is provided herein, shall not be deemed to be a waiver of those provisions, nor to affect in any way the validity of any part of this MOU, or the right of IMC thereafter to enforce each provision.

14.8 Any provision of this MOU which is invalid or unenforceable in any jurisdiction shall be ineffective to the extent of such invalidity or unenforceability without invalidating or rendering unenforceable the remaining provisions hereof, and any such invalidity or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

14.9 The expiration or termination of this MOU will not destroy or diminish the binding force and effect of any of the provisions of this MOU that expressly, or by reasonable implication, come into or continue in effect on or after such expiration or termination, including, without limitation, governing law, limitation of liability and indemnity.

14.10 The Parties agree to execute this MOU in the English language. Either Party may undertake to produce a translation of this MOU in its local language. In such event, the Parties agree that the English version of this MOU shall be considered as the authentic text, and in case of a conflict between the content of the English original and a translation thereof, the English version shall prevail.

14.11 Neither this MOU, nor any rights or obligations hereunder, may be assigned or subcontracted to any third party, unless such assignment is pursuant to the other Party's written consent.

14.12 The foregoing represents the complete and exclusive statement of the agreement between the Parties, which supersedes any prior oral or written agreements, proposals, commitments, understandings, or communications with respect to the subject matter of this MOU.

Signatures on following page

IN WITNESS WHEREOF, the Parties hereto have duly executed this MOU as of the date of signing by their authorized representatives below:

Signed and agreed to on behalf of **International Medical Corps**

Signature: _____

Name: _____

Title: _____

Date: _____

Signed and agreed to on behalf of **[INSERT FULL NAME OF OTHER PARTY]**

Signature:

Name: **JERRY P ABRAHAM, MD MPH CMQ**

Title: **DIRECTOR, KEDREN VACCINES**
FAMILY & COMMUNITY MEDICINE
GLOBAL INJURY EPIDEMIOLOGY

+1.832.687.3242
abraham.jerry@gmail.com

Date: **12 FEBRUARY 2021**

Gmail Jerry P Abraham, MD MPH <abraham.jerry@gmail.com>

Josh Fryday Visit

1 message

Verdin, Cristian <cristian.verdin2@redcross.org> Thu, Mar 4, 2021 at 7:48 PM
To: "Abraham.jerry@gmail.com" <Abraham.jerry@gmail.com>
Cc: "Estournes, Janelle" <janelle.estournes@redcross.org>, Kedren COVID19 <vaccines@kedrenhealth.org>, "Ramirez-Gomez, Victoria" <victoria.ramirezgome@redcross.org>

Hi everyone,

Would Josh Fryday's team happen to have communicated this to y'all? Below is the agenda.

9:00 AM	Arrive at Kedren
9:00 – 9:15 AM	Tour of facilities/operation
9:15 – 9:45 AM	Talk with AmeriCorps members
9:45 – 10:00 AM	Volunteer
10:00 – 10:15 AM	Photos/content; Wrap-up/goodbyes

All my best,

Cristian Verdin (he/him)
AmeriCorps Program Manager

American Red Cross
1450 S Central Ave
Los Angeles, CA 90021
(213) 248-8732 (c)
cristian.verdin2@redcross.org

AmeriCorps Disaster Services
Deployment Request Form

Thank you for your interest in engaging AmeriCorps members. California Volunteers (CV) is partnering with organizations throughout the state to assign AmeriCorps members to provide disaster services.

Directions: The purpose of this form is to give California Volunteers AmeriCorps a thorough idea of how you propose to utilize AmeriCorps members during this critical need.

If you would like to have members placed with your organization, please complete the following form electronically and submit it to disasterresources@cv.ca.gov, as soon as possible.

Member Responsibilities

- ✓ Organizations must provide full-time, rewarding service for Members that aligns with agreed upon service activities.
- ✓ All designated supervisors must have experience in supervision.
- ✓ Members are not to engage in AmeriCorps prohibited activities.
- ✓ Members cannot be engaged in general clerical support or supplant staff positions.
- ✓ Members must have (*as applicable*) regular access to office space, telephone, computer, Internet, and an agency vehicle or reimbursement ($.58/mile) for private vehicle use for site specific service.
- ✓ Members must adhere to all AmeriCorps policies.

Please note - California Volunteers Disaster service members are not employees of organizations and cannot be treated as such. They are not to perform administrative functions. AmeriCorps members must serve in roles that fill unmet needs; therefore, organizations are not allowed to replace an existing employee with an AmeriCorps member.

Do you agree to these terms? ☒ Yes (please check if you agree)

Request Submitted By:
Date/Time Submitted:

REQUESTING ORGANIZATION INFORMATION	
Organization Name: **KEDREN HEALTH**	Physical Address: **4211 S Avalon Blvd, Los Angeles, CA 90011** **location members where would serve*
Organization Website: **https://www.kedren.org/**	Mailing Address: Click here to enter text. **if different than physical address*
ORGANIZATION CONTACT INFORMATION ****Primary point of contact throughout the CV placement process***	

Name: **Dr. Jerry Abraham; DIRECTOR, KEDREN VACCINES**	Title: **Trustee, California Medical Association CMA Secretary, Los Angeles County Medical Association LACMA, Family& Community Medicine Global Injury Epidemiologist**
Email: **Abraham.jerry@gmail.com**	Phone: **: 1.832.687.3242**
MEMBER SUPPORT INFORMATION	
Member Supervisor: *The site supervisor should be someone who currently has the technical skills and abilities to perform the tasks at the project site and will train members on completing the project tasks. Provides direct member supervision and guidance.*	
Member Supervisor Name: **Abraham.jerry@gmail.com**	Title: **Trustee, California Medical Association CMA Secretary, Los Angeles County Medical Association LACMA, Family& Community Medicine Global Injury Epidemiologist**
Email: **Abraham.jerry@gmail.com**	Phone: **: 1.832.687.3242**
DEPLOYMENT INFORMATION	
Travel Status: do you prefer your member serve in person or remotely?	☒ In person ☐Remotely ☐ Both/Either Lodging, food, and transportation arrangements (if on travel status): Click here to enter text.
Anticipated Service Dates:	Start Date: **02/25/2021**
	End Date: **03/26/2021**
Number of Members Requested:	**7-10**
Earliest day organization is able to host a member:	Date/Time: **02/25/2021 8 a.m.**
Knowledge, skills, fitness level, and other abilities needed to fulfill the assignment: **must be physically able to stand for long hours**	
Additional guidance regarding what to wear or bring (e.g. equipment): **Face mask, gloves (when appropriate)**	
COVID-19 and other health and safety concerns related to the mission or surroundings: Click here to enter text.	
Safety/PPE equipment provided: **Gloves will be provided on-site, volunteers should arrive with masks, surgical masks and N95 masks available**	
MEMBER DISASTER SERVICE ACTIVITIES DESCRIPTION	
Members will perform the following duties: *Write a brief but thorough description of disaster services members will provide for your organization.* **Volunteer manager, Crowd management/ gate attendance, Registration, Operations and clinical support (stockers, runners), data entry and reporting**	

Member Training to be provided: **On-site volunteer manager will guide members through their preferred volunteer post**	
MEMBER SCHEDULE	
What is the anticipated schedule for member service? **Monday – Friday 8 a.m. – 4:30 p.m. (Half hour lunch)** **Members should serve no more than 8 hours/day, 5 days/week.*	Days per week: **5** Hours/day: **8**
Organization Orientation: **Includes introduction to organization operations as well as systems training*	Date: **02/25/2021**

AMERICORPS NCCC

SPONSOR GUIDE

Strengthen Communities. Develop Leaders.

Corporation for NATIONAL & COMMUNITY SERVICE

Project Cycle

2 Project Development

3 Orientation & Training

4 Project Communication

5 Project Closeout

Service Learning

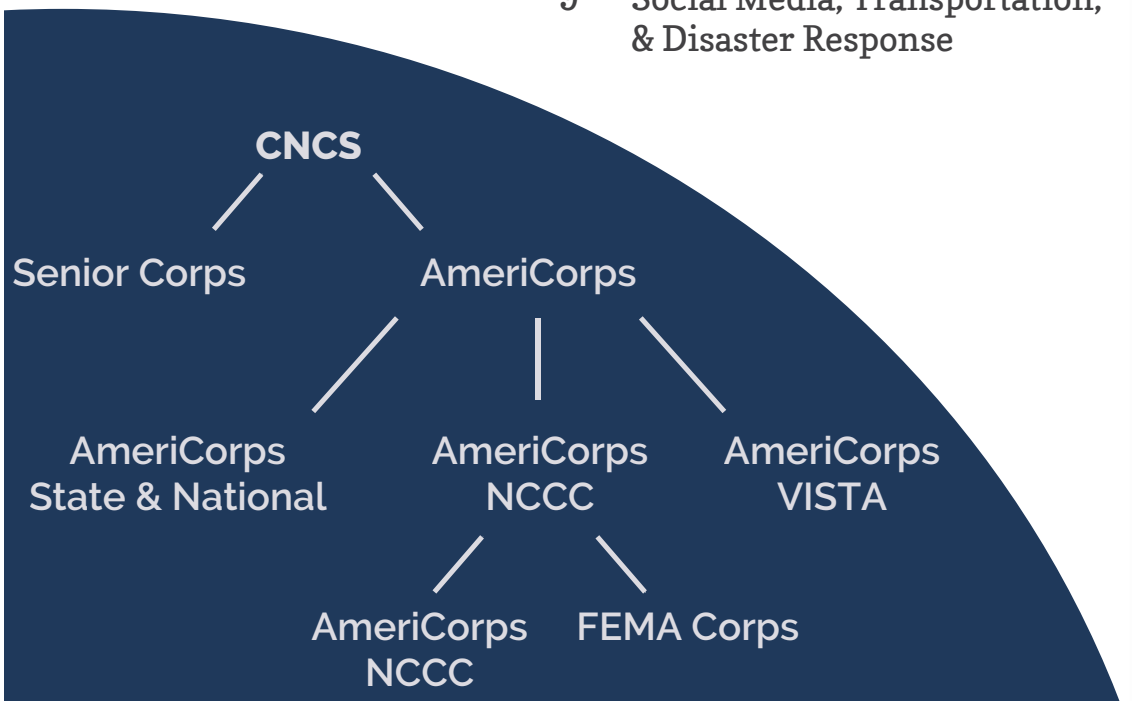
6 Service Learning

Guidelines

7 Safety Guidelines

8 Prohibited Activities & Waivers

9 Social Media, Transportation, & Disaster Response



AmeriCorps NCCC is part of the Corporation for National and Community Service (CNCS) and provides teams of young adults to organizations to help meet community needs. Established in 1993, CNCS is a federal agency that engages millions of Americans in service through core programs - Senior Corps, AmeriCorps, and the Social Innovation Fund - and national volunteer efforts. As the nation's largest grantmaker for service and volunteering, CNCS plays a critical role in strengthening America's nonprofit sector and addressing our nation's challenges through service.

Project Development

Sponsoring organizations and AmeriCorps NCCC teams partner to address community needs through meaningful and measurable service. This flow chart highlights pivotal steps and the corresponding AmeriCorps NCCC POC in the project life cycle.

Service Project Application

The Service Project Application includes a project work plan and an orientation and training agenda. The project work plan is a detailed, well-planned daily and weekly schedule that includes designated times for project specific training. Sponsoring organizations are required to update the work plan to reflect the most current information and to prepare the organization's staff for the team's arrival. Review and ensure the work plan includes:

- A minimum of 40-45 hours per week of service and additional tasks in the event a team completes primary tasks,
- Adequate inclement weather (indoor) tasks for at least 25% of project time frame,
- Prioritized tasks in the event that unexpected circumstances affect the original plan's implementation.

Sponsor Agreement

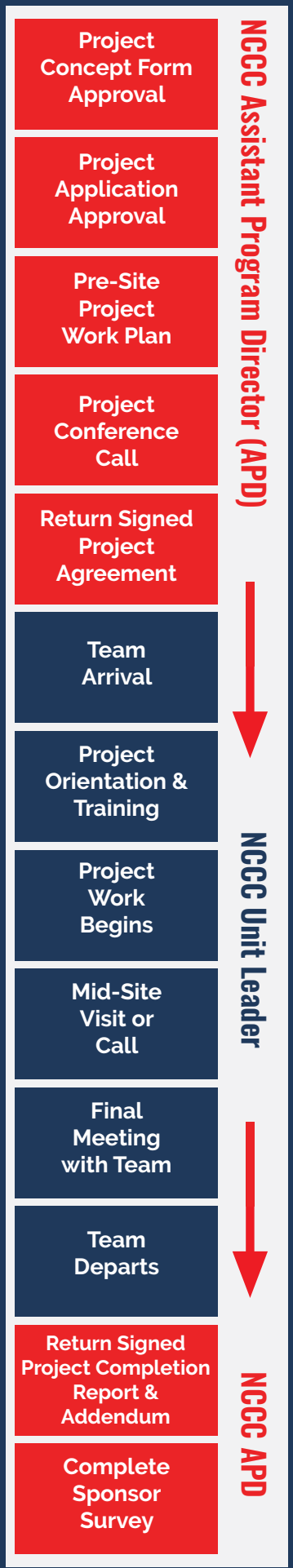
The Sponsor Agreement is an agreement that specifies the roles, responsibilities, and contributions of your organization and NCCC. An authorized representative from your organization must sign a Sponsor Agreement with NCCC before NCCC teams begin working on a project.

Hand-Off Call

The project call is to introduce your organization to the NCCC Team Leader (NCCC member) and supervising Unit Leader (NCCC staff). Additionally, the call will confirm any last-minute questions and final details before the NCCC team arrival.

Ensure Tools, Equipment, and Permits are Secured

Prior to the AmeriCorps NCCC team's arrival, ensure tools, equipment, and supplies provided by your organization are prepared and ready for use. Confirm any tools requested for both the project and housing with the APD. Secure all required work or site permits. Review safety policies, procedures, and equipment specific to the project (Page 7).



Orientation & Training

Project Orientation

Sponsoring organizations prepare an on-site orientation for the Members covering the scope and intended impact of the project that includes:

- Team and Site Supervisor introductions
- Organization history, background, mission
- Tour of the organization's facilities
- Summary of the project scope, goals, and intended community impact
- Overview of work plan and tasks for the upcoming week
- Rules, guidelines, safety issues, and emergency procedures
- Introduction to the community and local culture (Directions to local hospitals and clinics, grocery stores, banks and ATMs, parks, places of worship, etc.)

Housing Orientation

Sponsoring organizations provide or coordinate an orientation of the housing facilities for the NCCC team that includes:

- Ground rules and expectations of the team
- Any access limitations and processes, including keys or access codes, and any curfews
- Smoking policies
- Cleanliness expectations and supplies overview
- Emergency procedures

In addition, the NCCC team will complete a Pre-Housing Inspection Form which sponsoring organizations review, validate, and sign. The form will document the condition of the housing facilities at team arrival and is used with the Post-Housing Inspection Form.

Project Specific Training

Prior to beginning work, Members must be provided the technical training necessary to complete the project including each task outlined in the work plan. Trainings for the team must be basic and introductory to cover all skill and experience levels.

PROJECT COMMUNICATION

WEEKLY TEAM LEADER CHECK-INS AND TEAM DEBRIEFS

Communication is key to ensuring a successful project and positive environment. The Site Supervisor and Sponsor Representative will be expected to meet at least weekly with **a)** the Team Leader and **b)** the full NCCC team to discuss:

- Service accomplishments
- Schedule changes and upcoming tasks
- Strengths and areas for improvement
- Team morale and engagement
- These topics should be discussed both from the perspective of the NCCC team and your organization

MID-PROJECT VISIT OR CALL

During the project, the Unit Leader, or another NCCC staff person, will conduct a mid-project visit or call. The purpose of this visit or call will be to discuss the following elements related to the project:

- Accomplishments, strengths, and areas for improvement
- The NCCC team's performance and engagement
- Clarification on policy or NCCC structure

It is your organization's responsibility to work with NCCC staff to coordinate and attend this mid-project visit or call.

CHANGES TO THE PROJECT

NCCC strives to meet the goals outlined in the project application and work plan. Changes to the work plan should first be discussed with the Team Leader prior to the entire team and may require a project amendment submitted to the campus for approval; decisions may take up to 5 days. To prevent project delays, submit changes to NCCC staff as soon as possible.

Examples of changes that may require an amendment include:

- Major changes to the primary goals and scope of work
- Tasks with additional safety or liability concerns such as using a chainsaw or large equipment, working with youth, etc.
- Tasks with a different agency that has not been previously approved
- Change in housing location

PROJECT CLOSEOUT

Final Team Debrief

Before a team completes a project and returns to the NCCC campus, the sponsoring organization holds a final debrief with the team and Site Supervisor(s) to reflect on challenges and accomplishments, to communicate project information and relevance to the AmeriCorps NCCC mission, and to process and evaluate the overall experience.

Post-Housing Inspection

At the end of the project, the Team Leader completes a Post-Housing Inspection Form, similar to the Pre-Housing Inspection Form, and ensures housing is left in the same condition it was at the team's arrival. The sponsoring organization is expected to review, validate, and sign off on the condition of all housing facilities where NCCC members stayed.

Reporting Requirements

At the completion of a project, the sponsoring organization receives a Project Completion Report (PCR) and PCR Addendum for each NCCC team that served with the organization. Sponsoring organizations are required to review, complete, and have an authorized representative sign the report. The authorized representative is responsible for reviewing the sections of the report completed by NCCC, making any requested additions prior to signing, and promptly returning the report back to the appropriate NCCC campus.

Sponsor Survey

Following the completion of the project, the organization's Site Supervisor or Sponsor Representative is administered a survey. NCCC uses feedback from these surveys to build on best practices and to identify and address areas for improvement. Survey responses are not anonymous. However, responses do not impact the organization's ongoing or future NCCC or Corporation for National and Community Service applications. Sponsoring organizations are strongly encouraged to complete the survey.

SERVICE LEARNING

Service Learning for AmeriCorps NCCC is a methodology through which Members acquire the knowledge and skills needed to perform community service projects and gain an in-depth understanding of the value and impact of their work. Service Learning is gained through the project orientation and training, project activities, and learning about the social issues the project impacts.

NCCC's PARC Model facilitates Service Learning throughout the duration of the project:

Preparation: Learning about the organization, community, and need addressed during orientation and throughout the project

Reflection: Understanding the importance of service through discussion and journaling & sharing the impact of the service to Members, organizations, & the community

Celebration: Commemorating the time and value of the service experience while recognizing challenges and accomplishments

Role of Project Sponsor in Service Learning

The project sponsor plays an important role in ensuring the team understands the purpose of the service project. Simple suggestions to assist in facilitating thoughtful conversations and cultivating a strong service learning opportunity both initially and over the course of the project.

Emphasize why the organization applied for a team during the project orientation (page 2) and check-ins (page 4).

- How will the community be impacted by the team's service work and overall presence?
- How might the community be impacted if a team was not chosen to complete this service work?
- Where does this service fit in to a larger issue at the state or national level?

Share your professional experiences with the team, contribute to Life After AmeriCorps (LAA), or take part in an informational interview about your position.

Include a mix of service learning opportunities to help members gain an understanding of the relevant issues and problems facing the organization or project opportunities can be built into the teams' work plan.

Check in on a weekly basis and engage in constructive dialogue with the team about successes, areas for improvement, skills gained, and reflection about the performed work and organization's mission.

Consider any additional training opportunities that may benefit members and expose them to a wide variety of opportunities, skills, and social and community issues the project addresses.

Examples of service learning opportunities include:

- Inviting local experts to speak about issues related to the project goals
- Creating an opportunity for the team to interact with those directly impacted by their work to learn from their stories
- Having the team attend staff meetings to gain a better understanding of how their sponsoring organization works and to learn more about the staff Participating in a team's weekly reflection activity facilitated by the team's Service Learning Initiators

Your organization should begin to think about how to expand these examples of service learning to align with your project, organization, and community prior to the team's arrival.

Safety Guidelines

Ensuring the safety and security of AmeriCorps NCCC members and others in the community is a critical component of any project. NCCC takes safety seriously and aims to establish open communication and awareness between NCCC members, NCCC staff, and your organization's staff and volunteers.

AmeriCorps NCCC Team & Team Members

NCCC teams are expected to follow the safety guidelines at all times during their service. The NCCC team is expected to conduct a safety briefing each day and ensure that tools and safety equipment are in good working order. Your organization is responsible for training on the specific safety requirements, expectations, or hazards unique to your organization's environment.

Environmental Safety & Inclement Weather

The NCCC team leader and the organization's site supervisor are responsible for working together to determine if daily conditions, such as temperature, precipitation, and wind chill are appropriate for service work assignments. Cold weather conditions below 20 degrees (when adjusted for wind chill) and hot weather conditions above 85 degrees Fahrenheit may require special precautions. At these temperatures, site supervisors must ensure members:

- Are dressed appropriately for weather conditions
- Have access to an adequate supply of clean water
- Are working in pairs
- Are closely and frequently monitored
- Are given the opportunity to take frequent breaks
- Are assigned outside for limited periods of time
- Wear SPF 15, at a minimum, sunscreen/block
- Are trained to recognize and be alert to symptoms of heat exhaustion and dehydration or symptoms of frostbite and hypothermia
- Do not work when thunder is audible or lightening is visible

Sponsoring Organization & Site Supervisors

Sponsoring organizations are required to provide necessary safety training and orientation specific to project and project site conditions. The organization's site supervisor should be someone who currently has the technical skills, abilities, and knowledge to perform the tasks at the project site and will train members on completing the project tasks safely.

Ladders, Scaffolding, & Roofing

For projects involving ladders, scaffolding, or roofing, the organization's Site Supervisor will be responsible for ensuring:

- A skilled and qualified individual trains members on how to safely and properly use ladders and scaffolding
- A skilled and trained supervisor is monitoring the setup of scaffolding at all times
- Only trained individuals from your organization design hoists to handle desired loads
- Members have a spotter when using a straight or extension ladder

Use of Personal Protective Gear & Clothing

AmeriCorps NCCC members are expected to wear protective clothing, equipment, and protective gear as needed on the work site. Evaluated on a task-by-task basis, protective gear and clothing can include, but is not limited to: proper eye protection, gloves, hard hats, fire or mold resistant clothing, boots, and ear protection. If your organization does not have the protective gear necessary, contact the appropriate NCCC staff.

Hand & Power Tools

For projects involving hand or power tools, the organization's Site Supervisor will be responsible for ensuring:

- Tools are in proper working conditions
- Members are trained by a skilled and qualified individual on how to safely and properly use tools
- Members are supervised by a skilled and qualified individual while using the tools
- Chainsaw use requires specialized training and personal protective equipment

In Case of Emergency

If there is a medical, safety or security, or other emergency situation, contact official emergency personnel as soon as possible. As soon as possible contact NCCC staff to inform them of the situation and provide relevant details.

PROHIBITED ACTIVITIES

Service Project Limitations

Members may not engage in any project assignments that:

- Attempt to advocate or influence legislation
- Organize or participate in protests, petitions, boycotts, or strikes
- Assist, promote, or deter union organizing
- Provide direct benefit to any business, union, political organization, or nonprofit
- Prepare grant applications for any federal agency
- Engage in political or inherently religious activities
- Conduct voter registration

Political or Religious Activity

Members may not:

- Participate in partisan political activity as part of their service or duties
- Display posters, stickers, etc. that have a partisan theme while serving or wearing the AmeriCorps NCCC uniform
- Represent themselves as speaking or writing on behalf of NCCC, AmeriCorps, or CNCS
- Give religious instruction, conduct worship services, or engage in any other religious activity as part of their service or duties, maintain facilities primarily or inherently devoted to religious instruction or worship
- Engage in a project in which religious instruction, worship, proselytization, or other religious activity will be conducted

Prohibited Relationships

Members may not engage in any nonprofessional relationships with staff or volunteers affiliated with your organization. Nonprofessional relationships include, but are not limited to:

- Intimate or sexual relationships
- Borrowing or lending money, automobiles, or property
- Soliciting contributions for gifts, services, or other gratuities that include the use of position to influence or coerce others into buying commodities, goods, or services
- Allowing services to be performed that have no reasonable connection with NCCC activities
- Any activity and/or relationship that, in the judgment of NCCC staff, may reasonably be perceived to undermine discipline, good order, or morale of NCCC, AmeriCorps, or CNCS
- Engaging in business or financial dealings

WAIVERS & LIABILITY

Waivers

AmeriCorps NCCC Corps Members or Team Leaders may not generally sign documents that are provided by the Project Sponsor or any representative or employee of the Project Sponsor. In addition, CNCS/NCCC, on behalf of a team, may never sign agreements that contain "hold harmless" or "indemnification" provisions, or any employment related documents. Notwithstanding the above general prohibitions, there are some circumstances under which members may sign such documents as photo releases, acknowledgment of trainings received, use agreements, conduct agreements, and confidentiality agreements. To the maximum extent practicable, all documents should be provided to the NCCC for review and processing ahead of the team's arrival.

Non-Discrimination Guidelines

Under federal law, a project sponsor receiving assistance from NCCC may not unlawfully discriminate on the basis of race, color, national origin, religion, sex, gender, age, political affiliation, or disability (for otherwise qualified individuals). CNCS policy also prohibits discrimination on the basis of sexual orientation, marital or parental status, military service, and social affiliations. Project sponsors will be required to sign an assurance of non-discrimination as part of the Sponsor Agreement.

Liability and Worker's Compensation Claims

CNCS is a self-insured federal agency. Consequently, members and federal employees of the NCCC are covered by the provisions of the Federal Tort Claims Act (liability claims) and the Federal Employees Compensation Act (workers' compensation claims) 42 U. S. C. §12620 (b) & (c). Accordingly, the United States Government will assume responsibility for any injuries or property damage caused by the negligence of a member or an employee who was acting within the scope of his/her employment. Similarly, any on-the-job injuries received by an NCCC member or federal employee will be processed by CNCS and the Department of Labor.

SOCIAL MEDIA

NCCC Online

In an effort to support and streamline communication and highlight important work, please reference the CNCS Communications Guide to improve social media posts. Follow CNCS accounts on Facebook, Twitter, Instagram, Snapchat, and YouTube. Tag @AmeriCorps and @NationalService. "Retweet" and "like" national service-related posts by AmeriCorps members, and use the #GetThingsDone hashtag to highlight your program's impact on the community.

TRANSPORTATION

Federal Government Vehicles

AmeriCorps NCCC vehicles may only be used for official purposes. These vehicles may only be driven by NCCC staff or NCCC members who have completed NCCC's classroom instruction and driving test. Typically, teams deploy in a one-15 passenger van. Federal government vehicles may only be used to transport NCCC employees and members and project related cargo that is the property of NCCC, however, sponsors can ride with Region Director approval.

Sponsoring Organization Vehicles

Sponsor vehicles (including ATVs, 4-wheel mules, gators, and tractors) may be driven by a designated NCCC driver for official project tasks and purposes only. NCCC approved drivers will be the only NCCC members driving sponsor vehicles with proper training and safety equipment. The Sponsor Agreement indicates if NCCC drivers are authorized to operate the organization's vehicles or not. If sponsor vehicles are used, the project sponsor and/or partnering organization agrees to ensure that such drivers are authorized operators under the sponsor's automobile liability insurance and further agrees to hold harmless AmeriCorps NCCC for any damages to the project sponsor's vehicles that may occur as a result of the NCCC's authorized use of such vehicles. The project sponsor and/or partnering organization also agrees to assume all costs of repair for any damages to sponsor's vehicles. Refer to the Sponsor Agreement signed by your organization for more information about vehicle use and liability.

DISASTER RESPONSE

Disaster & Fire Response

NCCC members and staff are part of the Federal Emergency Management Agency (FEMA) and American Red Cross National Disaster Response Network. In addition, the NCCC assists local, state, and national forest services with wildfire suppression. Project sponsors should note that in the event of a natural disaster or homeland security crisis, members may be recalled from projects to serve as part of the relief efforts. This could result in a decrease in the number of members assigned to your project, a delay in the deployment of a team, or cancellation of a project.

Housing Guidelines for AmeriCorps NCCC Sponsors (COVID Operations)

1. AmeriCorps NCCC Sponsors are required to review the below housing guidelines and work with NCCC to develop written alternative plans to maintain the necessary health and safety standards if the guidance below cannot be fully met.

2. NCCC Members should be the only people residing in the team's designated housing area. At no time will anyone outside of NCCC enter designated team sleeping areas, unless advance arrangements are made with the Team Leader or NCCC staff.

   The designated housing area will be defined in collaboration with NCCC staff and the sponsoring organization. This area will have controlled access that can be monitored and managed by the NCCC team.

   Sponsor or housing staff, clients, the general public, etc., should not be allowed in the team's designated kitchen, bathroom and other common spaces unless advance arrangements are made with the Team Leader or NCCC staff. This is to ensure these spaces remain sanitized and to reduce cleaning burdens on the team.

   When the designated housing area must be accessed by someone other than a member of the NCCC team, a written schedule of such infrequent use by non-NCCC members is strongly encouraged (e.g. kitchen to be used by church members from 10 a.m.-noon on Sundays and 5-7 p.m. on Wednesdays). NCCC will work with the sponsor/housing staff to explore reasonable alternatives to using the team's designated space. For example, could the church bring premade food and drinks directly to the fellowship hall, so the kitchen does not have to be utilized? Can staff working at the housing site set up a temporary space elsewhere in the building for making coffee and storing their lunches?

3. Sponsors will have housing cleaned prior to NCCC arrival. NCCC teams will maintain the cleaning of kitchen, common space, bathrooms, and bedrooms during stay and prior to departure.

4. Sponsor will work with NCCC to establish a plan for deep cleaning of the housing if a member(s) tests positive for COVID-19.

5. In general, a generous amount of team-designated sleeping space is preferred, to allow as much distancing between members as possible. At a minimum, the space must allow cots/beds to be separated enough to provide a minimum of 6 feet between members' heads.

6. Sponsors that will use hotels will have no more than 2 people per hotel room following 6-feet sleeping guidelines. There shall be no sharing of beds.

7. Sponsors are encouraged to provide hand soap or alcohol-based hand sanitizers that contain at least 60 percent alcohol at key points within the housing location (e.g. entrance to housing, kitchen). Sponsors that do not have supplies of hand soap or alcohol-based hand sanitizers will work with NCCC staff to explore other options.

8. Housing will provide quarantine space for members, to include a separate sleeping area/room and a separate bathroom, if possible.

Housing Guidelines for AmeriCorps NCCC Teams

1. Cleaning parameters such as CDC Cleaning and Disinfecting Your Home document will be followed daily, in addition to:
    a. Washing bed covers upon arrival, departure, or if beds change.
    b. Washing hand, dish, and other towels regularly.

2. If sponsor/housing staff or community members utilize the team's kitchen, bathroom or other designated team spaces, the team will clean and disinfect that space before utilizing it.

3. Anyone other than Members entering housing in the presence of members must wear a mask or other NCCC approved alternatives in line with CDC provided guidance .

4. Team Leader will visibly post CDC Signs and Symptoms in each team's housing area.

5. NCCC will issue the following PPE and cleaning supplies (regardless of what sponsor provides)
    a. Cloth masks
    b. Disposable gloves
    c. Disinfectant wipes (or paper towel/disinfectant spray alternative)
    d. Bleach or other EPA registered household disinfectant
    e. Trash bags
    f. Hand sanitizer – at least 60% alcohol

This is a tool that can provide an NCCC APD additional information and visibility on what a sponsor could or could not provide based on research of current CDC recommended practices for co-habitation. If there are any "No" responses, the APD will work with the DRDP to discuss next steps.

APD Name:_____ Sponsoring Organization:_____

Project Number:_____ Date:_____

Physical Distancing				
Housing Considerations		**Yes**	**No**	**Notes**
Kitchen	Will the team have sole access to cooking and meal prep spaces? (If not, is use by non-team members infrequent and able to be scheduled ahead of time? Describe in Notes.)	☐	☐	
	Will the team have readily available access to potable running water for handwashing, hygiene, and dishwashing?	☐	☐	
Bathroom	Will the team have sole access to their bathroom(s) including showers? (If not, is use by non-team members infrequent and able to be scheduled ahead of time? Describe in Notes.)	☐	☐	
	Is a second/separate bathroom available in case of needed quarantine?	☐	☐	
Sleeping Areas	Do sleeping arrangements allow for Members to maintain 6 feet of space between heads while sleeping?	☐	☐	
	Do sleeping arrangements allow for multiple Members to sleep in the available housing? If yes, how many Members can utilize the housing space (please list number in Notes)?	☐	☐	
Communal Spaces	Will the TL be able to visibly post CDC Signs and Symptoms in housing?	☐	☐	
	Do shared spaces allow Members to maintain 6 feet of separation?	☐	☐	
	Do Members have sole access to communal spaces? (If not, is use by non-team members infrequent and able to be scheduled ahead of time? Describe in Notes.)	☐	☐	
Quarantine	Are separate living quarters available for quarantining of members potentially exposed or with a positive test?	☐	☐	
	Do you (sponsor) have an emergency management plan that includes response measures in case of a COVID-19 outbreak at the housing site? Do the measures include a cleaning plan?	☐	☐	
Other	Can parking at the housing location accommodate 2-3 vehicles (if needed for proper distancing during travel)?	☐	☐	
Cleaning and Hygiene				
Housing Considerations		**Yes**	**No**	**Notes**
Supplies	Will the sponsor provide COVID-19 prevention supplies including soap and water, alcohol-based hand sanitizers that contain at least 60 percent alcohol, cleaning agents with bleach or other EPA registered household disinfectant, disposable gloves, tissues, and trash baskets?	☐	☐	
Laundry	Will the team have readily available access to laundry to frequently launder clothes, sleeping bags, and cloth face masks? This can be a nearby commercial laundromat.	☐	☐	

Worksite Guidelines for AmeriCorps NCCC Sponsors (COVID Operations)

1. The AmeriCorps NCCC team will be considered a family unit. In this way, the members of the team will not need to social distance from one another, only from non-NCCC personnel. This would include any community member, volunteer, staff, site supervisor, contractor, or other individual associated with the project sponsor that the team may interact with.

2. The sponsor will provide access to cleaning products, hand sanitizer, gloves, masks, physical barriers, as well as soap and water at work sites as needed and that is appropriate to the specific project.

3. It is expected that the sponsor will ensure that worksites are sanitized in accordance with CDC guidelines and frequency both before the team's arrival and throughout the project. Cleaning and sanitation of common spaces will regularly occur depending on use (i.e. once per day, once per week, etc.). The team may assist with the regular cleaning of items/spaces they use. The sponsor and Team Leader will communicate regularly to discuss the frequency of cleaning and sanitation needs for these spaces.

4. The sponsor and team will utilize the weekly debrief time as an opportunity to assess COVID Operations safety practices and concerns, in addition to other typical debrief topics. This may include emphasizing the need for masks in specific circumstances (as noted in this document) or requesting additional hand sanitizer at the worksite. Please note that the sponsor or team should not wait until the weekly debrief to address sensitive or urgent concerns.

5. AmeriCorps NCCC Members are expected to wear masks in accordance with CDC guidance. The guidance will address the importance of masks when working indoors and when working outdoors and cannot retain a 6-foot distance between themselves and any non-NCCC personnel. Exceptions can be made in concurrence with NCCC Regional Leadership.

6. Non-NCCC personnel should maintain a 6-foot distance between themselves and members of the NCCC team and wear masks. This may require rearranging workspaces and planning for project work. It is understood that sometimes this may not be possible at a work site (e.g. demonstrating use of a tool or certain construction techniques). Whenever non-NCCC personnel get within 6 feet of an NCCC member whether indoors or outdoors, the non-NCCC personnel must wear a mask.

7. To the greatest extent possible, members should only drive and ride in the NCCC government vehicle. It is understood that sometimes this may not be feasible (e.g. driving to a wooded area only accessible by truck).

8. When members are asked to drive sponsor vehicles (as documented in the Sponsor Agreement) the sponsor and team should ensure that the vehicle is properly cleaned and sanitized prior to the next use. In the case that members of the team need to ride in a sponsor vehicle with a sponsor, everyone in the vehicle should wear masks at all times, including the sponsor. If there are any changes to the sponsor vehicle use plan during the project the sponsor will inform the Team Leader. This includes vehicles such as ATVs, gators, bobcats, golf carts, backhoes, tractors, riding lawnmowers and forklifts.

9. The sponsor will allow the Team Leader to display CDC signs and symptoms on the worksite and is asked to read and refer to the CDC guidance as it relates to
   - Sanitizing the worksite
   - Sanitizing vehicles
   - Using Personal Protective Equipment

10. Team interactions with non-NCCC personnel should be limited and will require pre-approval from the team's Unit Leader if not already documented during project development. This includes anything beyond regular direct project work that was not listed in the application, such as not previously planned service-learning opportunities, community meals, or other social gatherings with non-NCCC personnel. Sponsors should utilize outdoor spaces, if possible, when asking the team to serve in close proximity to large numbers of community members.

11. When any of the above guidance cannot be met, the sponsor will work with NCCC to develop written alternative plans to maintain the necessary health and safety standards.

Worksite Tool for AmeriCorps NCCC Sponsors (COVID Operations)

Purpose: This is a tool that can provide NCCC staff with additional information on the capacity of sponsors to follow designated procedures to ensure a team's safety on the worksite.

Use: The Assistant Program Director (APD) should complete this checklist in conjunction with the sponsor and retain the completed checklist for project records. This document will be provided to all sponsors during project development.

If there are any "No" responses, the APD will work with the Deputy Region Director for Programming (DRDP) to discuss next steps.

APD Name: _____

Date Completed: _____

Sponsoring Organization: _____

Project Number: _____

Physical Distancing					
Work Site Considerations		**Yes**	**No**	**N/A**	**Notes**
Volunteers and Staff	Will staff and volunteers remain 6 feet away from members whenever possible and wear a proper mask?	☐	☐	☐	
	Will the sponsor ensure that any non-NCCC personnel working with the team receives proper training/notification on NCCC safety expectations?	☐	☐	☐	
	Will non-NCCC personnel be held accountable to ensuring that worksite common spaces are kept clean and are sanitized daily, based on use? (May include shared bathrooms, lunch areas, conference rooms, etc.)	☐	☐	☐	
Vehicle Use	Will members only ride in sponsor vehicles with sponsors if masks are worn by everyone, including the sponsor?	☐	☐	☐	
	If a team is expected to be in a sponsor vehicle, will it be properly sanitized prior to use?	☐	☐	☐	

	Will NCCC staff be kept apprised of any changes from the original vehicle usage plan after project initiation?	☐	☐	☐	
Orientation and Training	Will the team receive an orientation to sponsor safety guidelines and the location of health and safety gear that is accessible to them?	☐	☐	☐	
	Will the TL be able to visibly post CDC signs and symptoms on the work site?	☐	☐	☐	
	Will the weekly sponsor debrief include PPE status updates, reminders on safety expectations, emphasis on sanitizing tools and the larger worksite, and troubleshooting questions and issues?	☐	☐	☐	
	Will sponsor read and refer to the CDC guidance in relation to sanitizing the worksite, sanitizing the vehicles, and using PPE?	☐	☐	☐	
PPE	In the event an outdoor space is not available, will a physical barrier (i.e. plexiglass screen) be utilized for project work involving direct continuous interaction with the public?	☐	☐	☐	
	Will hand sanitizer and hand soap and water be provided on the work site?	☐	☐	☐	
	Will staff and volunteers be provided with proper PPE (including masks and gloves when needed) by the sponsor?	☐	☐	☐	
Sanitizing	Will an initial cleaning and sanitizing of the worksite and tools be completed prior to the arrival of the team?	☐	☐	☐	
	Will the team be provided with cleaning products to regularly sanitize the work space and tools/gear?	☐	☐	☐	
Sponsor/Team interactions	Will the sponsor ensure that team events or gatherings are conducted in safe locations where social	☐	☐	☐	

	distancing (and, if available, open-air facilities) are possible?	☐	☐	☐	
	Will the team be provided information about non-essential activities at least 3 days in advance, to allow for Unit Leader approval (i.e. sponsor BBQ or event)?	☐	☐	☐	

Additional Notes:

AmeriCorps National Civilian Community Corps (NCCC)
Disaster Response Project Application Instructions

These instructions correspond to each question on the Service Project Application. Answer each question as fully as possible. During this step, AmeriCorps NCCC Regional staff will have the ability to provide you with technical guidance, should you solicit it. If you have any questions or need additional clarification about any item on the application, please contact them.

APPLICANT INFORMATION

1. Enter your organization's name and contact information. Organizations may jointly apply for an AmeriCorps NCCC team under a single application. If you are applying with a partner agency or "Secondary Sponsor," please include their information in the corresponding blanks. Please contact your AmeriCorps NCCC Regional staff should you have further questions about jointly applying for a team.

2. Enter your organization's EIN and the EIN of the secondary sponsor (if applicable). Known as the Employer Identification Number (EIN) or the Federal Tax Identification Number, the EIN is a unique nine-digit number assigned by the Internal Revenue Service (IRS) to business entities operating in the United States for the purposes of identification. This number allows CNCS to quickly and accurately identify all organizations that have received CNCS resources for reporting and tracking purposes.

3. Select your organization type. Only organization types specified here are eligible to apply. If you have questions on what category your organization may fall into, please contact the representative at your AmeriCorps NCCC Regional Campus.

4. The Authorized Representative is the designated representative from your organization that is legally authorized and certified to submit the Service Project Application. This person is often referred to as the Project Sponsor and will be the primary person that AmeriCorps NCCC Regional staff communicates with regarding the allocation of AmeriCorps NCCC teams and organizational support. This person should also be the signatory on the Service Project Application, and, if approved, the Sponsor Agreement between AmeriCorps NCCC and your organization. The Authorized Representative is responsible for completing any closeout paperwork from an approved project after the team departs, including the Project Completion Report and the Sponsor Survey.

PROJECT INFORMATION

5. Please indicate the proposed start date and end date for the project.

AREAS AFFECTED BY THE PROJECT

6. Enter the geographic location(s) where the team will be serving. First, select the state or territory and then provide the corresponding city, county or equivalent. If there are multiple sites, please note both state and county of all locations. You may list up to four locations.

LOCATIONS OF SERVICE

7. The Location of Service site(s) is the physical location(s) a team will be performing work during their time with your organization. It is important to accurately document where the team will be performing their service. AmeriCorps NCCC uses this information to ensure the safety of teams and to report where teams are performing work across the country. Given the physical location(s) of service site(s) may be difficult to identify during disaster response, please provide the City or Town Hall address of the local area(s) being assisted if you are unsure of the service site(s).

Additionally, AmeriCorps NCCC requires a Site Supervisor to provide technical guidance, training, and instruction during the service project. The Site Supervisor should be someone who currently has the technical skills and abilities to perform the tasks at the project site and will train members on completing the project tasks.

Location of Service

A. Indicate the organization's name.
B. Indicate if this is the primary site of the project.
C. Check the box if the project site is accessible for persons requiring mobility, vision or hearing accommodation. Please describe in more detail accessibility in the Project Design Narrative (Question 24). Because teams are not assigned to the project when the application is submitted, accommodations may or may not be needed. If a member of the assigned AmeriCorps NCCC team has special accessibility requirements, AmeriCorps NCCC Regional staff will work with you to arrange accommodation if the project has been approved.
D. Indicate the street address, city, state and zip code where members will be serving, which may or may not be the location of the organization listed. During disaster response, if you are unsure of the specific service site(s) please provide the City or Town Hall address of the local area(s) being assisted.
E. Indicate the name of the supervisor that will be providing daily site supervision throughout the team's work on the site.
F. List the organizational title for the Site Supervisor.
G. List the Site Supervisor's phone number. A cell phone number is strongly encouraged.
H. List the Site Supervisor's e-mail.

If applicable, for any additional sites, please follow the above instructions. Please include an attachment with the information required above for each additional site location.

LODGING SITES

8. If selected for service, the sponsoring organization is required to provide lodging for the team and, where applicable, is responsible for any fees associated with the lodging space. Accommodations should be responsive to the following requirements in the table below.

ACCOMMODATION REQUIREMENTS	
1	Adequate space for 8-12 members with separate female and male sleeping facilities.
2	Access to bathroom, shower, and laundry facilities.
3	Availability of cooking and food storage facilities or meals provided by sponsoring organization. Providing food and/or meals is encouraged, but not required in order to receive a team.
4	Availability of cleaning supplies and basic cleaning tools proportionate to the size of the accommodations and team. AmeriCorps NCCC suggests basic supplies such as toilet paper, trash bags, cleaning supplies, light bulbs and shower curtains be available at the lodging site.
5	Measures in place for the safety and security of members, their personal belongings, and equipment.
6	Reasonable driving distance to/from project site location (inquire with your Regional Staff for specifics).

Note: Some AmeriCorps NCCC regions may be able to provide lodging for projects on their campus facilities. When available, these projects must be within a reasonable driving distance of the regional campus. Please inquire with your AmeriCorps NCCC Regional staff to learn more about availability and driving distance requirements. If this lodging option applies to you, please select "NCCC Campus" in the Type of Lodging field.

Lodging Site

In this section, list the locations and contact information of all the anticipated lodging facilities that will be provided to the AmeriCorps NCCC team.

A. Indicate the organization name of the lodging provider.
B. Indicate the team's anticipated arrival and departure date at the lodging site.
C. Select the lodging type from the list.
D. Select the lodging category from the list.
E. Indicate the street address, city, state and zip code of the lodging site.
F. Check the "Accessible for people with disabilities?" box if the lodging site can accommodate individuals with mobility, vision, or hearing limitations. Because teams are not assigned to the project when the Service Project Application is submitted, accommodations may or may not be required. If a member of the assigned AmeriCorps NCCC team has special accessibility requirements, AmeriCorps NCCC regional staff will work with you to arrange accommodation if the project has been approved. Please include additional information about reasonable accommodation in the dialog box below.
G. Check the "Beds Provided?" box if beds are provided at this site. Providing beds is not required; however, AmeriCorps NCCC requests this information in order to ensure teams are provided with the equipment they will need. Please include additional information in the dialog box below.
H. Select whether a full kitchen is available on site for the team to use. Please detail the use and appliances available in the dialog box below. A full kitchen includes a full-sized refrigerator, a stove and/or oven and a sink large enough to clean dishes. If a full-sized kitchen is not available on site, please provide the closest kitchen facility available or if there is a refrigerator of any size is available to the team in the dialog box below. As long as a full kitchen is available for the team's consistent use, providing food and/or meals is encouraged, but is not required in order to receive a team. If any meals are provided, please note if dietary restrictions are accommodated, and on which days in the dialog box below.
I. If a full kitchen is not available, please indicate whether a microwave is available to the team. Please include additional information in the dialog box below.
J. Select whether showers are available on site. Detail the expectations on use of the shower (e.g. cost, scheduling, and location) in the dialog box below. If showers are not available on site, please detail an alternate accommodation in the dialog box below.
K. Select whether laundry is available on site. If applicable, please include additional information about fees in the dialog box below. If laundry is not available on site, please provide the closest laundry facility available to the team in the dialog box below.
L. Please provide the lodging contact name. This person will be the primary contact for anything related to the lodging site.
M. List the phone number and email for the lodging contact person. A cell phone number is strongly encouraged.
N. ***Further Describe Team Lodging Accommodations – Additional Information***
This section is required. In the dialog box, please provide information regarding indoor lodging, camping options, and the safety and security of the proposed lodging facility. If you checked 'yes' on any of the Lodging Site questions, please provide additional information here (e.g., number of beds provided, number of meals provided and when, if dietary restrictions are accommodated, etc.). If you did not check a box, please detail the alternative(s) available.

INDOOR LODGING

I. Provide a descriptive overview of the lodging.
II. Number and type of rooms along with any furniture available (if applicable).
III. Any appliances available to the team for use (e.g. stove, refrigerator, microwave, etc.).
IV. Additional lodging information and rules of use of the facility.

CAMPING

I. Teams performing camping projects must have access to a substantial structure or facility where they can spend the night, if necessary, in the event of excessive inclement weather or for emergency evacuation (e.g., excessive rain, hot or cold temperatures, tornadoes, hurricanes, bug/mosquito seasons, etc.).
II. Use of bathroom and shower facilities. Consider associated costs, scheduling, location, etc.
III. Cooking location and expectation for food preparation.
IV. Expectations for food storage (including dry and cold storage).
V. Overview on what items your organization can provide (e.g. electricity on site, screened tents, canvas tents, propane, ice, indoor kitchen facility, etc.).
VI. Details on weather conditions and considerations when camping during the proposed time of year.
VII. Detailed information about the indoor location for the team to retreat in case of inclement or emergency weather.
VIII. Additional information about the camping location and use of the facility.

LODGING SAFETY AND SECURITY

I. A description of how the team's belongings will be secure during the project.
II. Any precautions members should take while traveling & living in the community.
III. Local emergency response procedures.
IV. Distance to the closest medical facilities.
V. The community in which the team will be housed. Please consider cultural sensitivity, rules and expectations on use of space and additional information you would like us to know about the use of space in your community.
VI. Any other information related to lodging safety and security.

If applicable, for additional lodging sites, please follow the above instructions and include an attachment with the information required above for each additional lodging site location.

NARRATIVES

If you find that your organization's responses are too long for the fields provided, please provide an attachment noting the section and question number above your continued narrative. Multiple narrative responses may be included in the same attachment, provided everything is clearly labeled.

8. Need Narrative

Please describe the overall mission of your agency and how the mission is fulfilled by your various programs. Please describe unmet community need(s) you propose to address using AmeriCorps NCCC resources. Please provide a detailed overview of the disaster and its impacts to the community, the geographic area impacted, and the anticipated target audience to be served.

9. Project Design Narrative

Please describe the work plan that includes the specific service tasks and activities the team will perform. The project must engage each team member in service throughout the duration of the project, a minimum of 40 hours a week per member.

10. Project Management Narrative

Please describe how you will equip members to properly prepare and perform the tasks outlined.

A. **On-Site Orientation:** Please provide a comprehensive on-site orientation agenda. Please include in the agenda: an overview of your organization and the project, introductions of the team to the staff of the sponsoring organization(s), tour of the work site(s) and the community, safety and security and a lodging use overview.
B. **Training Plan**: Provide a training plan outlining the training that members will receive during the project. This plan should include tool training, safety training, and project specific training. If a variety of tasks have been proposed in the work plan, the training plan should identify how/when members will be trained to perform the task. Also include how these trainings will be delivered (video, hands on, classroom, etc.).

11. Safety and Security Narrative

The safety and security of AmeriCorps NCCC members is of the upmost importance for the AmeriCorps NCCC program. The Site Supervisor should be present with the team daily and should possess the awareness, experience, and technical competence to address the project's safety and technical issues. AmeriCorps NCCC staff are always available to provide consultation and answer questions around safety and security issues.

Please provide an overview of any safety considerations an AmeriCorps NCCC team may need to be aware of when serving on this project; include plans to mitigate any associated risks. Include the following:

A. If you answered 'yes' to any of the questions below, please explain the hazards or conditions. Selection of 'yes' does not preclude your organization from receiving an AmeriCorps NCCC team.
    a. Does this project include possible exposure of AmeriCorps NCCC members to asbestos, lead paint, hazardous waste, mold, or any other safety hazards?
    b. Will members be required to work with potentially hazardous chemicals such as solvents, acids, pesticides, herbicides, adhesives, etc.?
    c. Are there any health or environmental conditions that might preclude an AmeriCorps NCCC member from fully participating based on project location or project conditions?
B. If members will be utilizing tools, please describe safety concerns and how tool safety will be addressed during the project. Be sure to include this in your training plan.
C. Any environmental conditions that might be present at any work site (poison ivy, allergens, extreme weather conditions, etc.).
D. Any recommended or required immunizations.
E. Describe how medical emergencies would be handled during the project.
F. Any other safety considerations.

12. Tools and Equipment Narrative

In this section, please provide the following information:

A. Equipment and tools that **your organization** and community will provide for the AmeriCorps NCCC team to deliver on project goals.
B. Equipment, tools, and quantity **requested from AmeriCorps NCCC** to supplement what is available locally in order to meet project goals. AmeriCorps NCCC has limited access to tools and cannot guarantee the availability of requested items; applicants are encouraged to provide tools and equipment for the service project.
C. Access to internet/WIFI to the team for official team business and project-related purposes.
D. Appropriate personal protective equipment; respirators, gloves, goggles, etc. should always be available to the team as needed. AmeriCorps NCCC Regional staff and the project sponsor must ensure this availability.

SERVICE PROJECT APPLICATION SIGNATURE

Please review the document for completeness and the elimination of any errors. Then review the 'Important Notices' section at the end of the application. Sign and date the Service Project Application. The person who signs the document must be the applicant organization's authorized representative who has the authority to commit resources to your organization. An electronic signature is accepted and encouraged.

SUBMISSION INSTRUCTIONS

Complete and submit the Service Project Application to the AmeriCorps Regional staff representative. A directory of AmeriCorps Regional staff contacts is located at the end of this document in Appendix A and on **https://www.nationalservice.gov/ncccsponsor**. AmeriCorps NCCC has regional deadlines for Service Project Application submissions, and are based on the dates for which you are requesting a team. Please include any required or supplemental attachments. It is preferred that the Service Project Application be submitted electronically by email. Once received, AmeriCorps NCCC Regional staff will notify you to discuss the next steps of the process.

Appendix A

AmeriCorps NCCC has four regional campuses located in Aurora, CO; Sacramento, CA; Vicksburg, MS; and Vinton, IA. These campuses are the hubs from which AmeriCorps NCCC operates and deploys members to service projects around the country. Each campus serves as a headquarters for its multi-state region and can lodge and feed its entire regional corps, which ranges in size from 150 to 500 members. The staff at the campuses support both the members and project sponsors as they engage in service activities.

Southwest Region
15001 East Oxford Ave.
Suite B
Aurora, CO 80014
Tel: (303) 844-7400
Fax: (303) 844-7410
E-mail: NCCCSouthwest@cns.gov
States Served: AR, AZ, CO, KS, MO, NM, OK, TX, WY

Pacific Region
3427 Laurel Street
Sacramento, CA 95652 Tel: (916) 640-0310
Fax: (916) 640-0308
E-mail: NCCCPacific@cns.gov
States Served: AK, CA, HI, ID, MT, NV, OR, UT, WA, Pacific Territories

North Central Region
1004 G Avenue
Vinton, IA 52349
Tel: (319) 472-9664
Fax: (319) 472-9666
E-mail: NCCCNorthCentral@cns.gov
States Served: IA, IL, IN, MI, ME, MN, ND, NE, NH, NY, OH, PA, SD, VT, WI

Southern Region
2715 Confederate Avenue
Vicksburg, MS 39180
Tel: (601) 630-4040
Fax: (601) 630-4071
E-mail: NCCCSouthern@cns.gov
States Served: AL, CT, DC, DE, FL, GA, KY, LA, MA, MD, MS, NC, NJ, RI, SC, TN, VA, WV, USVI, PR

AMERICORPS NATIONAL CIVILIAN COMMUNITY CORPS (NCCC)
SERVICE PROJECT APPLICATION

INTERNAL USE ONLY:
Project Title:
Project ID:
State:
Focus Area:
APD:
Select one: ◯ Rural ◯ Urban ◯ Suburban
Select one: ◯ New Sponsor ◯ Repeat Sponsor

APPLICATION INFORMATION

Please refer to the application instructions for full details on requirements for each section.

1	Organization Name	KEDREN HEALTH				
	Mailing Address	4211 S Avalon Blvd				
	City	Los Angeles	State	CA	ZIP	90011
	Office Telephone	832-687-3242	Ext.			
	Secondary Sponsor Organization Name	LOS ANGELES COUNTY DEPT OF PUBLIC HEALTH				
	Mailing Address	313 N. Figueroa Street				
	City	Los Angeles	State	CA	ZIP	90012
	Office Telephone	213-637-3600	Ext.			
2	EIN		Secondary Sponsor EIN			
3	Organization Type	◉ Community-Based Nonprofit Organization; ◯ Federal Government; ◯ Indian Tribe; ◯ Local Government or Municipality; ◯ National Nonprofit; ◯ School; ◯ State Government				
4	Authorized Representative	Dr. Jerry Abraham				
	Organizational Title	Director, Vaccine Program				
	Phone Number	832-687-3242	Ext.			
	Email Address	abraham.jerry@gmail.com				

PROJECT INFORMATION

5	Project Start Date	2/3/21	Project End Date	6/30/21

AREAS AFFECTED BY THE PROJECT

6	State or Territory	California	City or County	Los Angeles
	State or Territory		City or County	
	State or Territory		City or County	

LOCATION OF SERVICE

7	Organization	KEDREN HEALTH				
	Primary Site	◉ Yes ◯ No	Accessible for people with disabilities?	◉ Yes ◯ No		
	Street Address	4211 S Avalon Blvd				
	Address Line 2					
	City	Los Angeles	State	CA	ZIP	90011
	Site Supervisor Name	Dr. Jerry Abraham				
	Organizational Title	Director, Vaccine Program				
	Email Address	Abraham.jerry@gmail.com	Phone Number	832-687-3242		

OMB Control Number: 3045-0010
Expiration Date: 10/31/2022

LODGING SITE

8

Lodging Provider	Salvation Army California South Division
Anticipated Arrival Date	2/3/21
Anticipated Departure Date	6/30/21

Type of Lodging

- ○ Apartment or Condo
- ○ Bed and Breakfast
- ○ Cabin
- ○ Campsite
- ○ Church or Other Faith-Based Organization
- ○ Community Center
- ○ Dorm
- ○ Homestay
- ○ Hostel
- ○ Hotel
- ○ Military Facility
- ○ NCCC Campus
- ○ Recreational Vehicle
- ○ School Room or Classroom
- ○ Trailer
- ○ Vacant Home
- ◉ Volunteer Housing
- ○ Yurt
- ○ Other:

Lodging Category

- ○ Community or Faith-Based Organization
- ○ Federal Government
- ○ Indian Tribe
- ○ Institute of Higher Education
- ○ Local Government or Municipality
- ○ Military
- ○ National Nonprofit Organization
- ○ National or State Park
- ◉ Other: Salvation Army

Street Address	5600 Rickenbacker Rd, Building 1-C & 1-D, Bell, CA 90201				
Address Line 2					
City	Bell	**State**	CA	**ZIP**	90201
Accessible for people with disabilities?	◉ Yes ○ No	**Beds provided?**		◉ Yes ○ No	
Full Kitchen (stove and fridge) on site?	◉ Yes ○ No	**If no full kitchen, microwave oven on site?**		◉ Yes ○ No	
Showers on site?	◉ Yes ○ No	**Laundry on site?**		◉ Yes ○ No	
Lodging Contact Name					
Phone number	213-747-6285	**Email Address**			

Please use the space provided below to further describe team lodging accommodations.

Working in Partnership with the Salvation Army California South Division Emergency Disaster Services.

NARRATIVES	
Please refer to the application instructions for full details on requirements for each section.	
9	**Need**

We are requesting 40 volunteers to assist in COVID-19 Vaccine Distribution in a non-clinical role. Work includes patient registration, crowd control, line security, and post vaccine monitoring.

10	Project Design

Kedren Health Covid-19 Vaccine Distribution is a mini mega-pod located in South Los Angeles with the mission of providing Covid-19 vaccinations to communities and populations that have been historically underserved. We are a walk up clinic, accommodating people unable to make appointments online, many of whom have no internet access or ability to navigate the online system.

We are requesting 4 teams of 10 to help our expansion as we develop more pods and mobile units, to meet underserved communities and the mobility challenged where they are.

Teams will provide reliable and stable help in a non-clinical role as our operation expands.

11	Project Management

Main supervisor is Dr. Jerry Abraham.

12	Safety and Security

Kedren Health Security team is stationed throughout the walk up site, as well as at the gate and entrances to ensure the safety of persons and property.

Covid precautions: All PPE (Personal Protective Equipment) will be provided. As an outdoor walk up vaccine distribution site it is low risk for airborne virus transmission.

See attached sheet.

13	Tools and Equipment

All PPE (Personal Protective Equipment) will be provided.
Gloves, hand sanitizer, N95 masks, and face shields are in plentiful supply.

IMPORTANT NOTICES SECTION

PAPERWORK REQUIREMENTS: If the Service Project Application is approved and teams perform the service project, the project sponsor will be required to review and sign two additional documents: the Sponsor Agreement and the Project Completion Report. Sponsoring organizations will also be asked to complete a survey to capture their evaluation of their partnership with AmeriCorps NCCC.

SPONSOR AGREEMENT: Once the Service Project Application has been approved, a formal agreement (called a Sponsor Agreement) will be executed between the sponsoring organization and AmeriCorps NCCC, which will specify the roles, responsibilities, and contributions of both parties. Teams cannot begin work on the project until this agreement is approved by signature by both parties.

PROJECT COMPLETION REPORT: After the project is completed the project sponsor will be required to review, approve, and sign the AmeriCorps NCCC Project Completion Report, and return it to AmeriCorps NCCC regional campus staff within five (5) days of receipt.

SURVEYS: Project sponsors and secondary sponsors who have used the services of teams will be asked to complete surveys designed to provide AmeriCorps NCCC with feedback that will inform continuous improvement of services.

OPTIONAL ATTACHMENTS: The supporting materials requested below are OPTIONAL and will help AmeriCorps NCCC Regional staff develop a better understanding of the project.

LODGING PHOTOS: Please provide at least one clearly labeled photo of the proposed team lodging. Applications often include photos of team living quarters, kitchen and bath facilities and storage areas for personal belongings.

WORKSITE PHOTOS OR SUPPORTING DOCUMENTS: If feasible, clearly labeled photos of work site tasks, maps of service site locations (e.g. a camp map, community housing map, etc.), or similar supporting documentation.

DISASTER/FIRE RESPONSE: AmeriCorps NCCC members and staff are part of the Federal Emergency Management Agency (FEMA) and American Red Cross National Disaster Response Network. In addition, AmeriCorps NCCC assists local, state, and national forest services with wildfire suppression. Potential project sponsors should note that in the event of a natural disaster or homeland security crisis, members may be recalled from projects to serve as part of the relief efforts. This could result in a decrease in the number of members assigned to your project, a delay in the deployment of a team, or cancellation of a project.

LIABILITY AND WORKERS' COMPENSATION CLAIMS: The Corporation for National and Community Service (CNCS) is a self-insured federal agency that administers the AmeriCorps National Civilian Community Corps (NCCC) program. Consequently, AmeriCorps NCCC Corps Members, Team Leaders, and Federal employees of CNCS are covered by the provisions of the Federal Tort Claims Act (liability claims) and the Federal Employees Compensation Act (workers' compensation claims) 42 U.S.C. §12620 (b) & (c). Accordingly, any injuries or property damage proximately caused by the negligence of an AmeriCorps NCCC Member, Team Leader, or CNCS employee will be assumed by the United States Government, if it is determined that the negligent individual was acting within the scope of his/her official service activity or employment at the time of the potentially compensable event. Similarly, any on-the-job injuries received by an NCCC member or federal employee will be processed by CNCS and the Department of Labor.

WAIVERS: No member of an AmeriCorps NCCC Team (including any Corps Member or Team Leader) shall sign any document provided by the Project Sponsor or any representative or employee of the Project Sponsor, including but not limited to: liability waivers, hold harmless agreements, indemnification agreements, or employment-related documents. In the event that a member of an AmeriCorps NCCC Team signs a document provided by the Project Sponsor or any representative or employee of the Project Sponsor, the signature on any such document shall have no force or effect of law. Neither the Team nor any Team Leader or Corps Member thereof, may legally bind the AmeriCorps NCCC Team or the AmeriCorps NCCC Program.

NON-DISCRIMINATION: A Project Sponsor receiving teams from AmeriCorps NCCC will comply with all federal statutes, including the National and Community Service Act of 1990, as amended, relating to nondiscrimination, which includes nondiscrimination on the basis of race, color, national origin, sex, age, disability, and in most instances, religion. CNCS prohibits all forms of discrimination based on race, color, national origin, gender, age, religion, sexual orientation, disability, gender identity or expression, political affiliation, marital or parental status, or military service. All programs administered by, or receiving Federal assistance from CNCS, must be free from all forms of harassment. Project sponsors will be required to sign an assurance of non-discrimination as part of the Sponsor Agreement.

SERVICE PROJECT LIMITATIONS: In the course of performing a service project, members cannot engage in any project assignments that involves direct fundraising, financial transactions, preparation of a grant application to CNCS or to any other Federal agency, or any political or inherently religious activities.

SIGNATURE	
The Service Project Application MUST be signed by the authorized representative of the sponsoring organization.	
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SOUTH LA

USC announces efforts to increase vaccination for vulnerable L.A. populations

One vaccine effort Wednesday aims to vaccinate about 500 people from the South L.A. region.

By: Anthony Gharib, Andrea Klick, Nicholas Cassol, Jolene Pumphrey, Amanda Zhang, Andrea Valeria Diaz Tolivia, and Emily Sures

March 1 at 8:03 PM

USC will host an event on March 3 to help vaccinate more people in the South L.A. community. This event comes in addition to other initiatives set out by the university to bridge the gap in vaccine access between wealthier regions of L.A. County and the South and East Los Angeles areas, officials announced at a press conference last week.

Although more effort has been put behind opening accessible testing sites across the city, vaccine equity remains a problem in Los Angeles County, according to a recent map from the Los Angeles Times.

Black, Indigenous and Latinx people are most at risk for contracting and dying from COVID-19, yet these communities are also less likely to be vaccinated and have accessible testing sites. These populations face a disproprotionate amount of risks as they're more likely to lack access to health care and safe housing, work in essential jobs and face discrimination within the medical field, according to the Centers for Disease Control.

About 2.2 million vaccines have been administered in L.A. County, according to the Official California State Government. About 20% of people in L.A. County who received the vaccine have been white, while just below a quarter of vaccine recipients in the county are Latinx, the group that has faced the highest death rates from the coronavirus. However, Black people make up less than 5% of that vaccinated population.

According to David Roman, a USC professor of English and American studies and ethnicity, medical service inequities have existed far before the pandemic in areas across Los Angeles.

"There's a smaller provider to patient ratio in [South L.A.]," Roman said. "That was a preexisting condition before COVID-19 came around… that meant that there's fewer doctors per individual here in this area."

On Friday, USC President Carol Folt revealed a campus vaccination plan to inoculate 1,200 people each week when supplies allow, which includes a bi-weekly testing program for undergraduates. As the USC community is developing a plan to help vaccinate students, USC experts held a virtual press conference on Feb. 23 to discuss COVID-19 and vaccine initiatives for the greater Los Angeles community.

Felipe Osorno, an executive administrator at USC Keck Medical Center, acknowledged vaccine distribution disparities by addressing different socioeconomic statuses in L.A. neighborhoods and comparing areas like Beverly Hills to Boyle Heights.

“Boyle Heights only has about 6% of adults vaccinated compared to other parts of the city,” said Osorno.

According to a map from the Los Angeles Times, one in 15 Boyle Heights residents has received a vaccine, whereas one in four Beverly Hills residents has been vaccinated against COVID-19.

Wealthier and whiter neighborhoods, such as Santa Monica, Beverly Hills and Culver City have a higher vaccination rate, while areas like Watts and Baldwin Hills have lower vaccination rates. These disparities may be related to variations in vaccination site locations. For example, as reported by LA Public Health mapping, Santa Monica has 18 vaccination sites compared to the six in Compton, even though both cities have similar population sizes.

Many school districts and community health centers in South L.A. are also attempting to increase the accessibility and availability of the vaccine to communities of color.

Los Angeles Unified School District is working to ease the disparities in testing in marginalized populations by offering free COVID-19 testing to students through an online scheduling system.

A part of the Southside Coalition of Community Health Centers, the Central City Community Health Center runs a number of units in the area that specifically work with underserved communities.

Dr. Sommer Kaskowitz, chief clinical officer at Central City Community Health Center, said there is demand for the vaccine, “but there is a lot of resistance that we’ve encountered within the [South L.A.] community.”

“We are having a little trouble finding enough patients to come in on a regular weekly basis to get everybody in to use our vaccines,” Kaskowitz said.

Throughout the press conference, USC said it has made a commitment to aid in the process of closing the disparity gap regarding vaccination distribution in South L.A. There is pressure for the university to partner with community organizations in South L.A. to help answer questions and battle uncertainty.

“The natural hesitancy with different vaccinations and health care in general is part of what we’re trying to tackle to reduce the inequity,” Osorno said.

USC has also implemented an initiative to partner with community organizations in East L.A. in and around Boyle Heights specifically, Osorno said. These collaborations include using churches, community centers, recreation centers and senior living facilities, as they have an established relationship with the locals. Through that partnership, 420 members from vulnerable communities were able to be vaccinated on one Saturday in February.

"We will continue these efforts because the gaps are large, and we want to make sure we help close them," Osorno said.

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Andrea Klick is a sophomore studying journalism, political science and human rights. She is an editor for Intersections South L.A. and a news editor for the Daily Trojan with a passion for local and community reporting. Outside of the newsroom, she enjoys trashy reality TV, cute cat photos and early 2000s Taylor Swift tunes.

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Transcript

00:00:01 Speaker 2

OK so I started recording and I know in California just two state law, I mean at two party law.

00:00:06 Speaker 2

So I mean you do consent.

00:00:09 Speaker 2

I'm being recorded.

00:00:10 Speaker 1

Correct?

00:00:10 Speaker 2

OK, excellent.

00:00:12 Speaker 2

So yeah, I wanted to call because.

00:00:17 Speaker 2

Are you have games in order of notoriety with with the vaccine rollout?

00:00:23 Speaker 2

I've noticed that you kind of it.

00:00:25 Speaker 2

You know you didn't have to ask, not only ask, but you had to demand vaccines from from your County.

00:00:34 Speaker 2

But my particular story has to do with the digital divide and I just wanted to ask how you kind of went around with people who had no access to the phones or tinting it because many people still don't realize that they are a luxury for many people.

00:00:54 Speaker 2

So I just wanted you to.

00:00:55 Speaker 2

Talk a little bit about your methods and reaching those people.

00:01:00 Speaker 1

Sure, give me a second.

00:01:03

Yeah.

00:01:12 Speaker 1

Yeah, I mean I'll just start by saying you know, welcome to texture in, you know, the cadron ways that we treat.

00:01:20 Speaker 1

People like people, we are gentle people treating people like gentle people with the gentle people that they are.

00:01:30 Speaker 1

We see the dignity and worth in every human being that walks through our doors.

00:01:37 Speaker 1

That's a big part of who we are. That is the character in wet and the people we serve that we've been serving since the 1960s when 22 black psychiatrists pounded Kendrick.

00:01:53 Speaker 1

People got because black people in mental health crisis had nowhere to go.

00:01:58 Speaker 1

We've been doing that ever since.

00:02:00 Speaker 1

It's ingrained in our DNA.

00:02:03 Speaker 1

It's a part of our genes.

00:02:07 Speaker 1

Need help?

00:02:08 Speaker 1

That is what we do every day.

00:02:11 Speaker 1

Covid or no kovid we help people.

00:02:14 Speaker 1

We help people who have no home.

00:02:16 Speaker 1

We help people have no food in their bellies without people who don't speak English, we help people that do not have documentation status in this country.

00:02:26 Speaker 1

We help people who are lost.

00:02:29 Speaker 1

We help people find their way.

00:02:31 Speaker 1

We help people who don't have a car.

00:02:34 Speaker 1

We help people who don't have Internet and don't have an email and don't have a phone.

00:02:40 Speaker 1

We help people who can't walk or can't see or can't talk or can't hear.

00:02:47 Speaker 1

That is what we do at cendron every day.

00:02:50 Speaker 1

And when the vaccines became available we got none.

00:02:54 Speaker 1

And that was really heartbreaking for all of us because we had nurses.

00:02:59 Speaker 1

We had patients with coded in our hospital and we just wondered why.

00:03:05 Speaker 1

Why did Kaiser Permanente? Why did Dignity Health? Why did UCLA and USC and Cedars get vaccines 1st and we were the ones with Kovit in South LA? And so we had to do something. So I do what I do. Every day I picked up the phone and I started calling and asking questions. Next thing you know, I'm going down to the Department of Public Health and beating down the door.

00:03:28 Speaker 1

An literally begging please.

00:03:31 Speaker 1

Where are our vaccine?

00:03:32 Speaker 1

Means and then eventually went down there and Decadron van and we knocked on the doors of the warehouse and said we're not leaving without vaccines, and that's how we got, you know, our first 100 vaccines that all started really Christmas Eve Eve and then by New year Steve we had put the first 50 doses.

00:03:55 Speaker 1

Into people's arms and the next day 100 and then 150 and very early on, we said don't give me vaccines if you're just gonna give us enough for our staff. This is not about Doctor Abraham vaccinating kedren's healthcare.

00:04:12 Speaker 1

Give us enough so that we can put on our own oxygen mask and then we were going to turn left and right and look for our brothers and sisters and make sure that they got their oxygen masks too.

00:04:18

So.

00:04:21 Speaker 1

So we very quickly became the safe haven.

00:04:25 Speaker 1

The Safe Harbor, especially for black and Latin X physicians and nurses and other health care workers who had nowhere else to go.

00:04:34 Speaker 1

For their vaccines, and they were extremely vulnerable.

00:04:37 Speaker 1

They were working on the front lines and they didn't know where to go for their vaccine, but they knew that Doctor Abraham would take care.

00:04:44 Speaker 1

And then we need, you know, as soon as the governor said everyone over 65 was eligible again. I told them do not give me enough for my staff. Do not give me enough just for health care workers. You better be ready to give me enough so that we can vaccinate all of the vulnerable.

00:05:05 Speaker 1

Elders in our community who are eligible.

00:05:08 Speaker 1

And so that's how we've gone from those 51st doses to over 52,000 doses today, and how we've done it is that we have broken down every barrier. We have literally broken the digital fortress, and that included.

00:05:28 Speaker 1

You know tearing up that appointment system, we said we were going to be a walk up site where nothing would stand in your way.

00:05:37 Speaker 1

No appointment, no problem, no Internet, no email, no cell phone, no home address, no ID, no.

00:05:48 Speaker 1

Uhm transportation.

00:05:50 Speaker 1

None of those were going to stand in between our people and their vaccine, and that's exactly what we did.

00:05:56 Speaker 1

We created work arounds.

00:05:57 Speaker 1

We created a paper form.

00:05:59 Speaker 1

We created a form in many Lang.

00:06:00 Speaker 1

Which is Spanish Korean, Mandarin Vietnamese?

00:06:05 Speaker 1

We broke down every barrier and it was heartbreaking.

00:06:11 Speaker 1

The number of times we had to fight with various entities to convince them that requiring an email address requiring a cell phone.

00:06:21 Speaker 1

Requiring a home address that is absolute and utter nonsense for the people we serve.

00:06:29 Speaker 1

What email address?

00:06:31 Speaker 1

What cell phone, what home these things were falling on deaf ears when we tried to explain that to them and it goes to show well intentioned people who created all full systems that resulted in barriers that literally stood in between people and their vaccines.

00:06:52 Speaker 1

And so that's really the story.

00:06:54 Speaker 2

OK then, so thank you so much for speaking about that.

00:06:58 Speaker 2

Yeah and I I can talk through all the interviews that you're very passionate about.

00:07:01 Speaker 2

This an I understand that kedren.

00:07:06 Speaker 2

Is primarily like a mental health clinic and I think that goes hand in hand with just being in a majority.

00:07:18 Speaker 2

Community, that of color.

00:07:21 Speaker 2

And speaking on that, I just wanted to ask.

00:07:25 Speaker 2

You know, since you're the last interview I saw, was well from Rachel Maddow.

00:07:30 Speaker 2

Like I mentioned on February 5th.

00:07:34 Speaker 2

Are people still showing a hesitancy in getting the vaccine?

00:07:38 Speaker 2

And are you you know, is that something that could be solved?

00:07:44 Speaker 1

Yeah, I'll just say that for me.

00:07:47 Speaker 1

And give me one moment, one second.

00:07:50

Yes.

00:08:28 Speaker 1

I have a favor to ask of you.

00:08:30 Speaker 1

OK.

00:08:30 Speaker 1

00:08:30 Speaker 1

For answer no.

00:08:34 Speaker 1

Let me just check here.

00:08:36 Speaker 1

Let's see.

00:08:41 Speaker 2

Huh?

00:08:42 Speaker 1

Talking to you is really helping me clarify what I'm going to tell the US Senate on Tuesday morning. I'm taking some notes as we go along. Is there any way that you can share your audio file after?

00:08:55 Speaker 2

Absolutely, absolutely.

00:08:57 Speaker 2

Just checking with my messages, do I send it to that email abraham.jerry@gmail.com?

00:09:03 Speaker 2

Correct, yeah, absolutely by all means.

00:09:06 Speaker 1

OK cool 'cause this is actually really.

00:09:09 Speaker 1

I was staring at this like 5 page testimony but I've noticed it's really helped me clarify, you know?

00:09:14 Speaker 1

Talking to you.

00:09:14 Speaker 1

00:09:19 Speaker 1

What happens and how to just kind of say it very eloquently.

00:09:22 Speaker 1

I only have 5 minutes before the senators and so just want to make sure I'm saying the most important thing, and I think this digital divide and this tearing down the digital Fortress has to be a part of it.

00:09:35 Speaker 1

So I'm just capturing some of that really quickly the appointments website.

00:09:39 Speaker 1

How flawed.

00:09:40 Speaker 1

I mean.

00:09:40 Speaker 1

In

00:09:41 Speaker 1

I have to tell you, Francisco, like our digital demons out there that are ready and have stolen Grandma's shot, including her appointment and it's just nonsense.

00:09:44 Speaker 1

There are.

00:09:44 Speaker 1

00:09:56 Speaker 1

And so you know, I beg and plead that the digital natives and detect hipsters.

00:10:02 Speaker 1

You know, please be our digital Angels.

00:10:05 Speaker 1

And help people who are shut out of the system help people get to a vaccine.

00:10:10 Speaker 1

Transportation for example, how people get their vaccine, how people get an appointment?

00:10:15 Speaker 1

When did we become these people vultures, you know?

00:10:20 Speaker 1

And it's really sad because they're literally stealing grandma's shot.

00:10:27 Speaker 1

And that doesn't make any sense to me, because I see the humanity and everyone as you can hear until and I don't understand when did we become a people that were willing to cut the line.

00:10:39 Speaker 1

Or not, should people like people or not realize we're not?

00:10:44 Speaker 1

You know we are all in this together and the faster we work together, the farther and faster will go.

00:10:53 Speaker 1

And that's how we'll end this epidemic.

00:10:55 Speaker 1

And that, to me, is just really still perplexing, because who?

00:11:01 Speaker 1

Are these digital demons that hacked the system that hang out on these?

00:11:06 Speaker 1

You know forums and you know whatever boards online and they're like figuring out how to.

00:11:14 Speaker 1

Break the codes for the appointments you know website and it's like.

00:11:19 Speaker 1

What's the point of that?

00:11:21 Speaker 1

Like what do you get out of it?

00:11:23 Speaker 1

Not to mention how these folks are like, you know, physically, socially distancing and isolated in their homes like I get that everybody wants this vaccine.

00:11:33 Speaker 1

I get everybody.

00:11:35 Speaker 1

Wants to get on with their lives?

00:11:37 Speaker 1

I don't blame anyone for wanting a vaccine, hence why I don't say things like vaccine chaser because I think that big matizes anyone who wants their lifesaving essential medicines.

00:11:51 Speaker 1

I am proud that there are blocks of Lions lines for my like you know, around the blocks of people wanting a shot at this vaccine.

00:12:04 Speaker 1

And so to demonize them too is not right.

00:12:07 Speaker 1

Because as I walked that standby line, I saw there were homeless people in that line.

00:12:14 Speaker 1

Maybe a different skin color, but they do deserve this vaccine.

00:12:18 Speaker 1

Why are homeless people and encampments not eligible right now?

00:12:22 Speaker 1

There were people in that line that were, you know, literally, seriously.

00:12:27 Speaker 1

Depressed or living with like panic disorder.

00:12:30 Speaker 1

There were suicidal people in that line.

00:12:33 Speaker 1

From yes.

00:12:33 Speaker 1

Different zip codes.

00:12:35 Speaker 1

Possibly from different local economic, you know, strata, maybe you know.

00:12:42 Speaker 1

Yeah, a different color, but they do are living with the comorbidities of this pandemic.

00:12:50 Speaker 1

They too deserve a shot at this shot.

00:12:53 Speaker 1

No one deserves to die because of Kovic, including by suicide because they can't take this anymore.

00:13:00 Speaker 1

They can't isolate any longer.

00:13:02 Speaker 1

They want to get on with their lives.

00:13:03 Speaker 1

We want to go back to work.

00:13:05 Speaker 1

We want to get back to school.

00:13:06 Speaker 1

We want to get back to loving Grandma and hugging and kissing again.

00:13:11 Speaker 1

So you know.

00:13:12 Speaker 1

So that's what I asked was where are our Angels, and I think that's what we need to remind, and that's what we do.

00:13:22 Speaker 1

So exceptionally well at catcher in.

00:13:25 Speaker 1

You know, if you come and I hope you do get to come one day to capture in, you know you're gonna see music blasting.

00:13:33 Speaker 1

You're gonna see people.

00:13:34 Speaker 1

Dancing, you're gonna see enjoy their erhai fonts there are.

00:13:38 Speaker 1

Thanks.

00:13:38 Speaker 1

00:13:41 Speaker 1

Air hugs, it is literally the happiest place on earth.

00:13:46 Speaker 1

Moves over Disneyland like we are ending this epidemic, can you feel that palpably when you come into our campus because we are at war with covid and we are winning and that?

00:14:02 Speaker 1

So like.

00:14:03 Speaker 1

We can definitely lean into that, and we need that and that's why we want to build this movement. That solutions orientedness that we are going to work together to combat this pandemic as fast as we can, and it doesn't just end in South LA. It's not just about the Los Angeles County.

00:14:24 Speaker 1

It's not about California or this great nation.

00:14:28 Speaker 1

We must end this global pandemic everywhere.

00:14:31 Speaker 1

So I do ask that as we also wait our turn.

00:14:36 Speaker 1

After it's your turn and ask you been vaccinated.

00:14:39 Speaker 1

Do your part to help others.

00:14:41 Speaker 1

And that also means we must look to our neighbors to slight doctor Abraham.

00:14:46 Speaker 1

Look to his left and right and got black and Brown health care workers vaccinated immediately.

00:14:51 Speaker 1

We need to look to our neighbors whether are there in Mexico or whether Central America.

00:14:57 Speaker 1

The Caribbean, South America.

00:14:59 Speaker 1

Whether it is in Sub Saharan Africa or the Middle East and Western Asia, whether that is in South Asia or Southeast Asia, East Asia, they too, must end this global pandemic, and so we cannot be in it for ourselves.

00:15:14 Speaker 1

The digital demon's speech.

00:15:14 Speaker 1

The digital.

00:15:15 Speaker 1

And we must be Angels, and we must help everyone get the vaccines.

00:15:22 Speaker 1

You must help everyone do what they're supposed to do.

00:15:26 Speaker 1

Play their parts.

00:15:27 Speaker 1

Be a part of the solution, and that may include.

00:15:32 Speaker 1

Continue to socially distance.

00:15:34 Speaker 1

Continue to wear masks.

00:15:36 Speaker 1

Continue to wash your hands and when is your turn annual?

00:15:40 Speaker 1

Offered a vaccine and we have engaged you and we have educated you and we have taken the time and we have met you where you are and all of your questions and answers.

00:15:50 Speaker 1

Have been answered.

00:15:50 Speaker 1

00:15:52 Speaker 1

I hope you two will roll up your sleeves.

00:15:56 Speaker 1

And take that thought.

00:15:56 Speaker 1

00:15:56 Speaker 1

Take that thought.

00:15:57 Speaker 1

Hashtag this is our shot.

00:16:01 Speaker 1

And so that is something that I think is very important too. So to your question, you know we thought Catcher in less than 1% black and Brown health care worker vaccine hesitancy. We saw less than 1%.

00:16:16 Speaker 1

Black and Brown elders with vaccine hesitancy.

00:16:21 Speaker 1

What we saw was that everyone, whether you're black or Brown or yellow or white or whoever you are, there are legitimate questions people have about these vaccines.

00:16:36 Speaker 1

They want to know what is M RNA?

00:16:39 Speaker 1

They want to know what is an M RNA.

00:16:41 Speaker 1

Vaccine they want to know how will this affect their bodies.

00:16:47 Speaker 1

I don't call that hesitancy.

00:16:49 Speaker 1

I call that being a very smart, savvy public health and health care consumer.

00:16:58 Speaker 1

It is good to ask questions.

00:17:00 Speaker 1

It is good to understand.

00:17:02 Speaker 1

It is good to learn what we're up against.

00:17:05 Speaker 1

Includes a lack of understanding of science in this country, what we're up against is a lack of public health infrastructure in this country.

00:17:14 Speaker 1

What we're up against is a broken health care delivery system in this country.

00:17:20 Speaker 1

What we are finding though is that when you take the time, people will talk you, myself included will listen.

00:17:26

Right?

00:17:34 Speaker 1

Then when it is our turn we will speak an answer and we will do the best we can and we will be honest with them and we're going to say.

00:17:42 Speaker 1

We don't have all the answers and we don't know everything, but this is what I know as of this moment right now, and I can tell you that no one has died from this vaccine.

00:17:52 Speaker 1

Two dates confirmed absolutely.

00:17:55 Speaker 1

Attributable to this vaccine, I can tell you millions over 60 million people have been vaccinated in this country and less than 30 serious adverse events have occurred where people have had to go to the hospital. I can tell you that I have vaccinated 52,000 people and not had to send anyone.

00:18:17 Speaker 1

To the hospital.

00:18:18 Speaker 1

I have not needed to. After 52,000 doses, an arms needed to inject anyone with epinephrine.

00:18:28 Speaker 1

Or using happy patent because of this vaccine, so that's what I tell people that I notice that when I tell them that they they're not so afraid anymore.

00:18:42 Speaker 1

And you know, people are very anxious. It's not just that though, like you know, as I always say, don't confuse a lack of access for vaccine hesitancy. So when we call those numbers 40 fifty 60% of the black and Brown community were hesitant.

00:18:58 Speaker 1

Let's take this vaccine.

00:18:58 Speaker 1

00:18:59 Speaker 1

Take this vaccine.

00:19:00 Speaker 1

In what I heard was what vaccine had never been offered a vaccine.

00:19:06 Speaker 1

When was I going to refuse this vaccine that you claim we are hesitant about?

00:19:12 Speaker 1

That, to me was very fascinating that that became the narrative that black and Brown don't want this vaccine.

00:19:18 Speaker 1

So that's why we don't give it to them.

00:19:19 Speaker 1

Hold on a moment.

00:19:21 Speaker 1

Let's rewrite this story.

00:19:24 Speaker 1

What vaccines you never offered me a vaccine.

00:19:28 Speaker 1

Do not confuse a lack of.

00:19:29 Speaker 1

Access for vaccine hesitancy.

00:19:33 Speaker 1

But I'll also say is do not confuse legitimate questions.

00:19:36 Speaker 1

Like I said, for vaccine hesitancy, do not.

00:19:42 Speaker 1

Hold on one second.

00:19:43 Speaker 1

I'm thinking about something else that.

00:19:49 Speaker 1

Smart consumers.

00:19:52 Speaker 1

I'll get to that in a.

00:19:53 Speaker 1

2nd, but what I was going to say here was do not.

00:19:59 Speaker 1

Yeah, do not confuse.

00:20:01 Speaker 1

I didn't have a ride for vaccine hesitancy.

00:20:04 Speaker 1

Do not confuse.

00:20:06 Speaker 1

I don't have childcare for.

00:20:08 Speaker 1

I do not want a vaccine.

00:20:10 Speaker 1

Do not confuse.

00:20:12 Speaker 1

I do not have paid time off for any sort of lead so I can go stand in line and camp out outside of Kedren for a vaccine.

00:20:19 Speaker 1

For I don't wanna vaccine.

00:20:21 Speaker 1

There are so many reasons just.

00:20:23 Speaker 1

Those digital barriers that we talked about there are physical ones that keep people from getting vaccinated again. Do not confuse those limitations, those frustrations, those barriers for a lack of vaccines in LA. There is like the fear of God in us for trying to find parking.

00:20:44 Speaker 1

That is not vaccine hesitancy that is living in LA Daily with the struggle of finding a place to park.

00:20:50 Speaker 1

That's not a reason not to get that statement.

00:20:52 Speaker 1

To overcome those challenges too, but I will say that being marked as hesitancy is fascinating to me too.

00:21:00 Speaker 1

So just like the data that we see, that comes out an you know we're always confused whether it's the Democrats that you know the African racial data that we've seen and others.

00:21:11 Speaker 1

There are stories to be told, you know, as a family physician and someone who cares for the individual patient.

00:21:18 Speaker 2

Yeah.

00:21:21 Speaker 1

You know, let's say Mrs Morales, who's your grandma who you know we care for every day, but doing what's right for Mrs.

00:21:21 Speaker 2

Yeah.

00:21:29 Speaker 1

Morales is very different from something.

00:21:32 Speaker 1

I'm doing what's right for the whole community or society at large, and those things can be at odds, and sometimes those things can align beautifully, and that's the struggle a family physician has, because we're constantly thinking about caring for the person right in front of my room or in my room with me.

00:21:49 Speaker 1

The exam room, or and.

00:21:52 Speaker 1

Advocating for the community at large and really being a community medicine physician. On top of that, I'm an epidemiologist so you know, I think about these numbers. These data points are not just numbers, there are people, and there's a story behind all of that. So there's a reason why Kedren became so effective when we saw only 3% of all vaccines.

00:22:16 Speaker 1

Who administered to African Americans in Los Angeles?

00:22:19 Speaker 1

We knew we were a huge part of that success to me.

00:22:24 Speaker 1

I didn't see failure.

00:22:25 Speaker 1

I said thank the Lord, they gave captain some vaccines because of.

00:22:30 Speaker 1

3% of those vaccines take into the arms of black and Brown LA. What I will say is when you start teasing out the numbers and you understand the narrative and you unpack it, you go wow, there are really troubling issues at hand, and it's not the headlines. It's not the click bait. It's not the ah ha I got you or the hit piece on the governor.

00:22:53 Speaker 1

It's wow.

00:22:54 Speaker 1

There is a legitimate lack of diversity in the healthcare workforce.

00:22:58 Speaker 1

If the first 4.

00:23:00 Speaker 1

Sure, so a vaccinating were limited to quote unquote essential health care workers, some who work from home, some who barely saw patients, some who really were not at risk, some who are in very wealthy zip codes.

00:23:14 Speaker 1

Those people lined up and got their shot 1st, and unfortunately, many of those people.

00:23:21 Speaker 1

May not be black and Brown.

00:23:23 Speaker 1

There is a lack of diversity in healthcare workforce.

00:23:25 Speaker 1

The health care workforce does not reflect the community we serve.

00:23:29 Speaker 1

The health care workforce that lives and works in South Delhi and is now black and Brown needed this vaccine also.

00:23:36 Speaker 1

So there's a lot that has to be unpacked when we look at some of those racial and ethnic statistics.

00:23:42 Speaker 1

But I will say.

00:23:43 Speaker 1

Then

00:23:45 Speaker 1

You know why were?

00:23:50 Speaker 1

You know you have to say why is the health care workforce not diverse and then you start to understand.

00:23:57 Speaker 1

I now see why so many white people and Asian people got vaccinated in the earliest days in the flow of a bigger system is a flaw of our society at large.

00:24:07 Speaker 1

But do not confuse that with a bus.

00:24:10 Speaker 1

Roll out by the County, for example, which is what the narrative can become.

00:24:15 Speaker 1

I think you know that something that was really important is everybody seems to be in crosshairs.

00:24:21 Speaker 1

Whether it's doctor Abraham, whether it is the County of Los Angeles, Department of Public Health, whether it is state of California or Governor Gavin Newsom, or whether it is the CDC or the Secretary of Health or the White House.

00:24:36 Speaker 1

You know, and I just feel like what we have done exceptionally well at Catcher is we do not play the blame game.

00:24:41 Speaker 1

We do not waste time trying to figure out who to throw under the bus.

00:24:46 Speaker 1

We all need to get on board and we need to get moving just like I did when I got on board in my van and knocked on the door of the public health warehouse said I'm not leaving till I've got vaccines and so likewise, we gotta wonder these certain shots vaccine rollout challenges.

00:25:06 Speaker 1

These are.

00:25:07 Speaker 1

Living literally and dying from the consequences of a broken health care delivery system and a lack of public health infrastructure and a lack of health literacy.

00:25:21 Speaker 1

A lack.

00:25:22 Speaker 1

Of basic science understanding a lack of we're all in this together and this community spiritedness.

00:25:32 Speaker 1

And the faster we work together, the faster we end this if you will, so that to me is the story.

00:25:41 Speaker 1

But look at how much time.

00:25:43 Speaker 1

It's taken just to tell you that story and know why.

00:25:46 Speaker 1

Under no one, but except maybe your friend Cisco in Chicago once tell this story or should right away to share it because it's not easy to understand.

00:25:57 Speaker 1

You know this is a very complex system, highly complicated and there's nothing easy about.

00:26:04 Speaker 1

And some people asked one day ask and I noted as noticed.

00:26:08 Speaker 1

Often it is the historically white media that asks Doctor Abraham.

00:26:12 Speaker 1

Why do you do it?

00:26:13 Speaker 1

And I'm like what do.

00:26:14 Speaker 1

You mean why do we do it do?

00:26:17 Speaker 1

We have a choice, hashtag can't stop, won't stop like what do you?

00:26:22 Speaker 1

Mean why do we?

00:26:24 Speaker 1

Do it.

00:26:24 Speaker 1

We are the community.

00:26:25 Speaker 1

I live on Skid Row where my patients live.

00:26:29 Speaker 1

I work in this hospital.

00:26:31 Speaker 1

My hospital is full of black and Brown health care workers who live in the community.

00:26:36 Speaker 1

We are the patients, our families, our brothers and sisters.

00:26:41 Speaker 1

Our parents were dying from Kovit and you have the.

00:26:44 Speaker 1

Also asked me at Kendricks, why do you do it?

00:26:47 Speaker 1

Doctor Abraham and this labor of love that we've taken on.

00:26:52 Speaker 1

I mean, it's there was no option.

00:26:56 Speaker 1

I was gonna say why did I go down that Rd?

00:27:00 Speaker 1

Uh, because nobody wants to tell that story and so hold on one second, there was another thing that you just reminded me about.

00:27:08 Speaker 1

So I've noticed there's certain questions that come up.

00:27:10 Speaker 1

Why did we do it?

00:27:14 Speaker 1

What was the other one there?

00:27:15 Speaker 1

Was something else hold on?

00:27:19 Speaker 1

So that I'll just.

00:27:20 Speaker 1

Finish the point of the story.

00:27:21 Speaker 1

There was.

00:27:26 Speaker 1

That this is a.

00:27:28 Speaker 1

Oh, I know what I was gonna say.

00:27:30 Speaker 1

Why did you do it?

00:27:31 Speaker 1

Doctor Abraham.

00:27:32 Speaker 1

Oh, you know it's like it didn't dawn on them that's like not a matter of choice.

00:27:38 Speaker 1

It's a matter of life and death for us.

00:27:41 Speaker 1

You know another thing that I found fascinating was.

00:27:45 Speaker 1

People always ask why?

00:27:46 Speaker 1

How did you do it?

00:27:47 Speaker 1

You know, did you know someone?

00:27:50 Speaker 1

Do you know the governor?

00:27:51 Speaker 1

Or did you call someone in DC?

00:27:53 Speaker 1

No, no.

00:27:54 Speaker 1

I banged on doors and we do what we do best.

00:27:57 Speaker 1

Overcoming health disparities in addressing social determinants of health and achieving HealthEquity.

00:28:02 Speaker 1

We jumped up and down and we waved our hands like we're on a.

00:28:06 Speaker 1

Lonely deserted island and this is our one shot at fof at a plane flying over and we screamed and we shouted an we did what we had to do.

00:28:17 Speaker 1

We advocated for our community and we got vaccines but it doesn't end there.

00:28:22 Speaker 1

This is a highly complex comma.

00:28:25 Speaker 1

Located system that's not easy to figure out.

00:28:28 Speaker 1

You are dealing with a very complicated, cold supplied pain.

00:28:33 Speaker 1

You have to maintain temperatures. You have a lot of expiration dates next month in the freezer, 30 days in the fridge, once outside 12 hours, plus that vials been punctured six hours. You've got to maintain temperatures below 77 degrees Fahrenheit. You have to keep all these things in mind.

00:28:53 Speaker 1

Constantly, plus you've got a line that with needles and bandaids, and with gloves you've got to make sure that you've got hands.

00:29:02 Speaker 1

Volunteers, people to serve and actually administer these vaccines.

00:29:06 Speaker 1

You have to have resources.

00:29:07 Speaker 1

You have to have infrastructure when you come to catch and you're gonna go.

00:29:11 Speaker 1

Whoa, am I in a war zone like you're going to feel like you're on an episode of Mash you're gonna feel like the army core of engineers came and built this.

00:29:22 Speaker 1

Field medical military style operation and no, no we did it.

00:29:27 Speaker 1

It was Doctor Abraham, Clinical leadership and his quote unquote work.

00:29:33 Speaker 1

Husband Mr spun.

00:29:34 Speaker 1

It ran clinical operations lock and step.

00:29:39 Speaker 1

That you know I stuck my heel and he helped me.

00:29:41 Speaker 2

Ah.

00:29:44 Speaker 1

I practice really good medison and he helps me do it.

00:29:48 Speaker 1

He's built every tent I've asked for.

00:29:50 Speaker 1

He's gotten me all the supplies I needed.

00:29:52 Speaker 1

He's bought every fridge and freezer I've asked for like when I look at this partnership this marriage.

00:29:59 Speaker 1

Between.

00:30:00 Speaker 1

Clinical leadership and clinical operations that has also been lacking, and that's a big part of why others haven't been able to figure out because it ketring there is no one person in charge at Kettering.

00:30:12 Speaker 1

We're all associates.

00:30:13 Speaker 1

We are all partners.

00:30:15 Speaker 1

We are all members of the same team.

00:30:17 Speaker 1

We're hashtag all in this.

00:30:20 Speaker 1

Together and so it is that strategy that allows us to be so highly effective because I don't do anything without the left hand knowing the right and that is the sunny and jerrianne everyone around us that makes this magical.

00:30:36 Speaker 1

You know, happiest place on earth hydrin vaccines happen.

00:30:41 Speaker 1

They another thing that I wanted to just check on this real quick so operations and then leadership clinical this marriage stuff.

00:30:42 Speaker 1

Books.

00:30:42 Speaker 1

00:30:51 Speaker 1

This marriage stuff is such a beautiful analogy and I'm just gonna put a little pause here because.

00:30:56 Speaker 1

These alegory's, whether they are you know of religious orientation or not.

00:31:04 Speaker 1

Every day at the front, another suicide.

00:31:06 Speaker 1

But you know at the front gate you know we have to close the gate at some point.

00:31:09 Speaker 1

You've got all those people in that unofficial highly discouraged.

00:31:12 Speaker 1

You know standby line or queue.

00:31:15 Speaker 1

I mean, it feels like Noah's Ark everyday like the floods are coming.

00:31:19 Speaker 1

It is pouring and I have to some point close the the art.

00:31:24 Speaker 1

You know I have to close the doors.

00:31:26 Speaker 1

And it's so heartbreaking.

00:31:27 Speaker 1

I mean, that is where it's so emotionally.

00:31:30 Speaker 1

Taxing and tolling.

00:31:32 Speaker 1

There's real moral injury here that.

00:31:35 Speaker 1

You know health care rationing in America is real. Just go to a vaccination point of distribution and you'll see holy cow. People are literally like it's 1929. the Great Depression waiting out there in a breadline begging for a vaccine, an.

00:31:51 Speaker 1

Yep.

00:31:51 Speaker 1

00:31:54 Speaker 1

We just don't have enough and we don't have enough hands.

00:31:57 Speaker 1

We don't have enough resources and funding and I have to close the gate at the end of the day and it breaks all of our hearts.

00:32:04 Speaker 1

I think of the analogy of the Hebrew slaves crossing the parted red seas.

00:32:10 Speaker 1

I'm getting across onto dry land to stop as they can, while Pharaoh's Chariots are just steamrolling along ready to crush them and their bones into the seabed, and thankfully, Moderna, Pfizer and Johnson and Johnson is arrived as this great fast.

00:32:29 Speaker 1

Ocean that's gonna come.

00:32:29 Speaker 1

00:32:30 Speaker 1

That's gonna come.

00:32:31 Speaker 1

Crush Pharaohs are in this case coronaviruses Chariots and that's such a beautiful story and then you know another story I see here is just you know, miracle of loaves and fish is. I'm only given 6000 vaccines today but I'm doing 2500 vaccines today. The math just does not add up. I'm doing well over 12,000 vaccines today.

00:32:53 Speaker 1

That's because we're literally.

00:32:55 Speaker 1

An arms race were literally in a race against time.

00:33:00 Speaker 1

And we have not a minute to waste, not a moment to waste not a drop to waste.

00:33:06 Speaker 1

That's a big part.

00:33:07 Speaker 1

We had this mantra that kedren one of the monkeys decadron not a drop to waste.

00:33:13 Speaker 1

It breaks our heart.

00:33:15 Speaker 1

Dear, there are hospitals.

00:33:17 Speaker 1

And clinics and nursing homes.

00:33:18 Speaker 1

Throwing away vaccines because they claim they could not find arms to put them into before they expired.

00:33:27 Speaker 1

So what did we do we?

00:33:29 Speaker 1

So this week of vehicles that go all around LA County, literally like arms race like arms dealers stop looking and begging for expiring doses and getting them as quickly as we can to captions that we can vaccinate people by the end of the day and we were Clock in steps. We talk about marriage, so there's that. So let me finish the loaves and fishes analogy, but basically.

00:33:52 Speaker 1

We are making miracles happen everyday.

00:33:54 Speaker 1

Kendrick because we do a lot with the very little we were.

00:33:59 Speaker 1

Even to Lowe's or two finishes and five loaves or whatever the analogy is, and that's you know their creativity.

00:34:07 Speaker 1

That's the passion.

00:34:08 Speaker 1

That's the tenacity.

00:34:09 Speaker 1

That's the perseverance that has made that happen.

00:34:14 Speaker 1

So back to marriage, the marriage between sunny and.

00:34:19 Speaker 1

Jerry is clinical leadership in clinical operations.

00:34:23 Speaker 1

There's also a marriage between Pedrin an Arlo.

00:34:27 Speaker 1

Call public health jurisdiction.

00:34:29 Speaker 1

Need Los Angeles County Department of Public Health.

00:34:32 Speaker 1

We are so locked in step they call.

00:34:36 Speaker 1

As soon as they hear the expiring dose, then I send a scan.

00:34:41 Speaker 1

You know, racing across town or the County to go pick those doses up.

00:34:46 Speaker 1

We run everything by each other constantly.

00:34:48 Speaker 1

I'm on the phone with the County had vaccines every day.

00:34:53 Speaker 1

I'm talking to the head medical epidemiologist position.

00:34:57 Speaker 1

Every day, Doctor Shaw had a vaccine.

00:35:00 Speaker 1

Doctor Jerichau I talked to the program implementer from the County Lori every day, and so there's this beautiful, you know, public Private Partnership story that I want people to hear about.

00:35:14 Speaker 1

Two because that's how it should be.

00:35:16 Speaker 1

We shouldn't be entirely reliant on the County Department of Public Health to do it all.

00:35:20 Speaker 1

There an administrator there a distributor.

00:35:22 Speaker 1

They should be the ones being the direct provider in terms of putting the sauce in arms, they need to be wed lock in step with.

00:35:34 Speaker 1

The Conference of the World.

00:35:35 Speaker 1

Who can actually open their doors and get high volumes of people in and get them vaccinated.

00:35:42 Speaker 1

The other marriage that we must fix in America is this divorce that occurs at some point between Madison and public.

00:35:53 Speaker 1

Health and you.

00:35:53 Speaker 1

Health and.

00:35:54 Speaker 1

Doctor Mary those two together in many parts of the world.

00:35:58 Speaker 1

Public health adds medicine go hand in hand, but here for some reason they have been divorced.

00:36:05 Speaker 1

And so I think what?

00:36:06 Speaker 1

You're seeing with this whole epidemic. As of March 2020, today was really this lack of understanding of how public health and medicine.

00:36:16 Speaker 1

And are within the same domain an realm, and we must send them to marriage counseling. And we need to get them back together and I hope my testimony before the US Senate helps convince people, public health, infrastructure and revolutionize the health care delivery system. And when that happens and they go together.

00:36:37 Speaker 1

People will be healthier and happier and live meaningful and high quality lives longer.

00:36:45

Period.

00:36:46 Speaker 2

Yeah, I'm so glad that you said that because like from just hearing you talk, I just hear.

00:36:52 Speaker 2

A lot of similarities between South, South LA and the South side of Chicago because you know, like I said, part of the reason that I'm that I'm doing the story on is because.

00:37:07 Speaker 2

People like can only sign up by appointment.

00:37:12 Speaker 2

Through a service called Zocdoc in Chicago, but like most of the services are.

00:37:17 Speaker 2

In the South side of Chicago, the neediest are already booked, so I did want to ask.

00:37:23 Speaker 2

I mean from here you talk.

00:37:24 Speaker 2

It does sound like you.

00:37:27 Speaker 2

You gathered not only like your own team, but you guys are outside forces like community organizers and faith based organizations.

00:37:36 Speaker 2

However, it does seem.

00:37:39 Speaker 2

But the piece you're missing is digital volunteers.

00:37:44 Speaker 2

People who will sign up is is that?

00:37:48 Speaker 1

Yeah, I think you raise a really important point.

00:37:50 Speaker 1

Seems like you've already seen an if you don't mind, can you send me your email address?

00:37:52 Speaker 1

I can use.

00:37:52 Speaker 1

00:37:55 Speaker 1

I'll send you all of our media portfolio, but there's like several stories on the volunteer workforce itself.

00:38:01 Speaker 1

Volunteerism feels volunteerism helps.

00:38:05 Speaker 1

Volunteerism isn't just about the person you serve.

00:38:08 Speaker 1

But it truly is a meaningful life changing experience for the one who starts a combat burnout. It really combats all these terrible things that we see every day in healthcare where people want to quit or retire early. And so we can't. Do we do without over 200 volunteers a day, and we can't think.

00:38:27 Speaker 1

Everyone in our community all the way to the governor's office who answered that call when we pick up the phone and said we need help.

00:38:36 Speaker 1

Governor Newsom said California Volunteers California volunteers got the americor involved.

00:38:42 Speaker 1

America forgot the American Red Cross involved.

00:38:46 Speaker 1

American Red Cross got the Salvation Army involved with the Salvation Army, got the international medical core involved with the international Medical Core, got americares involved, and now we have tense, literally from Belgium.

00:38:58 Speaker 1

With UNICEF stamps on them because everybody mobilized quickly and this is all an entirely, you know.

00:39:06 Speaker 1

No boot strap.

00:39:08 Speaker 1

Shoestring volunteer operation and but hold on one second so you know when you come, you'll feel and see that you're going to see people from all those pieces and we're still needing more help.

00:39:21 Speaker 1

And we're hoping that the you know Governor will help us achieve that FEMA designation that we need.

00:39:27 Speaker 1

And we're hoping that that'll unlock more.

00:39:29 Speaker 1

Resources, including the California National Guard, but to your points now, we started having a few individuals who are helping us remotely from their own homes.

00:39:41 Speaker 1

Volunteer, for example, organize the database of volunteers because there are helpful hands and there are not so helpful.

00:39:50 Speaker 1

And so a desire to volunteer isn't enough.

00:39:54 Speaker 1

You've got to have the right skill sets and we have to have the right needs that we need to match them up properly.

00:39:59 Speaker 1

And that's a job, for example a.

00:40:03 Speaker 1

Volunteer who cannot come physically, whether because they are far away and not actually you know, able to get to capturing everyday or because of medical conditions or risk or this or that it got children.

00:40:15 Speaker 1

They're taking care of their aging parents.

00:40:18 Speaker 1

Their people want to help, so we've got to find ways for these digital Angels to actually, you know.

00:40:24 Speaker 1

Join the cavalry that's arrived and so for us.

00:40:28 Speaker 1

It's definitely been.

00:40:29 Speaker 1

The folks that are now helping us find you know that the volunteers, great, those that are helping us get more supplies.

00:40:37 Speaker 1

Awesome, those that are helping us do fundraising so that we can get more resources and hire more staff.

00:40:44 Speaker 1

The one drawback about volunteerism is that slavery is dead and I do not believe in.

00:40:50 Speaker 1

Unpaid labor so.

00:40:53 Speaker 1

We are dependent on a system that requires all of these official channels of volunteers, and I love it, but ultimately, why can't I just hire more people?

00:41:01 Speaker 1

Oh, 'cause there's not enough people in the healthcare workforce and there are not enough dollars to hire them.

00:41:07 Speaker 1

So you see how?

00:41:07 Speaker 1

It's all very systemic and it's all interconnected and related, but to your.

00:41:13 Speaker 1

Specific point, yeah, I mean, so we've been walking that line and we've noticed in that line, you know, in eleh there are people who work for Netflix.

00:41:21 Speaker 1

There people from the entertainment industry.

00:41:23 Speaker 1

There people from Uber and from you know, all the big media brands.

00:41:28 Speaker 1

It's like.

00:41:29 Speaker 1

And they always ask, how can I help and where can we give?

00:41:32 Speaker 1

And it's like come on like.

00:41:34 Speaker 1

I don't want to put brands out there because there's a lot of them that are out there, but I'm usually like dance. You get some of your workforce, so like actually call people that need appointments and actually walk them through getting it? Or can you create a phone tree or a text tree so as soon as I get like 1000 expiring doses from a nursing home?

00:41:56 Speaker 1

We can call the people in the community who need it most, and.

00:42:00 Speaker 1

And these digital Angels can even help arrange rides for them or arrange their Uber or Lyft or whatever like there's so much magic in this happiest place on earth that could happen if only we could, like, think creatively and be more solutions oriented.

00:42:18 Speaker 1

So that's what I would say.

00:42:19 Speaker 1

Is that absolutely?

00:42:21 Speaker 1

I want you know we're in Los Angeles.

00:42:23 Speaker 1

This is the city of Angels and there is a role for the digital Angel to play in ending this epidemic.

00:42:31 Speaker 1

And that's by getting Grandma an appointment that is by getting grandma to write to her vaccine and a lot of those things can be done.

00:42:41 Speaker 1

Staring into your laptop instead of playing Nintendo DS and sitting camped out outside of kedren like you're about to climb Kilimanjaro tomorrow.

00:42:51 Speaker 1

Why don't you take a moment and stop ordering an Uber eats and wanted to go help ground?

00:42:57 Speaker 2

Right and it it doesn't kind of sound like.

00:43:01 Speaker 2

Just hearing like a lot of people think it would take like some grand movement, which it it it does, but at the same time it sounds like people can volunteer just like from their their house like calling people they know and setting up their appointments.

00:43:17 Speaker 2

If you know they don't have a computer or something like that.

00:43:21 Speaker 2

Right?

00:43:21 Speaker 2

And I actually, I'm gonna send you a text if you don't mind.

00:43:25 Speaker 2

It's a it's a link to so Southside Weekly we set up a a bot will not me.

00:43:31 Speaker 2

It's called her name is be a mouse key and Charmaine rooms.

00:43:35 Speaker 2

They created a bot that records.

00:43:39 Speaker 2

The you know the vaccination rate and it's by zip code, but if you take a look at the at the map and tunnel Twitter.

00:43:45 Speaker 1

Yeah.

00:43:50 Speaker 2

I think you'll notice that you know the people who are vaccinated are the wealthiest areas.

00:43:57 Speaker 2

The downtown, the Loop and the darker areas where people are dying.

00:43:57 Speaker 1

Yeah.

00:44:02 Speaker 2

Like without no surprise are communities of color. Is that something that you've also seen in LA?

00:44:12 Speaker 1

Yes, absolutely.

00:44:12 Speaker 2

OK, So what did you start?

00:44:14 Speaker 1

Uh.

00:44:16 Speaker 1

So First off, we saw the Maps of Chicago and we saw the Maps of DC and you may have heard Rachel Maddow bring those up during our interview.

00:44:27 Speaker 1

That was one thing that I went to the County Department of Public Health very early on in at the end of December and said we will not let that happen to our community.

00:44:36 Speaker 1

You must.

00:44:36 Speaker 1

Send a zip, but you must send the vaccines to the zip codes where there are the highest rates of kovit.

00:44:42 Speaker 1

We will figure it out.

00:44:43 Speaker 1

Find your trusted partners like Hedren and we can trust them.

00:44:47 Speaker 1

Send them to vaccines and then they can make sure they get distributed quickly.

00:44:52 Speaker 1

You know we don't sacrifice effectiveness and equity for.

00:44:56 Speaker 1

Officially, we prioritize people, but we also get our data and what we do exceptionally well at capturing is that you know we need a high volume of people and we do it.

00:45:09 Speaker 1

Extremely equitably and justly, and fairly administering it, and distributing it.

00:45:16 Speaker 1

And then we report that data on that activity accurately and timely back to multiple jurisdictions.

00:45:24 Speaker 1

the CDC, the federal level, to the California Department of Public Health, the state level, and to our local jurisdiction.

00:45:30 Speaker 1

The County Department of Public Health.

00:45:32 Speaker 1

Again, when I talked about complexity, This is why no one else can really figure it out because it's not easy to do and so.

00:45:42 Speaker 1

I brought that up because your question was zip code.

00:45:46 Speaker 1

So now as of last week we have begged and pleaded and we've been saying since since the end of December and here we are at the beginning of March and I've finally been given permission to let anyone in from certain zip codes walk right in regardless of eligibility, regardless of age, regardless of what their job is and get back.

00:46:05 Speaker 1

Because they live in dense housing, they live in a multi generational home with 10 people.

00:46:11 Speaker 1

That house needs to get vaccinated.

00:46:13 Speaker 1

That apartment needs to get back to.

00:46:15 Speaker 1

That encampment needs to get vaccinated in the ZIP codes where people are dying from kovit.

00:46:21 Speaker 1

It doesn't make any sense is not like you were just now hitting.

00:46:24 Speaker 1

This is not rocket science people.

00:46:26 Speaker 1

I'm shocked that we're having to convince people.

00:46:28 Speaker 1

Hold on him.

00:46:29 Speaker 1

Woman keep your strategy in your clunky and your fancy and your theoretical, and you know this whiteboard that you've drawn up with all these phases and Kearse lovely, and I I it's great. I'm so glad you'll spend time on these white papers. However, get the vaccine out and get the vaccines out where they're needed today and let's go as fast as we can to achieve that 70%.

00:46:47

Thanks.

00:46:51 Speaker 1

Plus, you know herd immunity, so we can end this epidemic.

00:46:55 Speaker 1

I did want to sidebar, you know, one thing that I wanted to come back to, you know why are we?

00:47:00 Speaker 1

So in fact, if it's not just this marriage between clinical leadership and clinical operations is not shocked.

00:47:02

Yeah.

00:47:06 Speaker 1

You know this marriage between Catherine and the County Department of Public Health, but it's also because when you look at that first floor of our operation, this whole field hospital, it starts really with pre registration and you know everybody at catching gets an honorary doctorate from Doctor Abraham so.

00:47:23 Speaker 1

My friend security Guard is honorary Doctor Mohammed and Mohammed's job is to keep.

00:47:29 Speaker 1

To get everybody in who is eligible and needs a vaccine now and should ask that everybody else wait their turn and wait outside.

00:47:38 Speaker 1

And so that's a critical role and then you get to the registration.

00:47:42 Speaker 1

It takes less than 30 seconds of asking someone it takes over 12 minutes to check them in and to register them so that whole operation takes like 20 to 40 people every.

00:47:53 Speaker 1

Today it's utter and complete nonsense because all we need to do is vaccinate someone.

00:47:58 Speaker 1

Why does it take so long to not only does it impossible to get an appointment, but on our end it's impossible to find your appointment and to check you in and to do all the things and get your card and all the little tidbits that you know.

00:48:11 Speaker 1

Create the registration challenges and Bury.

00:48:14 Speaker 1

And then you go over to the vaccination tent where specially pokey with a needle and you get this lifesaving essential medicines Pfizer or Maderna.

00:48:24 Speaker 1

And now we have Johnson and Johnson.

00:48:26 Speaker 1

So we're using all three at Kentridge.

00:48:28 Speaker 1

Then you go to what we call post.

00:48:29 Speaker 1

That's where we observe you and we watch.

00:48:31 Speaker 1

And then we send you on your way and remind you the faster you do that, the faster I can get someone else.

00:48:35 Speaker 1

And and then you've got like that miscellaneous piece, the stockroom, the purchasing, the you know, all of the operational stuff.

00:48:44 Speaker 1

When you get to the second floor.

00:48:45 Speaker 1

Or that's where I live.

00:48:47 Speaker 1

Clinical leadership.

00:48:48 Speaker 1

And then you know, next door is clinical operations and next order that is operations from this whole thing is outside.

00:48:54 Speaker 1

So none of us are ever sitting in an office.

00:48:56 Speaker 1

None of us are ever hiding behind a zoom call or a teams meeting.

00:49:01 Speaker 1

We're actually always out and about and moving.

00:49:03 Speaker 1

And so when I'm talking about this, theoretical.

00:49:06 Speaker 1

Workplace, this is all just in our heads because we're all in this together.

00:49:12 Speaker 1

We're literally outside all day long, rain or shine, hot or cold, and we all are part of it so we understand it.

00:49:20 Speaker 1

And each domain has like their honorary doctor, so Mohammed with pre rented out with red.

00:49:25 Speaker 1

You know we've got.

00:49:26 Speaker 1

Honorary doctor Mario.

00:49:28 Speaker 1

An honorary doctor Sack and then when we get to clinical leadership, we've got our medical assistant.

00:49:33 Speaker 1

You know, Heather, and we've got our medical assistant in some R and then we get over to our, you know, everything on the post vaccine.

00:49:41 Speaker 1

Oh, that's a whole other team.

00:49:42 Speaker 1

And when you get to that stockroom and inventory team, you know you've got my French fries choice and century suit.

00:49:49 Speaker 1

Halen century Angel.

00:49:51 Speaker 1

Who really master getting everything opened up and all the box?

00:49:55 Speaker 1

And we're dealing with hundreds of boxes of shipments for these vaccines, including all the needles and yadda yadda.

00:50:00 Speaker 1

So it's critical piece.

00:50:02 Speaker 1

But when you move to that theoretical second floor

00:50:04 Speaker 1

Yeah, that's doctor Abraham.

00:50:06 Speaker 1

Clinical leadership.

00:50:07 Speaker 1

Can whole clinical leadership team around him, including his physician assistant.

00:50:12 Speaker 1

You know VHS man more acanya right?

00:50:16 Speaker 1

Who is always by my side.

00:50:18 Speaker 1

In fact I call her my commander and I'm constantly.

00:50:21 Speaker 1

We're always talking about Commander to the bridge.

00:50:23 Speaker 1

You know, because it's like there's another fire and she puts it out.

00:50:26 Speaker 1

And so this the hands and feet so that we can still be brains.

00:50:29 Speaker 1

And then you know we've got funny trend with this whole clinical operations team in the next to that, you've got operations or business manager Miss Irene, who keeps the lights on, get some bills paid, gets payroll out here.

00:50:40 Speaker 1

But really, the secret sauce to is this third floor, the executive suite, and that is where our President, Doctor John Griffith, the clinical psychologist who served as leader of pension for 40 years.

00:50:53 Speaker 1

He knew.

00:50:54 Speaker 1

Exactly what he had to do.

00:50:56 Speaker 1

He was going to just like Doctor Abrahams.

00:50:59 Speaker 1

Every barrier that stood between people and their vaccine, he removed every institutional barrier that stood between doctor Abraham, practicing medicine and getting this fake vaccine out.

00:51:10 Speaker 1

And so, unlike a lot of other health care systems where there were zoom call after zoom call, I don't know there's so many liabilities.

00:51:18 Speaker 1

People are scary.

00:51:20 Speaker 1

Yadda yadda yadda Doctor Griffith and our Chief Medical Officer Anarch Adren board said Doctor Abraham go with God do good and do well and we will step out of your way and we will remove.

00:51:36 Speaker 1

Move every institutional barrier that stands in the way from you doing your job.

00:51:42 Speaker 1

Vaccinating Angelinos right.

00:51:45 Speaker 1

And so I think this is a really critical piece to where the success comes from.

00:51:49 Speaker 1

But to your points, yes, using these systems are critical, and as I I brought that up, that was a little bit of an aside.

00:51:58 Speaker 1

But to go back to the zip code strategy we fought since the end of December.

00:52:01 Speaker 1

And now as of last week we we are a pilot site for this zip code strategy.

00:52:06 Speaker 1

So now we've partnered with the city councillors from the poorest zip codes.

00:52:10 Speaker 1

From the heat Maps where there are the most covid infections and now those zip codes get priority just like your when you come to Kenya, gonna feel like holy cow is this am I at LAX at my boarding a plane? 'cause there's gonna be like 6 or 7 lines and you're going to see priority boarding lines worth like an older person who's over 65 shows up. They walk right in.

00:52:32 Speaker 1

Health care worker walks right in appointment or no appointment. Ascential frontline workers who are eligible right now. Appointment or no appointment gets well created, but there's a zip code line and they get to walk right in. They show us proof that they live in 90011 and they are welcome on board at their leisure everyone.

00:52:49 Speaker 1

Now wait your turn and so that's when we get to some of these other lines that exist, plus that unofficial, highly discouraged standby line.

00:52:59 Speaker 1

But you know this zip code thing was critical and then to your point, you know the website itself is just ridiculous, because that's assuming somebody sits in front of a computer all the time.

00:53:09 Speaker 1

It assumes that people have access.

00:53:11 Speaker 1

To the Internet which is.

00:53:11 Speaker 1

Why for us partnered with the city and County on figuring out eight?

00:53:15 Speaker 1

Texting a tree and a phone call tree was so important because people do text a lot more than they may email and people do pick up the phone and call their loved ones or when they have a problem, they know how to call.

00:53:28 Speaker 1

You know whether it's a service provider for a utility company or a that build that they're like.

00:53:35 Speaker 1

I can't pay.

00:53:36 Speaker 1

People pick up the phone and calling their own problems.

00:53:38 Speaker 1

So like we're like, how do you harness that technology?

00:53:41 Speaker 1

I know it seems like analog.

00:53:42 Speaker 1

I know it seems foreign, ancient, arcane, archaic prehistoric, you know.

00:53:48 Speaker 1

But the truth is maybe just like Doctor Abraham.

00:53:52 Speaker 1

Used a bunch of paper to work around this whole clunky fancy Accenture consulting firm driven Salesforce platform with the third party Administrator Blue Shield.

00:54:05 Speaker 1

Watching it over all of it may be all you need to do is go get some rings of paper and put the fields on paper and get people.

00:54:12 Speaker 1

A pen and pencil in their hands.

00:54:14 Speaker 1

And sort of forming.

00:54:15 Speaker 1

Next thing you know, they're vaccinated far faster, and that means you've got a data entry team that's working around the Clock entering those forms.

00:54:21 Speaker 1

But to your point, we've got to.

00:54:23 Speaker 1

Figure out how do we tell people from those zip codes that they're eligible because it wasn't enough that we begged and pleaded for this zip code. Pilotin. Now the governor said we're moving to zip code based strategy yesterday and it's working because we got high rates of people in our community vaccinated, which were our communities, 90% Latino and then our.

00:54:43 Speaker 1

You know, whereas directly black institution where a lot of our patients are black and so immediately you just seemed high in like a real shot in the arm that rush of everyone who was out now is right in.

00:54:59 Speaker 1

Having those policies it enough because that's where you need to have the grassroots organizers organized labor.

00:55:05 Speaker 1

We need to figure out how do we get the people who need the shot, who are from the ZIP codes?

00:55:10 Speaker 1

They need to know that they are eligible now they need to know that they can walk right in, but it's not enough because it goes back to those bears talked about child care.

00:55:18 Speaker 1

And paid time off and all the things that are societal lows. So now what we're doing everything I just described is called capturing 1.0. We're building Cadron 2.0.

00:55:29 Speaker 1

Well, it Watson Compton Catcher in 3.0, is that the historically black medical school Charles Drew University and MLK Community Hospital, which we read about in the paper all the time where all the kovit is and then Kettering 4.0 is our fleet of mobile vehicles and captured. 5.0 is Max facts and that's really exciting. Where we're going to reach out to the millennials and the Gen Z's?

00:55:50 Speaker 1

We're partnering with entertainers, musicians, leaders, and we're going to hold, you know, 30,000 plus style LA Live Aid events where we're ending this epidemic by.

00:56:03 Speaker 1

Thing thousands of young people when they are eligible and they're going to roll up their sleeves, we're going to educate, engage them, educate them, and they're going to roll their sleeves. They're going to get back since we're really excited about those. Like very large scale events that we're now partnering with people. But this 4.0 is the mobile fleet, so we've just been given blessing by the County Department of Public Health last week.

00:56:23 Speaker 1

For now, go directly to where people work.

00:56:26 Speaker 1

So now we're going to take vans with vaccine.

00:56:29 Speaker 1

Means an with.

00:56:29 Speaker 1

Means an.

00:56:30 Speaker 1

So you know, hands that can administer them and we're gonna go to the meat processing plants.

00:56:36 Speaker 1

We're going to go to the food processing.

00:56:40 Speaker 1

We're going to go to the agricultural workers where they are and where they work.

00:56:44 Speaker 1

We're going to go to the garment and Fabric District, where all of the tailors and seamstresses who tirelessly worked to.

00:56:50 Speaker 1

So together our clothes everybody that's in this high risk, highly dense workspace is working to vaccinate.

00:57:00 Speaker 1

Them at work where they are doing what they do and what they do best, and they're living the lives that they live and we need to meet them where they are. And I will bring a vaccine to them and I will

vaccinate them at work if that's what it takes to end this epidemic, then we'll do it, and so that's why 4.0 is so critical because it's not just the meat processing plant workers.

00:57:20 Speaker 1

It's the homebound.

00:57:22 Speaker 1

The vulnerable, the elderly, the frail that can't ever get to Dodger Stadium or Kedren, we have to go to them with a fleet of ice cream trucks.

00:57:29 Speaker 1

Time building now is that we could actually go out into the community and go door by door.

00:57:34 Speaker 1

What we're talking about is very analogous to get out the vote kind of strategy just to get out the vaccine we have to canvas the neighborhood.

00:57:41 Speaker 1

We need to knock on doors.

00:57:42 Speaker 1

Need to find where people are.

00:57:44 Speaker 1

Please find out whether they've been vaccinated or not, and then we need to get them the vaccines, the shots and so this pattern 4.0 mobile and it's also very important for people like.

00:57:56 Speaker 1

Being counted in cabinets and that's why I think a single dose vaccine like Johnson Johnson is so critical because there are people like jail populations or homeless encampments where you may be very difficult next to impossible to maybe find certain individuals again in 21 days or 28 days. So a single dose vaccine helps to.

00:58:16 Speaker 1

Leave that herd immunity much faster and it removes that barrier of what happens if we can't find someone that should not be a barrier to not getting vaccinated because we're too afraid that if we give you one, we won't find you for the 2nd, and I know that's happening every day in America.

00:58:16

Yeah.

00:58:29 Speaker 1

So every time you find a barrier.

00:58:31 Speaker 1

Challenge, we just quickly, you know, give it to.

00:58:35 Speaker 1

What is the solution?

00:58:36 Speaker 1

What is the work around?

00:58:37 Speaker 1

How do we solve that problem and that's why the zip code strategy is so important.

00:58:42 Speaker 2

Yeah, and that's it's funny that you say that because that's exactly what it sounds like to me.

00:58:48 Speaker 2

Is that it does?

00:58:48 Speaker 2

It sounds like you're like a cap.

00:58:50 Speaker 2

You're canvassing for a candidate like that.

00:58:52 Speaker 2

I've done that before and that's exactly what it what it sounds like like a voter registration drive and I just want to add a couple more questions.

00:59:01 Speaker 2

One is.

00:59:02 Speaker 2

It does sound like.

00:59:05 Speaker 2

You know it is. It is a priority to to vaccinate the most vulnerable like the older and people of color. But do you think like the approach that we're doing now, which is only limiting to 65 and older? Do you think if it's I don't want to say it's the wrong approach? But do you think that approach needs to be?

00:59:26 Speaker 2

Revisited to include just anybody because for.

00:59:29 Speaker 2

People we have a Mac, a mass vaccination site opening up on Tuesday at the United Center, but one do you need an appointment an it's only for 65 and older?

00:59:42 Speaker 2

Do you think that that that approach needs to be open to to anybody, regardless of age?

00:59:51 Speaker 1

Well, the challenge there is that we just don't have enough vaccines.

00:59:54 Speaker 1

We don't have enough hands and we don't have enough resources to to do this in mass for everyone.

01:00:01 Speaker 1

So that's why we do have to create priorities, faces and tears.

01:00:06 Speaker 1

Then we have to roll out this vaccine in an orderly fashion.

01:00:10 Speaker 1

We can't, it won't work just like I was using the boarding a plane and Al.

01:00:16 Speaker 1

We will take a lot longer boarding the plane if the angry mob storms the literal boarding gate instead.

01:00:23 Speaker 1

What we have to do is have, you know, clearly organized line and people waiting their turn and people getting on board 1 by 1.

01:00:35 Speaker 1

And so the problem with the age based strategy that I pushed so hard to get the zip code based strategy instead was because you ended up right away when the 65 and older were eligible. You got a lot of like wealthy from different zip code.

01:00:56 Speaker 1

Elders who really are not exposed and they're living in their nice big homes and they're not interacting with a lot of people and they got to cut the line. It didn't really entirely make sense to us 'cause we're like. Wait, so the people living in a apt A1 bedroom apartment with 10 people in it?

01:01:16 Speaker 1

They're not even eligible yet, and they've literally like.

01:01:20 Speaker 1

You know 20. So in our community, 25% of people have had covitz. Looks like in that apartment of 10 people, you're telling me where three to four of them got covid? That apartment is still not eligible like what the? So it didn't make sense that when the 65 and older's were.

01:01:23 Speaker 1

So sexy.

01:01:23 Speaker 1

01:01:39 Speaker 1

Eligible, we say.

01:01:41 Speaker 1

People from Beverly Hills and Malibu come in droves and were like WTF like I have never seen this many white people in South Hill a like what is happening and I'll tell you another aside, you know I mentioned this on advice pieces.

01:01:57 Speaker 1

You know it's like a blessing in disguise, honestly, because.

01:02:01 Speaker 1

They come and they see and they go.

01:02:02 Speaker 1

Holy **** y'all.

01:02:04 Speaker 1

Don't have a Walgreens.

01:02:05 Speaker 1

You don't have that like CVS or Rite Aid.

01:02:08 Speaker 1

You guys don't have grocery stores like where the hell are we?

01:02:11 Speaker 1

Hello, we're in the County of Los Angeles where you live.

01:02:14 Speaker 1

I'm glad it took this freaking academic in this vaccine for you to get in your car and come over and see what you've been missing this whole time.

01:02:21 Speaker 1

But that should have been a field trip for every first grader to realize that the world is not fair, it is not equal and these are the dis.

01:02:29 Speaker 1

Parodies and the determinants that need to be overcome in order to truly achieve equity.

01:02:35 Speaker 1

But you know, that's been kind of a funny little aside that you see a lot is rich folks.

01:02:39 Speaker 1

You go, oh.

01:02:41 Speaker 1

Wow, I had no idea.

01:02:42 Speaker 1

It's like Oh my God, this is not an educational tour for you right now, you know, and but I'm glad that everybody is getting vaccinated.

01:02:51 Speaker 1

And I ideally really do want.

01:02:54 Speaker 1

To get everyone.

01:02:54 Speaker 1

01:02:54 Speaker 1

Get everyone.

01:02:56 Speaker 1

Vaccinated so ultimately, you know the stockpiles are coming and supply is going to outpace and outstrip demand, and so this is where the hesitancy questions you mentioned.

01:03:04 Speaker 1

Demand.

01:03:04 Speaker 1

01:03:08 Speaker 1

And they're not just that in hesitancy, but their hesitancy about I don't have a ride for parking out of health care.

01:03:13 Speaker 1

All those things that are keeping people from getting you know, registered those are going to start coming into play a lot, because now we're going to have way too much inventory.

01:03:21 Speaker 1

And not enough arms to put them in, right?

01:03:23 Speaker 1

So we're going to have to kind of match up very fast.

01:03:26 Speaker 1

How do we get this vaccine that's piling up into people that have not been vaccinated?

01:03:31 Speaker 1

At some point, you're just going to say, get everyone in.

01:03:34 Speaker 2

Right and what's your email address again?

01:03:37 Speaker 2

Do you mind texting me your email address you want?

01:03:39 Speaker 2

Yeah, I'll just send it in to you.

01:03:41 Speaker 1

Take your time OK?

01:03:49 Speaker 2

Oh

01:03:51 Speaker 2

At PM

01:03:54 Speaker 2

OK, just text it to you.

01:03:57 Speaker 2

Yeah it does.

01:03:57 Speaker 2

It does sound like a like.

01:04:01 Speaker 2

It's funny that you mention that because you know in Chicago we are one of the most segregated cities in the world.

01:04:07 Speaker 2

I well in the United States at least, and so it's funny to that like that.

01:04:15 Speaker 2

You know, sometimes the very wealthy never travel.

01:04:19 Speaker 2

You know they're scared even though I actually did.

01:04:23 Speaker 2

We do at the at Southside Weekly.

01:04:25 Speaker 2

We do a yearly issue called Best of the South Side because, you know, that's one of the we're trying to.

01:04:31 Speaker 2

We're trying to take away that stigma that the South side of Chicago is is a dangerous place.

01:04:36 Speaker 2

So we for feature works best, but.

01:04:39 Speaker 2

What I wanted to ask finally was.

01:04:42 Speaker 2

You know, it feels like if you look at people's Instagram stories, social media, they're they're partying, you know, because they feel like they're they. They see the light at the end of the tunnel. But I wanted to ask, do you think that you know testing is still a priority because people have kind of forgotten about testing?

01:05:01 Speaker 2

And at you know, I actually got tested I I got tested regularly yesterday.

01:05:08 Speaker 2

There was no line, no appointment needed.

01:05:10 Speaker 2

Do you think that's still something people should?

01:05:12 Speaker 2

2.

01:05:14 Speaker 1

Yeah, I'm so glad you brought that up for a sister that is absolutely critical. We backed up. We vaccinate over 2500 people today, but we actually passed over 2000 people a day at Kedren and we refuse to.

01:05:30 Speaker 1

Hold on the word is not swap, but we will not substitute testing people for vaccinating people because you need both.

01:05:39 Speaker 1

It's just a lot of these weird false.

01:05:41 Speaker 1

Voice is being made and put out there, and the truth is you need both because people are still getting kovid and we need to continue to contact trace and we need to continue to quarantine those that are positive and the only way you're going to know is if you're tested.

01:05:55 Speaker 1

So like UI to get tested every week.

01:05:58 Speaker 1

Still, even though I have been vaccinated twice because it's such still played a part in this.

01:06:03 Speaker 1

Yeah, they're all these analogies, whether it's marriage or biblical allegory, you know?

01:06:08 Speaker 1

This reminds me of the HIV AIDS epidemic in the earliest days of hashtag.

01:06:12 Speaker 1

Know your status and you know this race to get retroviral therapies out the door.

01:06:18 Speaker 1

There is so much going on.

01:06:20 Speaker 1

Yeah, this public private partnership success story.

01:06:23 Speaker 1

I mean, this is going to turn into a Hollywood blockbuster.

01:06:26 Speaker 1

This is going to be a New York Times bestseller, you know?

01:06:30 Speaker 1

I mean, there's a lot to unpack here.

01:06:32 Speaker 2

Thank you very much.

01:06:32 Speaker 1

An I really do think that when I think of the testing strategy, it is so critical.

01:06:40 Speaker 1

It is embarrassing again that I've had to quote unquote pedantically lecture people.

01:06:47 Speaker 1

You cannot substitute vaccinations for testing is for very different purposes.

01:06:53 Speaker 1

So you shutting down mega testing sites like Dodgers to become mega vaccination sites that you can't even keep open because you don't know how to run them.

01:07:01 Speaker 1

And you've run out of inventory and you have anti vaxxers shut down the whole operation.

01:07:06 Speaker 1

Shame on you.

01:07:07 Speaker 1

Shame on you for thinking that you need to test people anymore.

01:07:10 Speaker 1

See when you're thinking that all because all of a sudden everybody in Beverly Hills and Malibu is a vaccine that the the epidemic is over.

01:07:17 Speaker 1

You know what nonsense was.

01:07:18 Speaker 1

No difference in the HIV AIDS epidemic.

01:07:20 Speaker 1

We're still working tirelessly.

01:07:22 Speaker 1

I serve on the MBA HIV epidemic Commission and you know?

01:07:27 Speaker 1

We are still regardless of testing, regardless of treatment options, including taking antiretrovirals we are.

01:07:35 Speaker 1

I prescribe prep.

01:07:36 Speaker 1

Regularly, you know, and that's a critical pieces.

01:07:40 Speaker 1

That is all it is not.

01:07:43 Speaker 1

I mean, I personally get tested for HIV regularly, you know, and it's important like so.

01:07:49 Speaker 1

Yeah, testing yes treatments, yes.

01:07:52 Speaker 1

Yes, let's figure out from Desadier works.

01:07:54 Speaker 1

Let's figure out dexamethasone works.

01:07:56 Speaker 1

Figure out how we.

01:07:57 Speaker 1

People live longer on ventilate.

01:07:59 Speaker 1

So that they can really overcome you know and fight covid.

01:08:04 Speaker 1

Let's figure out all these, you know, exciting treatments, like when you talk about regenerx on and all those monoclonal antibody treatments.

01:08:10 Speaker 1

Wonderful, but also vaccines.

01:08:13 Speaker 1

And yes, also testing it is all of it, and these are false choices that are put before us.

01:08:20 Speaker 1

Austin, this is the wealthiest country in the world.

01:08:24 Speaker 1

Why are we operating like this?

01:08:26 Speaker 1

It makes no sense.

01:08:27 Speaker 1

Let's get it together America.

01:08:30 Speaker 1

We have no more time to waste.

01:08:32 Speaker 1

We have to end this epidemic now.

01:08:34 Speaker 2

Yeah, especially with you know all these new variants.

01:08:37 Speaker 2

I mean, and I think that's it's still a priority.

01:08:41 Speaker 2

I mean here in Chicago we just got the first or in Illinois.

01:08:45 Speaker 2

I think we've got the first Brazilian variant.

01:08:49 Speaker 2

But yeah.

01:08:52 Speaker 2

Kendall.

01:08:52 Speaker 1

Say you are a very, very, very intelligent person, Francisco.

01:08:57 Speaker 1

I am so impressed with your knowledge and understanding.

01:09:00 Speaker 1

I'm guessing you are not a doctor or health care worker.

01:09:03 Speaker 2

Now I am not.

01:09:04 Speaker 1

Your grasp and understanding of the complexity of this COVID-19 pandemic is exceptionally exceptionally impressive, and you're exactly right. I think when we talk about vaccine has that entity that is something I talked about very openly. We talked about him in a logical efficacy. We know that you know, Moderna Pfizer from the studies.

01:09:24 Speaker 1

For 9495%, but that's nothing that means nothing, because the truth is, those are.

01:09:29 Speaker 1

Theoretical things and every individual responds differently based on their own immune system and their own bodies. Ability to Mount a response to a vaccine. So this joke of like Oh well, diner giving me Johnson and Johnson is less than it's only 60% affective. Again, it goes back to take hold on everybody. What we won't see? The survivability rate is equal to that of whites.

01:09:52 Speaker 1

And rich people, right? And so I am not concerned about 95% immunological efficacy or effectiveness because.

01:10:00 Speaker 1

That is just something in your head, and they've planted that in a way that people are facing. This number that doesn't even exist because I can never tell you for sure that you are 95%.

01:10:13 Speaker 1

Immunized against this covert thing, but in addition to that you brought up this very scary and frightening word variance.

01:10:21 Speaker 1

You know people are worried that this vaccine is going to mutate them or change their DNA.

01:10:26 Speaker 1

What they should be scared of is that this virus is mutating every day and there may be a point where a mutation.

01:10:34 Speaker 1

Critically.

01:10:36 Speaker 1

Create anti China drift where vaccines or the ones we have are no longer effective while we share the small changes, the variance, the smaller mutations we can't.

01:10:48 Speaker 1

We can modernos currently tweaking to a next generation vaccine and there's talk about a third dose materna.

01:10:57 Speaker 1

You know booster shot or scene with Pfizer as well as that they have been highly effective at combating against the UK variant and the South African variant.

01:11:09 Speaker 1

And as you just mentioned this again, I applaud you for doing your homework.

01:11:13 Speaker 1

You are so exception.

01:11:15 Speaker 1

So in comparison to so many of the journalists that I have worked with to get these stories out.

01:11:21 Speaker 1

In fact, I've built up and now you will be included that profited media partner, I call it our embedded wartime correspondence and journalists.

01:11:32 Speaker 1

Our own Catherine Press core, because the ones who get it.

01:11:36 Speaker 1

I really hope that I can help them get the information they need to tell the right story and the fact that you understood and asked a very highly or you brought up a highly complex issue and I was thinking you were gonna ask some very important questions around these things like variance.

01:11:50 Speaker 1

I can't even get people to understand, you know, hold on.

01:11:53 Speaker 1

Do you even know how Moderna Pfizer works or what is John 6 like?

01:11:57 Speaker 1

Simply ask.

01:11:58 Speaker 1

Do you sell?

01:11:59 Speaker 1

Very ill informed questions right and so this issue of variance is critical because there are concerns there may be a New York variant we're seeing variants in Texas.

01:12:10 Speaker 1

We're seeing variants all throughout California from other places because we all are traveling and global.

01:12:16 Speaker 1

You know, I didn't make the decision to fly to DC lightly.

01:12:19 Speaker 1

I made it gravely because this is essential work that I am doing and it is an essential story that the Senate and America must here on Tuesday morning.

01:12:29 Speaker 1

So I don't take it lightly, but I know that there are people who should not be flying around the world doing just that and they are spreading these variants and so we've got to keep doing what we've been doing and we need to be extremely vigilant because we will find people who have been vaccinated will get covid, and it will probably be a variant or mutant strain that we just are not ready for.

01:12:52 Speaker 1

However, these made so much progress in such a short amount of time.

01:12:57 Speaker 1

Science has advanced very fast DNA.

01:13:00 Speaker 1

Which is on board and doing their part. The pharmaceutical companies are running trials. You know we're looking at whether we should vaccinate 1115 year olds. Now with the Pfizer study, we're looking at how we reopen schools. Will there be a covid vaccine to go to school for certain age groups for example? But yeah, what we've learned about, you know M RNA vaccines have been around for 20 years in the laboratory. He's been studying them on.

01:13:23 Speaker 1

Various models.

01:13:26 Speaker 1

And so likewise the Adino virus vaccine, the Johnson Johnson.

01:13:30 Speaker 1

I mean, that's how the flu shot works works.

01:13:32 Speaker 1

These aren't entirely new things, and because we've gotten so good at developing and rolling these out right now, what Maderna is doing, tweaking to their next Gen Moderna vaccine and then considering something like a third shot booster shot.

01:13:48 Speaker 1

You know we're going to be able to respond a lot faster, so in the meantime, while Doctor Abraham and Kevin and others are building and revolutionizing healthcare delivery systems, and we're building and putting into place a public.

01:14:00 Speaker 1

Infrastructure, and while science is advancing and taking more effective vaccines, when those variants Indians come just like we're at war, we will finally be armed and ready.

01:14:13 Speaker 1

We will be able to Mount a response that took so long from March till.

01:14:21 Speaker 1

The end of December when Doctor Abrahams banging on the doors of the Public health Department to where we are today, the 50,000 dose is literally a year.

01:14:29 Speaker 1

Here I mean she looks at the date.

01:14:31 Speaker 1

Here that this country has been going at it, it's not going to take a year.

01:14:33 Speaker 2

Oh

01:14:35 Speaker 1

The next go around because he's learned so much and I hope that our memories do us justice and serve us well, because let's not forget these lessons and let us remember them.

01:14:47 Speaker 1

And let's build so the next time around we're actually prepared and ready.

01:14:52 Speaker 2

Yeah, I think what you you mentioned something I think like the J&J, the single vaccine going. I think it's like one of the most.

01:14:52

Yeah.

01:14:52

01:15:00 Speaker 2

Misunderstanding like malign vaccine out there right now?

01:15:03 Speaker 2

But going into the arms of the homeless, I think, is is such an interesting strategy.

01:15:10 Speaker 2

I you know I don't want, I thank you so much.

01:15:12 Speaker 2

First of all for taking the time.

01:15:13 Speaker 2

It's been an honor so far, but I don't want to take too much of your time because I just wanted to ask a couple more since you brought him up.

01:15:20 Speaker 2

If you don't mind.

01:15:23 Speaker 2

Is there is a difference between a variant in a straight and correct like we have variance right now, but we don't actually have it, that's different.

01:15:33 Speaker 2

Strain is is that right?

01:15:37 Speaker 1

Can you repeat the question?

01:15:39 Speaker 2

I just wanted to ask like there there is a difference between a virus very and a virus strain, correct?

01:15:51 Speaker 1

It's a nuanced question.

01:15:53 Speaker 1

I'm not exactly sure what you're getting at, but variance just means that there is some tweak or modification and you know this gets really into genetics and biochemistry, but when you look at.

01:16:08 Speaker 1

Not.

01:16:09 Speaker 1

Any sort of like DNA or RNA structure, virus or bacteria?

01:16:15 Speaker 1

I mean, they're all including you and me constantly mutating, right?

01:16:19 Speaker 1

It's just that the vast majority are all silent mutations that mean nothing because so much of the code like you know the biggest library.

01:16:29 Speaker 1

Let's say the Library of Congress.

01:16:30 Speaker 1

The vast majority of the letters mean nothing, right, but so much of what's in there.

01:16:35 Speaker 1

The critical pieces.

01:16:36 Speaker 1

Now, if you accidentally tore out a page there, that's when it falls apart and stuff.

01:16:40 Speaker 1

The mutation occurs in one of those critical books in the Library of Congress.

01:16:45 Speaker 1

Now you're actually, you know.

01:16:48 Speaker 1

Missing that information or and it might have been very critical, right?

01:16:53 Speaker 1

So it might have been the way your body actually mounted the response, but now your body doesn't recognize that virus anymore.

01:16:58 Speaker 1

So now that virus gets away with sneaking in, you know.

01:17:01 Speaker 1

So that's where these the Corona is, the Crown.

01:17:05 Speaker 1

So those little thorny pokey things that you see on the model.

01:17:08 Speaker 1

I mean, that's what we're building.

01:17:10 Speaker 1

This vaccine around is to identify that so some points, and that's what we're worried about.

01:17:14 Speaker 1

These, like newer ones that are getting more affect infections like the Brazilian variants, have.

01:17:18 Speaker 1

They're getting through the door somehow.

01:17:20 Speaker 1

You know, they're sneaking past our system.

01:17:22 Speaker 1

And they're getting you know they're more highly infectious than what we've been used to so far.

01:17:27 Speaker 1

So that definitely is very frightening to us, but.

01:17:33 Speaker 1

Brain is a colloquial word that is not something we really use or describe.

01:17:38 Speaker 1

From my understanding, I do not have a PhD in biomolecular science.

01:17:41 Speaker 1

However, I will say that.

01:17:44 Speaker 1

No.

01:17:45 Speaker 1

I would say a strain is a word that we use much more colloquially.

01:17:50 Speaker 1

The truth is the science is mutations and there are mutations and some mutations matter more than others and that is our fear that there are critical mutations occurring that will result in something that we call antigenic drift.

01:18:06 Speaker 1

Where now your body doesn't recognize that molecule at all and that gets passed.

01:18:10 Speaker 1

Somebody who's been EE vaccinated and now they got covid right?

01:18:15 Speaker 1

So that's where we have to be ready, eyes wide open and woke and know what our blind spots and Blinders are.

01:18:23 Speaker 1

And we had many last January when Ruhaan doctors sounded the alarm and instead we silence them.

01:18:31 Speaker 1

That's why Doctor Abraham has been affected the whole time, because when I heard the Wuhan doctors and I was watching, I told Kevin Tobias with peas and be ready to gain change on the day the national emergency was declared that we had already moved our entire operation to remote operations telemedicine.

01:18:47 Speaker 1

Keeping patients away.

01:18:48 Speaker 1

Tell everybody to isolate.

01:18:49 Speaker 1

It's that very first week we went right into action.

01:18:52 Speaker 1

All because I listened to that doctor from move on and I posted as far as you go back and look at my face books that very.

01:19:00 Speaker 1

Early on I was like what the hell is happening and why are all those ophthalmologists in Wuhan dying of some weird respiratory illness? Then what was it about the wet markets or not and or what was it about the bioterrorism labs and or what was happening? And why was the WH or not being honest? And why was the Chinese government not being honest about what was happening?

01:19:20 Speaker 1

And why were all of us so?

01:19:24 Speaker 1

Of this is that Blinders, blindsided, blind?

01:19:25 Speaker 2

Yes.

01:19:28 Speaker 1

So.

01:19:28 Speaker 1

01:19:29 Speaker 1

Why were we not eyes wide open?

01:19:32 Speaker 1

Why were we not listening to the cries of doctors and move on?

01:19:36 Speaker 1

Why are we not doing more when we should have?

01:19:38 Speaker 1

It should have never gotten this far.

01:19:40 Speaker 1

That's the truth we lost months critical months between January and March.

01:19:45 Speaker 1

That we could have done a lot more early on and that may have played.

01:19:49 Speaker 1

That time last May very well have played the roles.

01:19:53 Speaker 1

The difference in whether or not we would have gotten so many variants and mutations that are now so highly infectious.

01:20:00 Speaker 1

Today it was bound to happen and it's going to happen.

01:20:02 Speaker 1

It's why we have a new flu shot every year, right?

01:20:05 Speaker 1

That is inevitable on that.

01:20:06 Speaker 1

Fine, but we didn't need to get to a place where.

01:20:10 Speaker 1

Millions of people around the world get covid and die.

01:20:16 Speaker 1

If we had just responded sooner and control that that's the CDC, the Centers for Disease Control and Prevention.

01:20:25 Speaker 1

This is an infection control strategy.

01:20:28 Speaker 1

Should have been controlled and squashed, and then everything we do to prevent including widespread vaccination programs, you know, place their parts, so hopefully that.

01:20:38 Speaker 1

Kind of helps answer your question, but it's a highly contentious one.

01:20:41 Speaker 1

It's one that I know there's a lot of scientific debate and discourse and possible discord around, but one that I cannot answer simply, and I won't.

01:20:51 Speaker 2

OK, no and then I thank you that you did it and.

01:20:55 Speaker 2

Just finally, you know, we're one of like outside of Europe we're the only country that doesn't have a region that doesn't have the Astra Zeneca one, and that one is slightly different, right?

01:21:07 Speaker 2

'cause it's not just M RNA, it actually is more like a little bit of old fashion that it has a little bit of the.

01:21:14 Speaker 2

The the virus.

01:21:17 Speaker 1

No, to clarify, AstraZeneca is a vaccine I believe brought out of Oxford University in the United Kingdom.

01:21:25 Speaker 1

It is used around the world.

01:21:26 Speaker 1

The concern there it is very similar to Johnson, Johnson and that they are adino virus vector vaccines.

01:21:35 Speaker 1

So that means there's a virus, a vector, a little bit of a virus.

01:21:39 Speaker 1

Not the covid virus of a harmless adino virus that doesn't really cause any disease in human adults.

01:21:46 Speaker 1

Odino virus causes certain restaurant on this in children, usually baby.

01:21:50 Speaker 1

But again, a very benign comma.

01:21:53 Speaker 1

She will but Adino virus.

01:21:55 Speaker 1

It helps us get in to the body and helps immune system.

01:22:02 Speaker 1

Now identifying that inside that vector.

01:22:05 Speaker 1

So imagine a circle, a cap said.

01:22:07 Speaker 1

So you've got a circle of RNA or DNA.

01:22:11 Speaker 1

And then it was already adino virus.

01:22:13 Speaker 1

Then we just modify it by injecting a little piece of the identity of coronavirus.

01:22:18 Speaker 1

Specifically that CAP said or the Corona, the proteins that the spike proteins, right is what we're trying to Mount for a recognition.

01:22:28 Speaker 1

Pattern immunologically for you.

01:22:31

Do it.

01:22:31 Speaker 1

Take this harmless adino virus and you put a little piece of RNA, not coronavirus.

01:22:38 Speaker 1

You're putting the books.

01:22:40 Speaker 1

The letters from the Library of Congress into that circular molecule, and then that goes in, and now your body recognizes.

01:22:46 Speaker 1

Oh, what is this spike?

01:22:48 Speaker 1

And now your body starts.

01:22:49 Speaker 1

Building antibodies to that spike, but the problem with the Astra Zeneca vaccine, which we do not use.

01:22:55 Speaker 1

the United States have not been approved yet because it's been shown.

01:22:59 Speaker 1

Beach less efficacious and specifically they stopped using it entirely in South Africa because the South African Spring was not susceptible. This vaccine was not effective at preventing the South African strains, so pretty quickly, Astrazeneca's vaccine fell out of favor because.

01:23:07 Speaker 1

Right?

01:23:07 Speaker 1

01:23:20 Speaker 1

It was not protecting us as much as the Materna, Pfizer and Johnson and Johnson Unite. Remind everyone that all three of these have gone through the US food.

01:23:32 Speaker 1

Drug Administration advisory panel and have achieved emergencies authorization.

01:23:38 Speaker 1

They have met the highest bars of an accelerated process so that we can end the epidemic that is a national emergency.

01:23:45 Speaker 1

But every one of those that it leaves that advisory panel approval and it sees the emergencies authorization.

01:23:53 Speaker 1

Is the vaccine that I will put into anyone's arm, including myself and whatever vaccine you are on.

01:24:00 Speaker 1

For when it is available, we've answered your questions and you have no medical contraindications to this vaccine.

01:24:06 Speaker 1

You roll up your sleeves and you take that Pfizer or Maderna or Johnson and Johnson such that it's Southeast line and that is my line too, and I stand with our scientists and our public health.

01:24:20 Speaker 1

At our healthcare scientists leaders, brightest minds, and that is exactly what I believe.

01:24:28 Speaker 1

And I stand a doctor.

01:24:29 Speaker 1

Rahm Emanuel, White House adviser.

01:24:32 Speaker 1

You know on Kovid.

01:24:34 Speaker 1

She said the exact same thing literally yesterday he called because he was like welcome to Washington.

01:24:40 Speaker 1

Look forward to hearing your testimony on Tuesday and we talked about this exact issue.

01:24:45 Speaker 1

Be prepared for people wanting to shift focus to, well, you're sending a less effective vaccine and this and that distraction.

01:24:55 Speaker 1

Pieces on Gavin Newsom distractions.

01:24:57 Speaker 1

Trying to find somebody to blame for a bust vaccine rollout?

01:25:01 Speaker 1

Distraction, Yep.

01:25:02 Speaker 2

Back

01:25:03 Speaker 1

Found out yesterday that the only thing that matters and just about you said and just from a manual has been just.

01:25:08 Speaker 1

On it.

01:25:08 Speaker 1

01:25:09 Speaker 1

Doctor Abraham is said whatever vaccine you are offered.

01:25:13 Speaker 1

You roll up your sleeves and you take that shot.

01:25:15 Speaker 1

If you are eligible and you have no.

01:25:16 Speaker 1

Contraindications.

01:25:18 Speaker 2

OK.

01:25:19 Speaker 2

Well, you have given me a lot to write about and a lot to think about.

01:25:23 Speaker 2

But yeah, once again I think that those are all the questions I have and I thank you again for taking the time to answer them.

01:25:33 Speaker 2

And you know, for another story.

01:26:04 Speaker 2

If you're willing some sometime in the future, I'd like to talk to you about the connection between the pandemic and mental health.

01:26:18 Speaker 1

You know you're gonna be crying talking about this, but we are a safe haven, a safe harbor for people and I don't ever want to hear somebody took their life, specially not because of this pandemic.

01:26:30 Speaker 1

I do have a personal story, you know, we have our own struggles.

01:33:57 Speaker 1

Yes, thank you Francisco.

01:33:59 Speaker 1

Enjoy your weekend.

01:34:00 Speaker 1

Will talk real soon.

01:34:00 Speaker 1

I'll send you an email now.

01:34:02 Speaker 2

Absolutely, I'll send this to you as soon as it's converted.

01:34:05 Speaker 1

OK great bye.

01:34:06 Speaker 2

Awesome.

01:34:07 Speaker 1

Thank you, Ciao.

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California will reserve 40% of COVID-19 vaccine for disadvantaged areas to speed reopenings

Drivers wait at the mass COVID-19 vaccination site at Dodger Stadium in January. (Irfan Khan / Los Angeles Times)

By RONG-GONG LIN II, LUKE MONEY

PUBLISHED MARCH 3, 2021 **UPDATED** MARCH 4, 2021 1:30 PM PT

SAN FRANCISCO — In a major shift in policy, California officials said Wednesday night they will now devote 40% of available COVID-19 vaccines to residents in the most disadvantaged areas in a move designed to both slow the spread of coronavirus and speed up the reopening of the economy.

After roughly another 400,000 doses are administered to people who live in California's hardest hit communities — which could happen within the next two weeks — officials in Gov. Gavin Newsom's administration said the state intends to significantly relax the rules for counties to exit the most restrictive tier of California's coronavirus reopening blueprint.

The shift comes amid mounting evidence that Latino and Black communities are falling behind white and Asian ones in getting access to the vaccine. This has sparked concern in part because those underserved communities have been hardest hit by COVID-19. They are home to many essential workers, who have contracted the virus on the job and then spread it at home.

But the move adds yet another shift in the state's rocky vaccine rollout, which has been marked by big shortages of supply. It comes at a time when more people are becoming eligible for immunizations.

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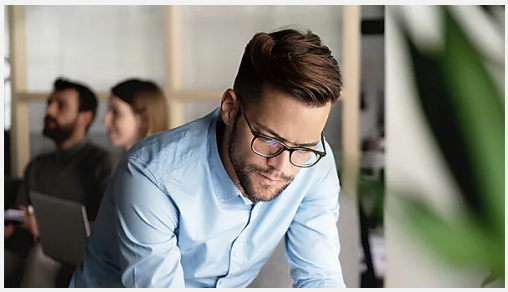
In a few weeks, the state will expand eligibility to millions of people with underlying health problems and disabilities. With large amounts of vaccine now reserved, there will be less to go around to other groups. Officials are hoping for major boosts in vaccine supply in the coming weeks.

Newsom himself foreshadowed the concept during a briefing in Long Beach early Wednesday afternoon, though he did not offer specifics at that time.

"We want to incorporate vaccination rates into the tiering, and that will allow people to move more quickly through the tiers," he said.

Currently, 1.6 million COVID-19 vaccine doses have been administered to individuals who live in the state's hardest-hit communities — specifically, those in the lowest quartile of the California Healthy Places index, a measure of socioeconomic opportunity that takes into account economic, social, education, housing and transportation factors.



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Once 2 million doses have been administered in these communities, the state will relax the threshold by which a county can exit the most restrictive purple category of the

restaurant dining rooms, gyms, museums, zoos and aquariums.

In Southern California, targeted communities would include South Los Angeles, the Eastside, Koreatown, Chinatown, Compton, southeast L.A. County, the eastern San Fernando Valley, Santa Ana, and a number of heavily Latino communities along the Interstate 10 corridor between Pomona and San Bernardino.

Administration officials said that quartile consists of roughly 400 different ZIP codes sprinkled throughout the state, though many of them are in the Central Valley and in and around Los Angeles County.

Counties' tier assignments are based on three criteria: average daily case rates, adjusted based on the number of tests performed; the testing positivity rate; and a health equity metric intended to ensure that the positivity rate in poorer communities is not significantly worse than the county's overall figure.

Currently, counties generally must have an adjusted daily coronavirus case rate at or below 7.0 new cases per day per 100,000 people to move from the purple tier to the more permissive red tier.

After the state achieves its 2-million dose goal, however, counties with a case rate of up to 10 new cases per day per 100,000 people will become eligible for the red tier.

The change in policy stands to accelerate the movement for many Southern California counties, allowing them to broadly reopen their economies sooner. Under the new proposed rules, L.A., Orange and San Bernardino counties would already be eligible to exit the purple tier, while Riverside, Ventura and San Diego counties would also be close to qualifying.

Per 100,000 residents, L.A. County currently has an adjusted daily case rate of 7.2; Orange, 7.6; Riverside, 11.3; San Bernardino, 9; San Diego, 10.8 and Ventura, 10.6.

Once a total of 4 million doses are administered to these lower-income communities, state officials will also relax the thresholds for entering the subsequent tiers, the orange and yellow tiers. However, they did not specify what those new thresholds would be.

The orange tier would allow sports fans to return to outdoor professional sports venues and allow indoor family entertainment centers like bowling alleys and escape rooms to reopen; the yellow tier allows large theme parks to reopen.

“Even with these steps, we will still have some of the strongest public health protections … in the nation,” said one Newsom administration official.

CALIFORNIA

Column: Of course, Californians misused vaccine codes. The system is designed for cheating

Feb. 24, 2021

Administration officials confirmed that the state's previously announced dedicated dose share for educators — 10% of California's weekly allotment — will remain in place.

Providers throughout California have administered more than 9.4 million total COVID-19 vaccine doses to date. Though the state has worked to ramp up how quickly available shots are going into arms, tens of millions of residents are still waiting for their turn in line.

Along with promoting equity in the state's vaccine rollout, the administration officials said the plan discussed Wednesday is pragmatic. Vaccinating those most at risk of being victims or vectors of the coronavirus will help stymie its spread. Plus, vaccinating significant numbers of people better armors the wider community against widespread transmission — meaning the thresholds to more widely reopen businesses and public spaces no longer will need to be as strict.

Though she said she wasn't privy to the specifics of the proposal, Los Angeles County Public Health Director Barbara Ferrer said Wednesday afternoon that she thinks it would make sense for vaccinations to play some kind of role in guiding the reopening process.

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"Once you are vaccinating millions and millions of people, you need to take that into account as you determine the safety of a variety of activities," she said during a briefing

Wednesday. “I think that’s completely appropriate. I mean, we said that all along: vaccines are, in fact, a game changer. But you have to have lots and lots of people getting vaccinated before it’s going to make a big difference.”

State officials are targeting COVID-19 vaccinations for people who live in the lowest quartile of the California Healthy Places index, places that are generally lower income, have crowded housing and have been hit hardest by the pandemic. (California Healthy Places Index)

Lin reported from San Francisco; Money from Long Beach.

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Big Pharma Shouldn’t Control Covid-19 Vaccines

laprogressive.com/control-covid-19-vaccines/

March 6, 2021

At a recent virtual gathering of parents and faculty at my children’s school, one parent who is a teacher and therefore eligible to receive a COVID-19 vaccine mentioned that she got her first Pfizer shot at a local pharmacy, and when she asked about a leftover dose that could be given to her husband rather than thrown away, her husband got lucky. The rest of us parents eagerly took down the drug store’s information and called about leftover doses after the meeting. Better for the vaccines to be dispensed than thrown into the trash, was our logic. But the pharmacist, perhaps tired of being hounded about extra doses, informed us they would no longer give them out to those who weren’t currently eligible.

It’s the vaccine Hunger Games. Or, as the creator of the Minneapolis Vaccine Hunter Facebook group told the New York Times, “It’s like buying Bruce Springsteen tickets.”

In the private Los Angeles Vaccine Hunter Facebook group in which I lurked for a few days, both as a bona fide member and as a journalist, I observed Southern Californians sharing tips about how to obtain leftover doses at Kedren Community Health Center in South Los Angeles, a private clinic serving a vulnerable community. Vaccine hunters reminded one another to be polite and considerate to the community they obviously did not hail from, and some even said they made a donation after getting their shots. Obtaining leftover doses requires standing in a separate line, sometimes for hours, with no guarantee of getting a vaccine. Many fear being judged.

> **While a public desperate for protection against COVID-19 is quick to shame "vaccine hunters," the real culprits are the companies refusing to share their publicly funded intellectual property and the governments allowing them to get away with it.**

There is shame and blame all around. There are accusations that those who are privileged are cutting ahead of others. There is disappointment and unfairness. In January, journalists like me were included in an early "tier" of eligibility in California, classified as essential workers under "Communications and IT." As a daily television and radio show host, I am required to come into contact with at least one staff member daily. News reporting cannot stop. And yet by February, the eligibility had disappeared as Los Angeles County reconfigured its eligibility tiers.

In the meantime, my husband, a work-from-home scientist, is classified as an "educator" because he is employed by a university. Although in-person classes will not resume until the fall on many campuses, he and others like him are eligible to get the vaccine now simply because county authorities decided so. As one vaccine hunter asked on Facebook, why are we "letting the government dictate who gets to live or die, and labeling who is essential and who is not essential to society"?

And yet, even for those who are eligible, finding a vaccine has turned into a blood sport. The conservative Wall Street Journal recommends that elderly Americans who may not be tech-savvy should simply "Recruit a College Kid with Tech Skills and Patience," to navigate the "bewildering field of online portals and limited supplies."

So far in California, most of those who need vaccines the most have not received them. According to the Associated Press, "African Americans have received 3% of vaccine doses while they make up 6% of the state. Latinos, who make up 39% of the state, have received 17% of doses." Meanwhile, Republican-led states like Texas and Mississippi are ending all quarantine and safety requirements, well before vaccination rates are at safe levels.

Given the extreme difficulty in obtaining a vaccine, authoritative exhortations by officials "to get a shot if it's offered to you" and to set aside any guilt about who deserves it and who is cutting in line ignore the real problem: we live in a nation where health care is considered an individual privilege by way of employment, not a right. Health care in the United States is considered an industry where profits are a critical priority over the delivery of care.

At the heart of the desperate stampede to obtain vaccines is one simple dilemma: there aren't enough vaccines against COVID-19 being produced. Variants of the virus are developing faster than nations are able to inoculate their populations, and plummeting infection rates in the U.S. have now leveled off.

Part of the problem is that former President Donald Trump, who quietly got vaccinated recently and wants all the credit for vaccine development, last year turned down the chance to purchase additional Pfizer vaccines beyond the first 100 million doses. After President Joe Biden threatened to invoke the Defense Production Act to force Pfizer and Moderna to produce more vaccines, the companies agreed to sell more doses faster than had been agreed upon.

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>
> — Dick and Sharon (@DickandSharon) March 5, 2021

Also showcasing that governments can indeed force private companies to do what is needed, Biden more recently brokered a deal with the pharmaceutical company Merck to produce extra doses of a new vaccine developed by Johnson & Johnson. Merck is being paid handsomely with $268.8 million of taxpayer funds. Biden has also invoked the Defense Production Act to help the company obtain the supplies it needs. Had Trump last year used the might of the U.S. government against these private companies, we might not be fighting to sign up for vaccines today.

Pharmaceutical companies whose vaccines were funded by massive public investments still refuse to share their intellectual property with the world. The Open COVID Pledge, created by a group of academics and scientists to make virus-related technology freely available, has urged corporations to prioritize public health over profit. But notably absent from the pledge's list of signatories are Pfizer, BioNTech, Moderna, Johnson & Johnson, or Merck.

The United States and other nations where these pharmaceutical companies are based could force them to share the life-saving information, especially because doing so keeps all of us safe. Unless nations stop all international travel across borders, hoarding vaccine technology from the rest of the world will not help anyone. The old adage of "no one is safe until everyone is safe" applies especially well to the pandemic.

Journalists with the Associated Press say they found three factories on three continents that could begin manufacturing "hundreds of millions of COVID-19 vaccines on short notice if only they had the blueprints and technical know-how." Except that such "knowledge belongs to the large pharmaceutical companies who have produced the first three vaccines."

Instead of blaming and shaming one another over the frustrating lack of vaccine availability and the individual race to obtain it, Americans ought to turn their gaze to the companies that are manufacturing the products. Pfizer and Moderna have earned near-mythical status for

the life-saving vaccines, but it behooves us to remember that these private entities were paid handsomely to do their job and cannot be allowed to hold humanity hostage over their profits.

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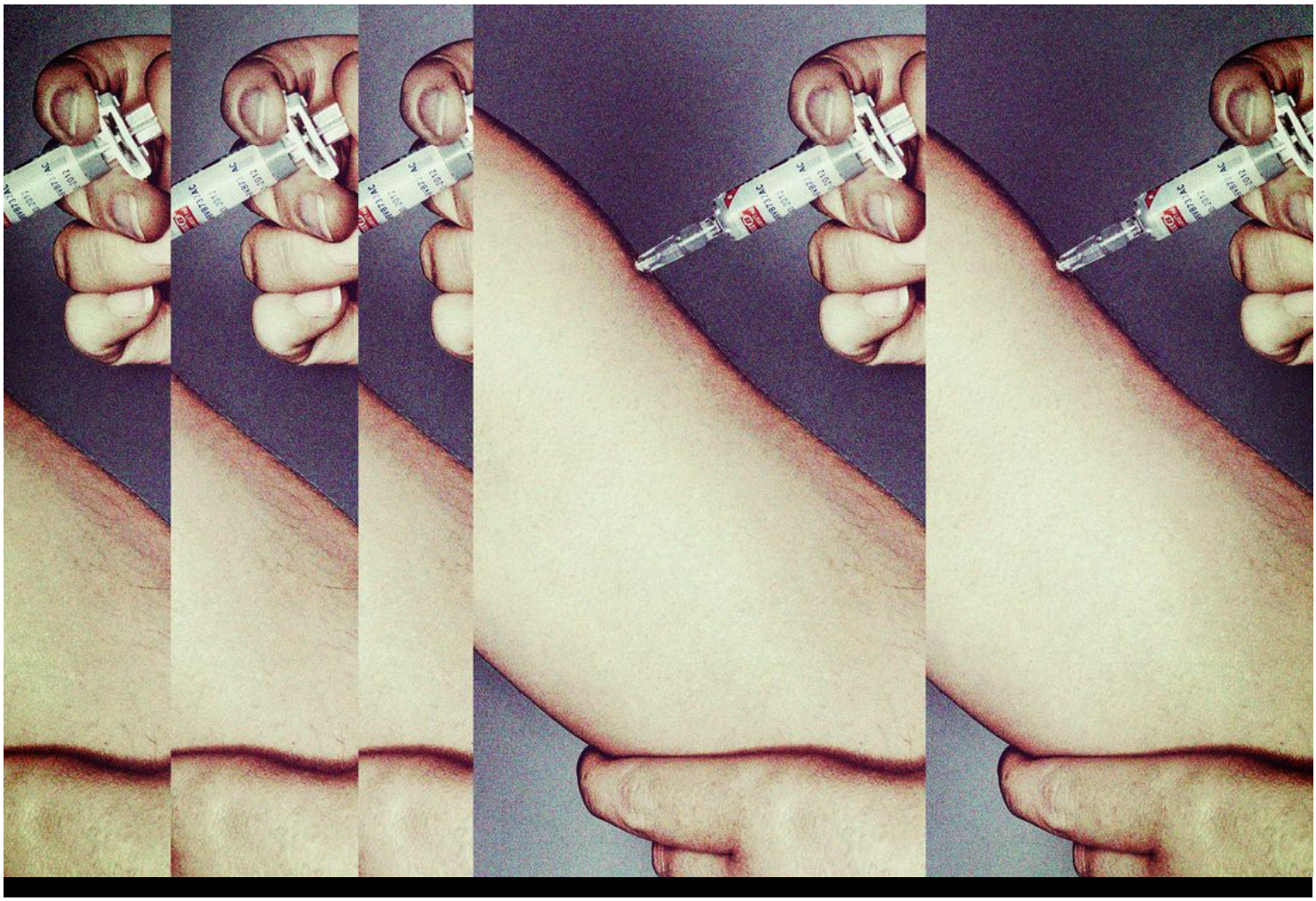

CORONAVIRUS | JAN. 21, 2021

'I Feel Like I Got in Through a Side Door' Five people who lucked into a COVID vaccine dose talk about their complicated feelings.

As told to Angelina Chapin @angelinachapin

Photo-Illustration: by Stevie Remsberg; Photos: Getty Images

The government's botched vaccine rollout has meant that many vulnerable Americans aren't

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that crash. But while the Trump administration completely blew its end-of-year goal to vaccinate 20 million mostly frontline workers and elderly people, a dystopian subplot has emerged: Relatively young, healthy adults who are currently ineligible for the vaccine have randomly lucked into extra doses that were set to expire (unfrozen vials of both FDA-approved vaccines are useless after six hours).

If someone doesn't show up to a scheduled appointment, those who are in the right place at the right time (a pharmacy, or even a street corner near a vaccination site), or who have the right personal connections (a nurse friend), get a coveted immunity that would otherwise go to waste. The phenomenon is becoming more common and deliberate, with lines forming outside of D.C. pharmacies and hundreds gathering at Brooklyn vaccination sites, like concertgoers hungry for rush tickets.

Some consider these shameful stories of people leapfrogging over those in desperate need. But medical ethicists agree that anyone lucky enough to get a vaccine should take it. Turning down a shot does nothing to solve the federal government's flawed system, which didn't even give states the money or guidance to plan for extra doses. Still, the backdrop of mass death and bureaucratic incompetence has left the randomly vaccinated with complicated emotions. The Cut spoke with five of them about how the relief of immunity is mixed with guilt and anger.

"I knew the right person, and I was able to be in the right place at the right time." —*Richelle Carey, 40s, Texas, Journalist*

One of my relatives has a nurse friend who gave my family a heads-up that she might be able to get us the shot if the hospital ends up with extras. She never knows if it's available until the end of the day. My 65-year-old mom got vaccinated first and texted me one or two days later to say, "I think she's going to contact you." After a few minutes, I got a message from the nurse that said, "If you can be here before five, we can do this." I got dressed immediately.

I was obviously excited. But I actually grappled with feeling a little guilty because I'm not in the high-risk group. I feel like I should be at the back of the line. I knew the right person, and I was able to be in the right place at the right time — that's how a lot of the world works. That

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Now my aunt is in the hospital with COVID, and I'm like, *Whoa, should I have taken her to get it instead?,* which actually just wasn't logistically possible in the time I had. I feel bad that I have the vaccine, and my cousin's 70-something-year-old uncle who is in terrible health hasn't been able to get it. That is gut-wrenchingly sad and enraging. It shouldn't be this hard for anybody. I've been trying to schedule shots for some of my older relatives, and I can't. So my family has made it known to this nurse that if you have any more extras, we would like to get some.

I was hesitant to tell my small circle of friends or shout from the mountaintops that I happened to get lucky. It felt kind of insensitive. But when I posted my news to social media, people responded by saying they were having similar experiences, and I thought, *Okay, I don't have anything to be ashamed of.* I have chosen to try and squash those feelings of guilt because it's not healthy. They come from how dysfunctional the whole process is. If the Trump administration had been competent and cared, none of this would be as bad. And, actually, quite frankly, I have gotten a little closer to just feeling relieved that I have it.

Student

My parents were driving me from D.C. to check into my NYU dorm the start of second semester. We were running an hour and a half late, which I thought would delay my mandatory COVID-19 test and the start of my quarantine. I step out of the car and start stretching, and 40 seconds later, this guy runs out of the alley next to my dorm. He comes up to us and is like, "Do you want to get vaccinated for COVID?" And I'm thinking, *Yo, what? Who is this guy? Is this real?* I just kind of look to my parents and I'm like, "Ugh, you guys want to get vaccinated?" But they already had COVID-19 and were just so passive about it. The guy was so frantic! He's like, "We have one dose up, you gotta come!" He told me later he was running throughout the streets trying to find people. So we're sprinting down this dark alleyway to the vaccination building. In the back of my mind, I was like, *Is this a scam?* Like, this would be a really good time to kidnap me. I'm a very trusting person at times, but it helped that he was wearing a face mask, face shield, and a bright orange vest. It seemed like he was a legit worker for a vaccine center.

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kidding. This random dude picked me up off the street and is letting me get the COVID vaccine 'cause they were gonna waste it WTFFFFF." My friends started FaceTiming me. They are letting me come back in 28 days for a second dose, which is crazy — there's no take-backsies.

I was really ecstatic. This stuff is gold. It's the most-wanted thing in America right now! I started talking with Justin, the guy who brought me over, and he was saying how frustrated he's been the past couple of weeks seeing the doses get thrown out. No vaccine is wasted if it goes in someone's arm. It could save a life, even if the shot should have gone to a more high-risk person.

Someone at my school posted to Instagram, "If you weren't supposed to get the vaccine until much later, but you managed to anyway, don't brag about it. You look like an a-hole." She was obviously referencing me, since I had posted about it. My reaction was that she was kind of meaninglessly virtue-signaling. This is not to shame her; we had a conversation. But I don't feel that I was bragging about getting the vaccine or talking about it in an arrogant way. I meant to express the randomness of the story and spread awareness about the vaccine so that people trust it.

I actually don't feel guilty for a very specific reason: I am just a lucky bystander who benefited from a systemic issue. Instead of personal guilt, I feel ashamed that something like this can happen. And I feel the collective frustration of the people who have been trying to get an appointment and they couldn't, especially in poor Black and brown communities. I got the vaccine through luck. I didn't pay my way in. My dorm happened to be in proximity to this vaccination center, which was in a more affluent area of Brooklyn, and that's where the privilege may come in. But I wasn't someone who had some kind of backdoor access.

"I texted her and was like, 'I can't. This feels so wrong.'" —*Susan*, 50, Washington, D.C., Journalist*

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patients who we think are vulnerable, and nobody wants it. If you come in the next hour, you can have it." My little 12-year-old son was home and he was like, "Go, go, go, go now!!" I literally left the house in my slippers. I had a kind of like Harry Potter–like notion in my mind of steam coming out of some potion that was going to expire any minute.

This doctor was an acquaintance of mine and called because she knew I have diabetes. She could have given it to her sister or best friend or whatever. There are people more vulnerable than me, but it wasn't just random. I texted her and was like, "I can't. This feels so wrong. Isn't there anyone else?" And she was like, "I have tried everyone. You're welcome not to come, but I'm going to throw it away."

The day I got it, there was a weird injection of hopefulness, like this sort of rom-com moment where there's glitter and everything. I haven't felt that free and light in months. At the same time, I feel like I got in through a side door. It reminded me of when I was in Russia in the late '90s asking someone, "How would I get that soft bread?" It was like: If you talk to this person or that person and put yourself in just the right place, then you'll get the soft bread. I was also wondering, *Why aren't her patients doing it? Is there some weird inequality even in the fact that she was calling me because she knows I will not be vaccine resistant?* I felt guilty because this is somebody who can reach me on my cell phone and knew that I would, and could, come right away. This doctor works in a clinic where her patients are mostly Black. She and her colleagues had tried to give the extra vaccine to those who are deeply vulnerable because they are wildly overweight, very diabetic, or have lung, breathing problems and offered to pick them up in a car. They went around and asked everybody sitting in the waiting room. And everyone they asked said no. So when you talk about feeling guilty, I'm basically benefiting from the kind of suspicion particularly poor Black people have toward a racist health-care system.

The vaccine hasn't radically changed my life. I do have diabetes, and it just keeps me from feeling extremely vulnerable. Otherwise, nothing's open, and none of my friends are vaccinated. There's not like a secret underground restaurant where all the vaccinated people can hang out and party.

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I got the vaccine on New Year's Day. My friend and I were picking up some ingredients at a Giant Food to make coconut-chickpea curry for dinner. As we're walking up to the pharmacy, we see a staff member offering the vaccine to an older lady. The woman was hesitant and confused. She said something like, "I just don't know enough about it." So the pharmacist turned to my friend and I and said, "Hey, I have two doses of the Moderna vaccine. We're closing in ten minutes, and if I don't give them to someone, then I have to throw them away. Do you want them?" I was just like, "Yes." No hesitation there.

I was very, very excited. It felt like winning the lottery. We had just walked in to get groceries and walked out holding a million dollars. I posted a video of me getting the shot to TikTok, which went viral. A lot of people have messaged me to ask where the grocery store is, and it's obviously not great for them to be waiting in line for eight hours to try and get lucky. But I'm glad people are excited. The fact that the woman ahead of me at the pharmacy was hesitant made me want to talk more about it. The only reason I was in this position was because someone else was afraid of the vaccine. I grew up in an anti-science, anti-medicine, anti-government kind of Evangelical cult community. Now I have a degree in physics and have spoken out about vaccine safety.

I don't work in any sort of health-care context. And the pharmacist who gave it to me said she hadn't even been vaccinated, which is absurd. I didn't ask why, but that really surprised me. I was like, "Oh, wow, so you are looking out for other people before taking it yourself." But I have young twins who are premature, so their lungs are a little more susceptible. Knowing that I'm not going to give them COVID made me feel happy. I've thought about whether I should feel conflicted, but there was only ten minutes before the pharmacy closed. Had there been more time, maybe I would have said, "Well, let me see if there's someone else who wants it." Honestly, I probably would have still taken it and then felt guilty that I should have done something different.

But, you know, the vaccine rollout has been so poor that just knowing someone's getting it is valuable. And, to me, that kind of outweighs any other feelings. The fact that there's no support to create some sort of a backup list for extras is ridiculous — the CDC could have known that this would be an issue. I'm a little worried about my second dose because

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definitely something that I'm concerned about. I'm happy I got the shot, but I wish it had been for a good reason, rather than as a symptom of just abject government failure.

"There's no guilt in that situation." —*Hannah Frishberg, 26, New York, Reporter*

A few weeks ago, I went to get a COVID-19 test at a clinic in Brooklyn. I was waiting in the lobby to be called, and I overheard a man on staff whispering to his colleague that there was an extra vaccination dose. "Is there anyone in the building who wants it?" I started jumping and saying "Me!," and he seemed kind of surprised by my sheer joy and giddiness. But he nodded and led me upstairs to the place where they were vaccinating people. I made sure that I wouldn't feel guilty by asking if there was anyone else around who was more eligible or vulnerable than me. He was like, "No, the clinic is closing." The only person ahead of me was the trash cans. I mean, wasting a dose versus giving me a dose? There's no guilt in that situation.

It felt like such a historic moment. I wouldn't shut up and was just rambling about how grateful I was that the nurses didn't waste the shot. A representative from New York's Department of Health told me they were disgusted by what happened and are launching an investigation into this clinic. [In Frishberg's piece, the DOH said: "It appears this clinic did not follow state guidance which clearly spells out specific steps providers must take to ensure all doses are properly distributed."] I think it's pathetic. I think it's horrific the way that nurses have continually had to bear the brunt of governmental failure throughout this pandemic and interpret an impossible web of contradictory guidelines. It's become a kind of Kafkaesque nightmare where paperwork and eligibility are being prioritized over saving lives and vaccinating as many people as possible.

**Interviews have been edited and condensed for clarity, and some names have been changed.*

TAGS: VACCINE EXTRA VACCINE EXTRA DOSES VACCINE EXTRA DOSE VACCINE VACCINE PHARMACY MORE

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THE LATEST

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Q&A | 1:09 P.M.

Advice From *Bling Empire*'s Most Mysterious Billionaire Anna Shay on rude guests, skin care, and body oil.

By Sangeeta Singh-Kurtz

11:48 A.M.

What Does It Mean If You're Dreaming About Drowning?

10:37 A.M.

Pamela Anderson Secretly Married Her Bodyguard?!

MY TWO CENTS | 9:30 A.M.

'My Sister Is So Cheap and It's Driving Me Nuts!' She might not know better, or she could just be a jerk. You won't really know unless you talk to her.

By Charlotte Cowles

9:00 A.M.

Seeing Myself in *WandaVision*

YESTERDAY AT 8:27 P.M.

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YESTERDAY AT 6:31 P.M.

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YESTERDAY AT 5:54 P.M.

I Knew This Conditioner Was 'The One' After One Wash

YESTERDAY AT 5:32 P.M.

Congresswoman 'Liked' Posts About Executing Prominent Democrats

YESTERDAY AT 5:14 P.M.

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YESTERDAY AT 1:17 P.M.

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YESTERDAY AT 12:45 P.M.

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YESTERDAY AT 12:31 P.M.

This Is the World's Strongest Argument for Deleting Instagram

THE CUT PODCAST | YESTERDAY AT 11:05 A.M.

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By the Cut

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