MEETING OF THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP)
Centers for Disease Control and Prevention (CDC)
Virtual Emergency Meeting
December 19-20, 2020

Excerpt: Public Comments

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Overview

The floor was opened for public comment prior to the Moderna COVID-19 Vaccine vote on December 19, 2020 and prior to the Allocation of Initial Supplies of COVID-19 Vaccine Phases 1b & 1c vote on December 20, 2020. The comments made during the meeting are included here. Members of the public were invited to submit a written public comment to ACIP. Written comments could be submitted through December 21, 2020. Comments for the December 19-20, 2020 ACIP meeting are identified by Docket No. CDC-2020-0124 using the Federal eRulemaking Portal. Go to http://www.regulations.gov for access to the docket or to read background documents or comments received.

Moderna COVID-19 Vaccine

Joshua Manson, Researcher
UCLA Law COVID-19 Behind Bars Data Project
University of California, Los Angeles

Thank you very much for this opportunity to speak at this important meeting. My name is Joshua Manson. I am a researcher at the UCLA Law COVID-19 Behind Bars Data Project. Dear members of the CDC's Advisory Committee on Immunization Practices, since the start of the pandemic, our team of data scientists and researchers has been collecting COVID-19 infection and death data in prisons, jails, immigration detention centers, and youth facilities directly from their respective agencies. This week, we convened around 400 experts in bioethics, the treatment of infectious diseases, public health, epidemiology, and criminology to urge this committee to prioritize incarcerated populations, including those in immigration detention and correctional staff, including on-site health care providers (HCP) to receive COVID-19 vaccine. The signatories to this letter are concerned that nearly half of states' plans do not mention incarcerated people as a high priority group. We firmly believe that incarcerated people and staff in carceral facilities must receive equal treatment to each other and to other populations living and working in congregate settings. During today's session, I'd like to briefly highlight four points. First, this pandemic has brought devastating consequences on the more than 2 million incarcerated individuals in this country and the many employees who work every day in jails, prisons, and other detention facilities. Roughly 250,000 incarcerated people have been infected by COVID-19 and close to 1,600 have died. More than 53,000 correctional staff have been infected and over 90 have died. Incarcerated people are 5 times more likely to become infected with COVID-19 and 3 times more likely to die from it as compared to their non-incarcerated same age peers. This week, The Marshall Project reported that 1 in 5 people incarcerated in state and federal prisons in this country has tested positive for COVID-19—a rate more than quadruple that as the nation as a whole. Because social distancing is often impossible in overcrowded facilities, when the virus enters an institution it spreads rapidly. For example, last month in the state prison in Lake County Kentucky where about 753 people are incarcerated, there was a dramatic spike from zero cases to over 600 in a 2-week period—an infection rate of 86%. Second, carceral facilities are critical vectors of COVID-19 transmission to surrounding communities. This places a particularly devastating strain on rural health systems. For example, in the county where the Kentucky prison I just mentioned is located, there are no major hospitals. The nearest one has only 25 critical care beds. Third, incarcerated people and staff should be similarly prioritized to receive the vaccine contrary to the preliminary plans of some states and the Federal Bureau of Prisons (BOP) which prioritize staff. Both populations are highly vulnerable to contracting the virus and both will continue to transmit as long as they live and work in congregate settings. Over 12 million people enter or are released from a prison or jail every year and each day, employees return home to neighboring communities. Because of

this constant churn, both incarcerated people and staff will continue to spread the virus into the broader community. In light of the historical legacy of medical experimentation, the reality of COVID control in carceral environments and the deep distrust incarcerated people and their families feel toward correctional authorities, careful steps must be taken to respect the autonomy . . . (time expired).

Charles Lee, MD, JD, MBA
President-Elect
American College of Correctional Physicians

Good morning or good afternoon. I am Charles Lee, the President-Elect of the American College of Correctional Physicians (ACCP). I would like to speak on behalf of the inmates and workers in correctional facilities. I have no conflicts. I would like to start by echoing many of the exact points that the previous speaker just made and they all bear repeating. As we know by the daily news outlets and newspapers, coronavirus is significantly increasing throughout the United States (US), especially in correctional facilities. We know why this is happening. Where else other than in a correctional facilities do you see congregate living? Perhaps in homeless shelters; however, those in homeless shelters can go outside if they choose. There is a significant increase in minorities in correctional facilities at a rate of 3 times that of the general population. Many of the inmates are older and elderly with many comorbidities. This has been significant because they have previously not had medical care and are undiagnosed and untreated. They are unable to abide by the CDC regulations. They cannot socially distance. They may not get masks. They may not get hand sanitizers. A correctional facility is an extremely difficult place to work. Many of the correctional officers, by necessity as a result of their job, must have physical contact and interactions with inmates. As was previously mentioned, this affects more than just the correctional facilities. It affects our community. It affects our community healthcare facilities. There are limitations of what treatments patients can receive in a correctional facility. They must be referred out to clinics, emergency rooms, hospitals, and intensive care units (ICUs), thereby placing an increased burden on those facilities—sometimes at the expense of community people. There are increased costs of this to the cities, the states, and the federal government all born by taxes. We commend the ACIP for looking at this and we hope that they approve the Moderna vaccine. It is needed. There is inadequate supply presently. We need more. We also hope that during tomorrow's discussion that the ACIP consider inmate workers and inmates and elevate them to Phase 1b and 1c as the committee deems appropriate. Again, we thank you for this opportunity to express ourselves on behalf of the inmates, correctional workers, and the physicians and medical providers and care for them. Thank you very much.

Meredith Whitmire
Policy and Advocacy Director
National Association of Nutrition and Aging Services Programs

Meredith Whitmire, Policy and Advocacy Director for the National Association of Nutrition and Aging Services Programs (NANASP). Thank you for the opportunity to speak. On behalf of our organization and the 4 million older adults our members serve every day, we commend you for your excellent COVID-19 work and decisions made to date. I am commenting today to make several requests of this panel. My first request is also reflected in a comment submitted yesterday by my organization and Meals on Wheels America. In short, we are urging you to develop policy guidance to ensure that senior nutrition providers, staff, and frontline workers are clearly and consistently considered essential workers and given priority as such for COVID-19

vaccinations. As you all know, the pandemic has disproportionately impacted older adults who remain at increased risk of COVID-19 and face unique barriers to accessing adequate nutrition and socialization. There are few services more essential than providing meals to the millions of seniors who currently rely on them to prevent malnutrition and other serious health risks. Additionally, the senior population is increasingly at risk of the harmful effects of social isolation as a result of the pandemic. Enabling senior nutrition providers to obtain the vaccine quickly will enable them to interact more directly and in-person with older adults in desperate need of human contact. In short, a clear and consistent directive from this federal panel designating senior nutrition providers, staff, and frontline volunteers as a priority population for the vaccination is urgently needed. My second request, which my organization has made before, is to suspend until the end of the pandemic your recommendation for sharing clinical decision-making between patient and provider in deciding whether a patient should get the PCV13 pneumococcal vaccine. I make this recommendation for several reasons. The first is the new reality created by the pandemic with fewer older adults visiting any healthcare provider where this decision-making discussion would take place. The second real concern and consequence is that fewer older adults will be vaccinated against pneumonia at a time when we should be striving for greater vaccination rates, particularly as we enter flu season. Even prior to the pandemic, for African-American and Hispanic older adults, the rate of PCV vaccination was a full 10% and 15% lower than for White older adults, respectively. This pandemic has exposed the degree to which health disparities have contributed to the disproportionate rates that older minority adults have contracted COVID-19. We cannot maintain policies that by their nature exacerbate disparities. Finally, I will also repeat our support for ACIP adding at least one member with expertise in geriatrics to better inform the work of the committee on issues of special significance to older adults. That expertise is even more important today during this pandemic. Thank you for your time.

Benjamin Newton, MBA
Fellow, Casualty Actuarial Society

Today, there is enough Moderna vaccine already produced to protect several billion people. How is this possible? A few facts plus some simple calculations support this conclusion. First, the data indicate that 92% efficacy is reached 14 days after a single 100 µg dose[1]. Second, two 100 µg doses induce an immune response 9 times as great as a single 100 µg dose[2]. Third, protection is immune response dependent[3]. Finally, the immune response decreases only 70% for each 90% decrease in dose[4]. Using these few items, we quickly see that two 10 µg doses would result in 2 times the immune response as 1 100 µg dose, while two 1 µg doses would evoke 86% of the immune response produced by a single 100 µg dose. That is, we can achieve 86% of the immune response known to provide greater than 90% protection and vaccinate 100 times the number of people.[5] On December 2nd, Moderna's Chief Executive Officer (CEO), Stéphane Bancel, was asked about this ability to synthetically increase capacity through changes in dosing and regimen. He indicated, without confirming dose or regimen, that Moderna is, and I quote, "not naive to the fact that there could be ways to increase the output using different regimen and/or dosing." Moderna's manufacturing capacity is currently 2 kilograms per month, leading to a monthly capacity to vaccinate 20 million people at 100 µg per dose, 200 million people at 10 µg per dose, and 2 billion people at 1 µg. Practically, the end of the pandemic is limited only by the availability of syringes and by our willingness to draw conclusions from the available data. If you don't want to use my calculations, Moderna has demonstrated an amazing ability to predict human response based upon pre-clinical data and can certainly provide more accurate estimates than what I can using publicly available data. I expect that there will be understandable hesitancy to vaccinate people at a dose lower than what was used in the Phase III trials. As far as safety is concerned, lower doses were

associated with fewer adverse events[6]. But what about efficacy? Can we really risk vaccinating people with a dose that might be less effective? Regarding this concern, a compromise might be reached that allots 90% of the available vaccine to be administered in 100 microgram doses, and the remaining 10% to be administered in 1 µg dose. This would mean that instead of vaccinating 20 million people next month, we could vaccinate 18 million people at 100 micrograms and an additional 200 million people at 1 microgram. Those who receive the lower dose could even still be eligible to receive a third dose later in 2021 when vaccine supplies increase. Given that 6 people have died from COVID during the time that I have been speaking, waiting until a lower dose has been formally studied in a months' long clinical trial feels irresponsible at best. Note that while these calculations were done on mRNA-1273, they all apply to the Pfizer/BioNTech vaccine, which means there is more than enough vaccine to end the scourge of COVID today. We must all remember that 90% efficacy for 100% of the population is better than 94% efficacy for 10% of the population. It is only a matter of time until doctors, Governors, and foreign regulators optimize vaccine supplies. It is better for the CDC and the FDA to lead those decisions today. Thank you very much for your time.

[1] https://www.fda.gov/media/144434/download page 28
[2] https://www.nejm.org/doi/full/10.1056/NEJMoa2022483 Table 2
[3] https://www.nejm.org/doi/full/10.1056/NEJMoa2024671 Figure 3
[4] https://www.nejm.org/doi/full/10.1056/NEJMoa2022483 Table 2 and https://www.nejm.org/doi/full/10.1056/NEJMoa2024671 The S-specific IgG binding (Figure 1C) and neutralizing GMT (Figure 1D) elicited by vaccination with 100 µg of mRNA-1273 at 4 weeks after the second vaccination were 5 times and 15 times as high, respectively, as in convalescent-phase serum specimens from a panel of 42 humans representing a full range of disease severity (see Supplementary Appendix 2).
[5] https://www.nejm.org/doi/full/10.1056/NEJMoa2022483 Table 2
[6] https://www.nejm.org/doi/full/10.1056/NEJMoa2022483

Bob Carey, CAPT, USN (Ret)
Executive Vice President of Advocacy and Planning
The Independence Fund

Thank you very much Chairman Romero and those on the Advisory Committee. My name is Bob Carey. I am the Executive Vice President for Advocacy and Planning at The Independence Fund, a veteran-serving organization. We will be sending over a letter here before the deadline from ourselves and at least 12 other veteran organizations regarding the applicability of the guidelines with the disabled veteran population. We agree that the ACIP's interim guidance assessment that healthcare personnel (HCP) and residents of long-term care facilities (LTCF) receive the vaccine in its initial phase and we agree with the Department of Veterans Affairs (DVA) plan to follow that guidance for healthcare workers within the Veterans Health Administration (VHA) and residents of VA living facilities. We are especially interested in the apparent discussion by your committee at its 23 November 2020 meeting where prioritizing next, after the healthcare workers, is either essential workers or adults 65 and older along with adults with high risk medical conditions. While the discussion slides prioritizing high-risk adults and essential workers averted more infections, it also showed prioritizing 65+ adults and high-risk adults averted more deaths. For disabled veterans, this is especially relevant because many have compromised immune and pulmonary systems driving them to forgo their VA-provided home health care for fear of infection. The ailments and disabilities which place these disabled veterans at higher risk may not be clearly and easily classified or are caused by toxic exposures for which there are not clearly defined diagnoses. Given that, we respectfully request that ACIP consider the unique elements and situations of disabled veterans in the prioritization of high risk adults. Specifically, we Believe high-risk adult disabled veterans should be considered for inclusion in Phase 1b. Further, we respectfully request that ACIP consider some process by which Veterans Health Administration providers can classify disabled veterans as high risk, even if they do not fit into one of the high-risk conditions identified by ACIP. Finally, we

respectfully request that ACIP consider adding the caregivers who are so-designated within the VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) caregiver program to the appropriate phase where the disabled veterans they support would be eligible and to support their receiving a vaccine with their disabled veteran, preferably from the VA. One of the problems the VA has in doing that is that they do not have current authority to provide medical care directly to caregivers, so this would have to be part of their fourth mission, which would be federal support to state and local officials for the normal Federal Emergency Management Agency (FEMA) and Health and Human Services (HHS) request process. A recommendation from ACIP for the VA to be able to do that under their fourth mission and their support to civilian authorities would be helpful. Thank you very much on behalf of myself and 12 other veteran-serving organizations.

Susie Olson-Corgan
Concerned Citizen

Thank you so much for the opportunity to speak today. I have been attending all of these ACIP meetings as well as the Food and Drug Administration (FDA) Vaccines and Related Biological Products Advisory Committee (VRBPAC) meetings to better understand the various vaccine candidates and their benefits and limitations. One thing that I've been really concerned about is the fact that the studies were not designed to show that these COVID-19 vaccines will stop transmission of SARS-CoV-2. However, we did see that the vaccination can lessen symptoms or even allow for asymptomatic carriers. Since the beginning of this pandemic, we've been inundated with the fear that silent spreaders, asymptomatic carriers, and pre-symptomatic individuals are a large component of increasing this pandemic. So I'm curious as to why that component of stopping the transmission of the virus was not included in these safety studies. There is also no guaranteed immunity from these vaccines. There is no long-term safety data, and now they are unblinding and vaccinating the placebo group. These placebo groups provide a critical point of comparison in gold standard clinical trials, allowing researchers to study long-term side effects over time. By unblinding and vaccinating the placebo arm of these studies, we lose this valuable data. How do you plan to track those long-term effects? There is also no manufacturer liability. Under the Public Readiness and Emergency Preparedness Act (PREP Act), the manufacturers hold no liability, the FDA holds no liability, your employer, even if they mandate this vaccine or coerce you in some other way to receive the vaccine, they also hold no liability. So if you experience an adverse reaction as thousands of people are, you are the only one that is responsible. You are responsible for that time off work, you're responsible to deal with any medical consequences that come, you are 100% responsible for what happens to you, so you are coerced into receiving a liability-free pharmaceutical product and then you are the only one there left to pick up those pieces. I have experienced this in my personal life and I can tell you it is a terrible experience. By getting this vaccine, you are still going to have to wear a mask. There are still going to be restrictions in place. You are still going to have to socially distance. So, I am just wondering what is the point of these vaccines? The FDA approved this, but they approved it under EUA, Emergency Use Authorization. I don't think that the general population understands the difference between FDA approval and EUA. I have spoken to several people that say, "Oh, it's FDA approved." But it's not. This is emergency use. They need to understand that that is not the same safety standard. The last thing I'll say is antibiotics did not need a big marketing campaign like these vaccines do because they worked. They worked, they are safe and effective, and they have been proven to work. If these vaccines are so safe and effective, we shouldn't need constant inundation in the news and in the media with everyone getting this vaccine is safe and effective, safe and effective, safe and effective. I'd really urge you guys to consider some of these points today. Thank you.

Lori Ciminelli
Concerned Citizen

Good afternoon. I find it astounding that an investigative, experimental, fast-tracked vaccine with zero liability is pushed to be delivered worldwide. Your own data claims a 99% recovery rate from COVID under the age of 74 without comorbidities. Above the age of 74, it's a 94% recovery rate. Yet a concoction from chemists paid millions of dollars has created a politicized potion to stamp out the virus. Seventy percent vaccination is required to achieve herd immunity says Dr. Fauci and the likes of your agencies. So still live with masks, social distancing, bankrupt economies, and isolation. Experts, including your own agency, comment that natural acquired COVID may only provide 3 to 4 months immunity. This is more magic. No one has the confirmed data. This vaccine is experimental and liability-free. You have claimed humanity as your test subjects. It is so wrong. The fastest vaccine previously created was the mumps vaccine in 4 years and we have watched that over and over with 100% compliance. You want to go first into the elderly and long-term care facilities alleging it's for their greater good. So without zero voice in the decision, your agency recommends, and other agencies like you, to keep them locked in with staff and isolated. So how does that work? Failure to thrive, cognitive decline, isolation, broken hearts, yet in the greater good this must happen. Well, it's been 9 months. Surges are still occurring in long-term care facilities. My mother's facility November 7th acquired one case. December 4th, it ballooned to 103 cases. All facility residents were involved and 50 staff. Your recommendation is to keep the family out. I wonder psychologically if they wouldn't have had a better opportunity to recover if we weren't allowed. Wearing of PPE doesn't take a rocket scientist. I'm very disturbed with elderly populations not having a voice and your determination of a panel of doctors making a recommendation to go give them all the vaccine. How long do they plan to be incarcerated? How long? No human contact. No love. It is proven medically that people recover better when they are in a better state of mind. Now you have determined you will vaccinate all of them, but the data is not . . . (time expired).

Allocation of Initial Supplies of COVID-19 Vaccine Phases 1b & 1c

Jeanette Contreras, MPP
Director, Health Policy
National Consumers League

Good afternoon. I am Jeanette Contreras here today on behalf of the National Consumers League (NCL). For over 120 years, our organization has advocated for vaccines as a safe and effective means to prevent disease. We extend our gratitude to this committee for the opportunity to present public comment. As consumer advocates, we applaud the transparency and access afforded to the public throughout the COVID-19 vaccine approval process. We are encouraged that the FDA has approved the Moderna vaccine and that the US government will lead distribution efforts. Due to its ease of transport and storage, the Moderna vaccine stands to readily ship to rural and hard-to-reach communities. NCL calls on federal officials at the helm of distribution to facilitate access to the Moderna vaccine in medically underserved areas. We have great trust in the FDA's and CDC's robust interagency collaboration to continue ongoing post-market surveillance of adverse events among recipients of the vaccine and to inform consumers of any additional safety recommendations. NCL urges the CDC to educate consumers about potential reactions and side effects as this transparency will further encourage compliance necessary to achieve herd immunity. The vaccine is expected to induce flu-like symptoms after the initial dose and this may deter some patients from getting their second dose if they aren't warned about what to anticipate. To address vaccine adherence, we encourage the CDC to conduct culturally competent public education about vaccine safety to ensure that

communities of color and persons with limited English proficiency are informed and feel empowered in their decisions to vaccinate. Adding to the complexity of administering the vaccine, public health officials will need to ensure the completion of 2 doses in a series. This stands to create additional challenges as evidence has shown that when a vaccine involves multiple doses, nearly 50% of patients fail to return for a second dose. We applaud the committee's recommendations to prioritize vaccinations for healthcare workers and long-term care facility residents in Phase 1a. Now that there are 2 approved vaccines, we encourage ACIP to prioritize recommendations to vaccinate the 87 million non-healthcare essential workers unable to work from home, such as bus drivers and grocery workers, who are at higher risk for exposure. Racial and ethnic minorities make up more than 40% of the essential work force and are the backbone to many essential Industries. The pandemic has illustrated that low-income minority communities experience more severe COVID-related illness requiring hospitalization and are at higher risk for death from COVID-19. Lastly, over 17.5 million individuals in the US have been infected with the coronavirus. It is expected that those who recover will acquire some natural immunity. Individuals who recover from the coronavirus want to know if they are protected from reinfection and for how long. We call on the CDC to expedite developing vaccine recommendations for persons who have recovered from COVID-19. Thank you for your consideration of our views on this important public health issue.

Karen Ernst
Executive Director
Voices for Vaccines

My name is Karen Ernst and I am the Director of Voices for Vaccines. I represent everyday families who look to your guidance to lead us out of this pandemic. First, I want to mention briefly that I was dismayed that the legitimacy of the CDC continues to be used by anti-vaxxers for information laundering to spread spurious claims about vaccine harms into public discourse. But really what I'm here to say is this, when can I get the vaccine? That's the number one question I am receiving on a day-to-day basis. Of course, people are concerned about what the fast delivery of these vaccines might mean as far as safety. ACIP can do a great service by explaining exactly how well-studied the safety of any COVID-19 vaccine is, but even people with concerns are saying, "You go first, but can I go second?" As much as I would personally love to be in line for a vaccine right now, I want to encourage ACIP to stress the importance of following CDC guidance and prioritizing vulnerable people. Both public health and the public need a clear vision of why vulnerable people need a place at the front of the line and encouragement for the rest of us to continue wearing our masks and keeping our distance. Of course, prioritizing is one thing, but getting the vaccine into the arms of the most vulnerable people requires stripping logistical barriers to vaccination such as transportation, paid leave for vaccination and post-vaccination, and childcare. These are just a few of the ways that we can make immunization more accessible. I want to end by saying thank you. Thank you to all the public health and healthcare folks who have been working overtime for the past year, who understand that there are stories behind the numbers and who have brought us to an incredible moment in history where we have 2 safe, effective vaccines for a disease most of us never heard of a year ago. Take a minute to really soak in what an amazing point in history this is and what an incredible job that every single one of you has played in it no matter how large or small. Thank you so much.

María Perales Sanchez
Elizabeth Mauldin Memorial Advocate for Migrant Women (EMMA)
Centro de los Derechos del Migrante, Inc.

Greetings advisory committee on immunization practices. My name is Nadia Petrova Sanchez and I'm with María Perales Sanchez and I'm with Centro de los Derechos del Migrante, Inc., which is the first transnational workers' rights law center based in Mexico. We are also Co-Founding members of the Elizabeth Mauldin Memorial Advocate for Migrant Women (EMMA) serving over 700,000 farm worker women and families nationwide. For over 15 years, we have worked with thousands of food and farm workers. These are seafood workers in processing plants, poultry processers, and agriculture workers. During the pandemic, they have rightfully received the title of "essential worker." However, workers report to us that they are not receiving the necessary protection to be safe at the workplace. I am here today to emphasize the need for these workers to be explicitly and unequivocally prioritized for vaccine allocation in CDC guidance. For context, workers in this industry face a disproportionate risk of contracting the virus. Since the COVID-19 pandemic began, at least 125,000 farm workers have contracted the virus. With workers in this industry being low-wage workers of color, we suspect the numbers are even higher across this industry. Pre-existing working conditions such as retaliation, little access to equipment and tools, discrimination, and cramped working conditions make these workers more vulnerable to the coronavirus. According to the "CDC COVID-19 Vaccination Program Playbook," vaccine allocation is at the discretion of state and local jurisdictions. Yet from our work, we know that the jurisdictions rely heavily on and look to the CDC for guidance on immunization practices when making this decision. The issue we rate today is that farm workers and food supply workers are not explicitly referenced in the more relevant CDC vaccination guidance or the Occupational Safety and Health Administration (OSHA) Hazard Identification Training Tool that classifies the risk of worker exposure to SARS-CoV-2. These are 2 guidances of state and local businesses reference for vaccine allocation. This is a grave public health concern. What about equity? While we know that farm and food workers are at some of the highest risk, the lack of clear mention in this guidance makes it easier to neglect them in vaccine allocation. We hear from workers every day. As breadwinners with some of the lowest wages and workplace protections, they are forced to remain in hazardous working conditions. We urge you to specifically reference and designate food chain supply workers such as farm workers, poultry workers, and seafood processing plant workers as a priority in CDC vaccination guidance, and to encourage OSHA to list these workers in the risk assessment tool. We thank you for your time and thank you for standing with workers. Thank you.

Claire Hannan, MPH
Executive Director
Association of Immunization Managers

Hi. This is Claire Hannon, Executive Director of the Association of Immunization Managers (AIM). Our nonprofit represents the state, territorial, and large urban area public health immunization programs. I first want to thank the CDC and members of the advisory committee for their ongoing guidance; commitment to the principles of safety inclusiveness, efficiency, and flexibility; and for the open, transparent meetings. It is quite an exceptional development that we now have 2 vaccines to fight this terrible pandemic. Although we do have difficult choices to make while the vaccines are in short supply, we must remember to keep this in context and understand that these decisions, while difficult, are life-saving and good. Every day that we vaccinate even one person should be viewed as a success. The dilemma facing jurisdictions

and the pressure on Governors and public health agencies cannot be minimized. This pandemic has impacted so many different individuals, some disproportionately harder than others, and so many workers have become essential. It's critical that we listen to and engage with all of these stakeholders, but it is simply not possible to put all of them at the front of the line. The guidance provided by ACIP is extremely valuable and will help jurisdictions make decisions. The balanced considerations for preventing death and supporting societal function help provide context to the phased rollout. Prioritizing frontline, essential workers, and those over 75 fits with the intentions of many awardees. The implementation challenges with these groups will require an array of public and private providers and diverse vaccination strategies. I would just like to emphasize that policing or enforcement of priority groups is not feasible. The guidance on transitioning between phases is especially helpful because some jurisdictions will move faster than others based simply on the need to keep vaccine from sitting on the shelf. As much guidance and justification as can be provided is needed, particularly communication strategies and talking points. Especially needed is messaging and guidance on vaccinating in congregate settings for incarcerated individuals and the homeless and the prioritization of essential workers who are young and healthy over adults at high risk due to underlying conditions. I agree that for planning purposes, a vote on phase 1b and 1c is needed today. I would be remiss if I did not once again call out the dire need for federal funding to support public health vaccine planning and response. The challenges related to equitable distribution of these vaccines continue to come. With larger allocations, larger prioritize populations, and large vaccination opportunity, public health finds Its role and responsibilities growing while its ability to hire to respond to plans is diminished by lack of resources. Thank you.

Kim Apouw
Family Provider

Hello, my name is Kim and I am speaking as a daughter and a granddaughter of seniors at high risk for COVID. These elders in my family are part Vietnamese, Filipino, Indonesian, and Persian communities and as such are strongly guided by cultural values. One of those family values is family-based care as they age and become frail. We take care of our elders. It is also out of necessity when the system doesn't meet their needs. But homecare also makes it easy for them to be invisible to the system. My parents and grandmother need access to the vaccine, but I'm concerned about government plans that rely on formal access points like congregate care settings for adult family homes. My grandmother in particular fits the priority population: elderly, high risk of mortality, receiving nursing home care level, and she lives in an area with disproportionate infection rates. However, she can't get the vaccine access because she's not in a facility and doesn't fall into the categories in the state plan, which include skilled nursing, assisted living, and adult family homes, HUD 202 low-income housing, and vets homes. In short, because she isn't in the system, she isn't connected to any of the touch points to be reached. I know there are community organizations that serve our communities who are known and trusted, but they need to be elevated and funded to do the work of reaching and assisting elders like my parents and grandparents. Please think about these specific populations as you deliberate how to prioritize vaccine distribution. Thank you.

Jocelyn Hybiske, PhD
Medical Communications
Volunteer Vaccine Advocate

My name is Jocelyn Hybiske. I am a professional medical writer and volunteer vaccine advocate. I have no relevant conflict of interest to declare. I want to first acknowledge the tremendous effort and dedication that has brought us here today to have vaccines developed and authorized for emergency use within the same year as the onset of a pandemic. Now that we have these effective vaccines in our arsenal, we must deploy them as efficiently as possible to prevent lives lost to COVID-19. The immediate hurdle is, of course, access. We are only a week into Phase 1a and we've already seen that the number of doses is not the only limiting factor. Logistical challenges such as ultra-cold storage and a 975-dose of minimum order for the Pfizer vaccine have already caused imbalances among the first group of vaccine recipients. Healthcare workers in smaller hospitals and clinics, particularly in rural areas, are effectively deprioritized compared to their counterparts in large hospitals. Inequitable access has occurred even within the same practice whereby physicians who are co-affiliated with a large hospital were able to access the vaccine while non-physician staff are not despite having the same high-risk status. Although authorization on the Moderna vaccine with more manageable storage and ordering logistics will alleviate some of these issues, these are real-world examples that highlight barriers to equity access early in the distribution process. The logistical challenges will only worsen as recipient groups expand. I hope the ACIP Work Group will map specific items and offer decision-making tools to help authorities that not only detail who the next phase groups are, but also when and how they will be notified and identified in order to improve outreach, close equity gaps, and maximize vaccine coverage, Centralized platforms to collect pre-registration of next phase recipients and provide rapid alerts when a vaccine becomes available to them are necessary tools to prevent wastage or delay. We must make every dose and every day count. With 2 vaccines now authorized and millions of doses on the way, we also must prepare effective communications to ensure that everyone lines up to receive their vaccine at the earliest time it is offered to them. A natural question when faced with two options is, "Which one is better?" The available evidence suggests that both vaccines have equivalent safety and efficacy profiles in adults. I urge the CDC to stress in communications to the public that the products are comparable and that there is no reason to wait to favor one over the other. Common concerns people have expressed about COVID vaccines boil down to long-term safety, especially for a seemingly new technology. Public messaging highlighting the duration of clinical experience to date with the authorized vaccines and their individual components, including leveraging long-term and widespread clinical experience of current FDA-approved similar products would help improve public confidence in the safety of these vaccines. I thank the committee for the opportunity to speak today.

Joseph Bick, MD
Infectious Disease Specialist
Director, Health Care Services
California Department of Corrections and Rehabilitation

Good afternoon. My name is Joseph Bick and I'm an infectious diseases specialist who is serving as Statewide Director of Healthcare Services for the California Department of Corrections and Rehabilitation (CDCR). I appreciate the opportunity to speak regarding the importance of ACIP specifically prioritizing those who work and live in our nation's jails, prisons, and detention centers in the first phase of COVID vaccination. Over 2 million people are incarcerated in this country and over 500,000 individuals interact with them on a daily basis—correctional officers, nurses cooks, physicians, teachers and others. More than 260,000 inmates

and 58,000 correction employees have been diagnosed with COVID, resulting in at least 85 employee and 1,700 inmates COVID-related deaths. The age-adjusted death rate due to COVID among the incarcerated is several fold higher than what is seen in the outside community. Case rates among both inmates and employees are significantly greater than those seen outside of incarcerated settings. Many of the largest recorded COVID outbreaks in this country have occurred in correctional facilities. Most inmates are housed in large, overcrowded, inadequately ventilated congregate living environments in which consistent physical distancing is not possible. Inmates are disproportionately people of color and often have multiple comorbidities that increase their risk for serious illness, hospitalization, and death. Delaying vaccine distribution to inmates will exacerbate the disparate racial impact of COVID-19. Age is one of the greatest predictors of poor outcome with COVID. The age-associated risk for prisoners begins to rise in their 50s. More than 10% of prisoners are 55 years of age or older. The ACIP recently recommended that initial vaccination should be offered to healthcare personnel and residents of long-term care facilities. The truth is that prisons are essentially long-term care facilities with bars. The California Department of Corrections developed a COVID risk score system that accurately predicts the likelihood that each inmate will be hospitalized if they become infected with COVID-19. Just 18% percent of our population accounts for 90% of hospitalizations and deaths. Targeted vaccination of a fraction of our inmate population could virtually end off-site hospitalizations. Correctional facilities are a major employer in some rural areas. When COVID is introduced by employees into these facilities, the disease is rapidly amplified creating large outbreaks, which quickly overwhelms bed capacity and surrounding community hospitals. Not including correctional staff and high-risk inmates in Phase 1 will result in preventable illness and death, additional burden upon local economies, and increased pressure upon overstressed community hospitals. Thank you.

Jonathan Eisen
Senior Vice President, Government Relations
International Foodservice Distributors Association

Thank you very much. I am Jonathan Eisen with International Foodservice Distributors Association (IFDA). On behalf of our member companies, I would like to thank the CDC for giving me the opportunity to speak today on behalf of our industry. I'm asking the Advisory Council on Immunization Practices to ensure that employees of this frontline essential industry are included in Phase 1b in the next set of federally-recommended guidelines. There are two separate supply chains distributing food products in the United States. IFDA represents foodservice distributors who provide the warehousing, transportation, and logistics support to ensure that fresh safe food fills the kitchens of our nation's hospitals, nursing homes, schools, US military, restaurants, and other food away from home operations. Foodservice distribution is a $303 billion industry and employs more than 350,000 people. There are 15,000 foodservice distribution center locations in the United States which deliver 8.7 billion cases of food and other products annually. All of these businesses have continued to operate throughout the pandemic to ensure their customers have the food products they need. As food demand has grown, the industry has also worked closely with food banks and other nonprofits to provide food aid for hungry Americans. Food service distribution has been defined by the Cyber Security and Infrastructure Security (CISA) Agency of the US Department of Homeland Security (DHS) as an essential business during COVID-19 that is critical to maintain the country's infrastructure. Distributors are frontline essential workers. They cannot work remotely and are on the ground in warehouses and delivering food and supplies in trucks. Even with a pandemic, a nationwide shortage of commercial truck drivers has meant that companies are still having difficulty finding and training the drivers they need to service their customers. A single driver coming down with COVID can create significant strain for a distributors operation, often forcing them to delay or

cancel deliveries. A nursing home facility for example must have the products the distributors deliver to feed their residents each day. Making the employees of the foodservice distribution industry a priority for vaccines will help ensure that they do. The Centers for Disease Control has determined the frontline essential workers are one of the groups that should be considered for early vaccination if supplies are limited. Ensuring the continuing supply of food to American consumers and foodservice customers is a critical government responsibility. Including foodservice distributors in the next set of federally recommended priorities will send a strong signal that state vaccination plans must include the industry in their priority plan. It is critical for the men and women who work in the warehouses and drive the trucks to deliver these products and safely continue to fulfill their vital mission. The 350,000 hardworking Americans of the foodservice distribution industry have continued to come to work every day throughout the COVID-19 crisis to service their customers. They deserve to have their health protected. The committee must recommend that state vaccination plans make foodservice distributors a priority industry. Thanks very much.

Harald Schmidt, PhD, MA
Assistant Professor, Department of Medical Ethics and Health Policy
Research Associate, Center for Health Incentives and Behavioral Economics Perelman School of Medicine, University of Pennsylvania

My name is Harold Schmidt. I am an Assistant Professor in the Department of Medical Ethics and Health Policy at the University of Pennsylvania. I'd like to start by congratulating the committee members, especially also the staff again for their work under intensifying pressure and some quite confused media characterizations of central issues in recent days. I'd like to highlight 3 points to do with limitations of promoting equity through phased sub-populations alone, problems with rigid numeric age cutoffs, and the use of Tiberias. First, on promoting equity through a phased system alone, within each of the phase population groups, there is considerable variation, especially in terms of the risk of getting infected and the need to have a vaccine for economic livelihood and other important considerations. The strongest line of defense against current criticism would be to align phasing more with the National Academies framework. This includes specifically the recommendation that quote "in each population group, vaccine access should be prioritized through CDC's Social Vulnerability Index (SVI) or another more specific index." But given where we are, it certainly seems not too late to recommend the use of a disadvantage index, for example, in the clinical considerations that were mentioned earlier. Doing so would also align with the fact that at least 19 states are already using this for related purposes, especially also monitoring uptake that was rightly noted earlier today. Disadvantage only increases in importance if, as is likely, the current phasing is kept because neither public health nor equity is helped if a healthy 40 year old factory worker is offered the vaccine before a disadvantaged 66 year old grandmother living with multiple generations in a crowded setting. Second, on rigid age cutoffs, as was said in an earlier ACIP committee meeting, "The older we get, the more different we become." Especially if over 65 year olds are phased in parallel with essential workers, it is critical to be aware that while many older adults in this group can likely safely wait a few months for vaccines others cannot, including minorities whom ACIP seeks to benefit by phasing essential workers earlier. It is therefore important that the exemplary 66 year-old economically disadvantaged grandmother living with multiple generations in a crowded setting is offered the vaccine before a wealthy suburban retired couple or a 40 year old healthy clinical worker. My colleagues submitted a written comment for ACIP which further details the problems with rigid age cutoffs and recommends that guidance to jurisdictions include a recommendation to adjust the age by local differences and other sources of risk. Given jurisdiction planning is as complex as it is, a pragmatic alternative would be again to recommend using a statistical measure of disadvantage that is likely to correlate quite well

and aligns with state's current planning. Finally, it appears that technology can facilitate one element of planning equity in the relatively straightforward way. By integrating legally sound SVI or similar weights in the Tiberius software as an opt-out rather than opt-on option, jurisdictions' autonomy will be preserved and chances that more disadvantaged communities face less scarcity would be increased. Ideally, we would also use the same function for centrally monitoring coverage rates across SVI sections. Thank you for the opportunity to provide comments.

Jeffrey Caballero, MPH
Executive Director
Association of Asian Pacific Community Health Organizations

Thank you. My name is Jeff Caballero. On behalf of the Association of Asian Pacific Community Health Organizations (AAPCHO) and our member community health centers and health organizations around the country, I thank you for the opportunity to submit a comment. AAPCHO is a national nonprofit association of 33 community health organization and 28 Federally Qualified Health Centers (FQHC) that advocate for the diverse health needs of medically underserved Asian Americans, Native Hawaiians, and Pacific Islanders providing culturally and linguistically appropriate care that are vital to supporting our communities through the COVID-19 crisis and every day. Asian Americans, Native Hawaiians, and Pacific Islander Communities must be a priority population. Recent data from the Kaiser Family Foundation (KFF) show that Asian Americans are more likely to test positive for COVID-19 and they have the highest risk of hospitalization and death rates among race and ethnic groups. Similarly, the National Pacific Islander COVID-19 Response Team found that Pacific Islanders have the highest confirmed rate of COVID-19 in California; King County, Washington; and Clark County, Nevada and the second highest case rates in the states of Utah, Oregon, Arkansas, and Colorado. Immigration status must not be a barrier to vaccine access. Since 2010, Asian Americans have been the fastest growing racial ethnic group in the United States. Today, 59% of all Asians are foreign-born. Federal law prohibits immigrants from access to many health benefits programs such as Medicaid for the first 5 years of residing in the United States, with certain Pacific Islander communities from Micronesia, Marshall Islands, and Palau categorically ineligible under the law. Moreover, anti-immigrant policies such as public charge have made immigrant families, including many Asian Americans and Pacific Islanders, fearful of seeking care out of fear that doing so could jeopardize the immigration status of their family members. Health centers are vital to reaching these communities of color and other hard-hit communities. Community health centers serve approximately 28 million patients of which 63% are racial and ethnic minorities, including 1.2 million Asian Americans and Native Hawaiian/Pacific Islander patients. As trusted members of the community, health centers are able to support individuals who are experiencing prejudice and racism in their communities, making them less scared to engage with health care providers. Health centers also provide critical enabling services, including in-language services and culturally appropriate care necessary to improving health outcomes for their patients. In conclusion, I appreciate the opportunity to discuss these issues and thank the committee for listening.

David Curry, MS
Foundation President, Center for Vaccine Ethics and Policy, GE2P2 Global Foundation
Affiliate Faculty, Division of Medical Ethics, New York University School of Medicine

Thank you. This is David Curry, President of the GE2P2 Global Foundation and head of its Center for Vaccine Ethics and Policy (CVEP). I am also Affiliate Faculty in the Division of Medical Ethics at New York University's (NYU's) School of Medicine. Our foundation receives support from a range of individuals and organizations, including Moderna, Pfizer, and the Gates Foundation to support a free weekly digest of global immunization news. Our comment today focuses on the information to be presented to recipients and caregivers as they are offered or seek COVID vaccination. We argue that this information must be clearly presented for comprehension; be appropriately written and presented for limited literacy, numeracy, and reading levels; be broadly translated for the diverse populations that will need to be vaccinated; present alternative vaccine options as they become available; and be otherwise supporting of recipients in making a well-informed decision to accept or decline any vaccine offered. We recognize that the FDA's Emergency Use Authorization does not require formal informed consent and that the information that is required is a fact sheet. But we must note that the EUA fact sheets are presented in text only with no graphical information to support comprehension, and as important at a reading level that using the standard Flesch Kincaid Grade Level Assessment, is 9th or 10th grade at least with a reading ease assessment that is fairly difficult to difficult to read. As such, these fact sheets are simply not fit for purpose for many in the priority populations discussed today to support their informed decisions about COVID immunization. So we energetically urge and are confident that CDC will extend and accelerate its best efforts to develop a range of graphically rich translated content to complement the fact sheets, supporting informed choice about COVID vaccination. In this spirit, we continue to be concerned that the CDC toolkit content now posted appears still to not have any content available to specifically support decision-making by residents of long-term care facilities who are, of course, now being vaccinated. Finally, we applaud the ACIP discussions today which noted the importance of vaccine confidence and trust, especially in communities that face health access challenges. We believe strongly that the ability to make a well-informed decision about COVID immunization will be a critical driver to build and maintain such confidence and trust. Thank you for your time.

Minh-Tri Tu
Family Caregiver

My name is Minh-Tri Tu and I am a family caregiver. I'd like to share our family experience to spotlight broader issues in our community. My mother, who you may hear in the background here, is 90 and was diagnosed with dementia 6 years ago. She moved in with me here in Seattle and I've been her primary caregiver since. She's now in advanced stages, is completely dependent, and needs 24-hour care. While I've often felt it couldn't get any more challenging, COVID has actually made it so. To protect her, other members of my family can't come give respite and I can't hire formal help given the risk of outsiders. I've also lost income since caregiving doesn't give me enough time to work. Above all, knowing that if she were infected she would likely not survive terrifies me. As a first-generation Vietnamese refugee deeply involved in my community and as an equity and community development professional, I also know that our communities are more likely to care for our elders at home due to lack of culturally appropriate care. We often don't put them in facilities because the system doesn't meet our needs. As a result, my home functions like a nursing home but of one resident and I am a healthcare worker—just unpaid and unlicensed. Our communities also often have language barriers, which means less awareness and less ability to self-advocate. Because data on Asian Pacific Islanders is often aggregated, it masks the needs of specific subgroups, which we have

seen with COVID. Taken together, these factors make communities like ours easily missed. In researching vaccine rollout via your committee's earlier analyses and our state's vaccine plan, my heart dropped because I couldn't see where we fit or when we will be reached, leaving me worry we will fall through the cracks. We already struggle with inequities in the long-term care system. Having to wait any longer for the vaccine adds to that. Recognizing the pivotal role of the committee, I'd urge you to take 3 critical actions: 1) take a closer look at the 75+ group and disaggregate the data using an equity lens to better understand racial and social inequities in it and the disproportionate toll on families and communities of color and refugee and immigrant groups; 2) prioritize elders in home-based family-based care, especially those who are dependent and need skilled nursing care, which creates extraordinary burdens on their families; and 3) include family caregivers as part of essential and/or healthcare workers so that we might be afforded some relief. Thank you.

John Skoutelas
Vice President & General Counsel Northern US and Canada
National Director of Government Affairs
Waste Management Incorporated

Good afternoon. My name is John Skoutelas. I'm Vice President and National Director of Government Affairs for Waste Management Incorporated. Waste Management is the largest solid waste collection, disposal, and recycling company in North America. We have operations in all 50 states. During the pandemic, we have worked hard to preserve the safety of our 50,000 employees. They, in turn, have worked hard under extraordinary circumstances to preserve the public health by collecting and removing recyclables, medical, and solid waste. I also want to point out that my comments today are being made in coordination with the National Waste and Recycling Association (NWRA), who submitted correspondence to the committee on December 18th and with the Solid Waste Association of North America (SWANA) who submitted comments to the CDC on November 30th. These two organizations represent tens of thousands of private and municipal solid waste and recyclable workers. During the COVID emergency, recycling and sanitation workers were recognized by Homeland Security as essential. I suggest that after healthcare workers, sanitation workers are the most essential workers. Removal of waste and recycling is the most basic part of preserving public health. The national papers have reported numerous instances where due to COVID sickness and necessary quarantining, municipal and private solid waste operations have been unable to put a full crew on the streets, resulting in garbage piling up and unhealthy conditions. We also learned during the pandemic that recycling operations are a critical part of the supply chain for toilet paper, paper towels, and other vital products. We asked the committee to specifically mention and recommend to the states that recycling and sanitation workers be given priority in the Phase 1b vaccine distribution plans. Sanitation workers are vital protect public health. Many are from minority communities and are people of color or recent immigrants. They are perhaps the least recognized and appreciated of the essential workers. On behalf of Waste Management, the National Waste and Recycling Association, and the Solid Waste Association of North America, we thank this committee for their work, we thank all of our essential workers for keeping us safe during this pandemic, and we urge the committee to recognize sanitation and recycling workers for priority distribution in Phase 1b of the vaccine distribution. Thank you so much.

James Tu
Family Caregiver

Thank you for your time. My name is James Tu and I'm here to ask you to consider the needs of minority elders in our communities. We often care for our older people and parents in our homes because of our cultural values. As children, we respect our parents and honor them by taking care of them when they get older. But sometimes, that conflicts with American culture where older people are often put in nursing homes. When we don't do the same way, we become invisible to the system. My mother is being cared for at home and she needs the vaccine as soon as possible because she is at high risk, but she is not allowed access as part of group 1a and it looks like she may not be in group 1b either. I am very concerned that if she has to wait until group 1c because that is not until late Spring or Summer, that is too long. That also puts burden on my family members who are struggling to take care of my mom without any outside help. We need to provide her and them with relief as soon as possible. Thank you very much.

Michelle Fiscus, MD, FAAP
Medical Director, Tennessee Vaccine-Preventable Diseases Program
Tennessee Department of Health

Good afternoon. Thank you for the opportunity to speak to you. I'm Dr. Michelle Fiscus, Medical Director of the Tennessee Vaccine-Preventable Diseases Program at the Tennessee Department of Health. Our office is primarily responsible for the allocation and distribution of COVID-19 vaccines across Tennessee. I would like to take a moment to join the others in thanking the members of the ACIP on their thoughtful deliberation around the recommendations for the use of the Pfizer and Moderna COVID-19 vaccines over the past several weeks. We all look to the ACIP for guidance for the safest and most appropriate use of all vaccines that are used in the United States. The 64 jurisdictional immunization programs were required to submit to CDC our initial plan for the allocation and distribution of COVID-19 vaccines, including the phasing of population in mid-October. While these are living and breathing documents that are constantly updated revised, they are the framework we used to operationalize the delivery of vaccines and they were created after a thorough review of the National Academy of Sciences Engineering and Medicine's (NASEM's) "Framework for the Equitable Allocation of COVID-19 Vaccines" and the CDC's "Playbook for Jurisdiction." Many of these plans were also informed by robust stakeholder groups that represent residents of the jurisdictions, especially under-represented populations. As jurisdictions, planning is informed by our own demographics. We best know and understand the challenges in our own jurisdictions and many of us have chosen to focus on equitable allocation of vaccines that may not be addressed adequately by decisions made on the national level. So it's important to recognize that guidelines specifically around the prioritization of these resources might best be left to the jurisdictions to decide. I would ask that this extensive work of the jurisdictions be considered when ACIP enters into discussions around prioritizing populations to receive vaccines. Each time the committee votes to change these prioritized populations, jurisdictions are forced to make the choice to drastically change their vaccine distribution, administration, and communication planning when vaccines are literally in route to their administration sites or choose not to adopt the changes ACIP makes to the guidelines and proceed with the plans they've been working on for months. Obviously, this is not the position in which we would like to be placed. During a time when jurisdictions are already working at capacity, media scrutiny is exceptionally high, and career public health officials are burning out. I know I speak on behalf of all jurisdictions when I commend you for the difficult work you are doing to ensure vaccines are used in the safest and most equitable way possible. I would also ask that you also carefully consider downstream impact of the changes you vote upon today, and as we move forward through the months ahead. Thank you.

Hector Aldaz, PhD
Research Scientist in the Biotechnology Industry
Speaking as a Private Citizen of Mexican Descent

Hello, my sister Patti [Aldaz-Carrasco] has yielded her time to me. My name is Hector Aldaz. I'm a Research Scientist in the biotechnology industry. I have a PhD in Biophysics and have focused most of my professional career on developing antibody therapeutics and more recently developing the next generation of molecular diagnostics. However, I'm here today speaking as a private citizen of Mexican descent in order to share my observation and concern regarding the omission of a highly vulnerable group from the prioritized list of COVID vaccine recipients. The group I am referring to is composed of senior citizens who are both 1) not independent and 2) under family home care. In Mexican culture, it's very common for elderly parents and grandparents to live with their children in multi-generational homes through end of life. This is a celebrated way of life and involves the participation of many family members, especially as the elders become less independent. This form of elder care requires a community and cannot be done by an individual and isolation. Unfortunately, because of COVID, many of these caregivers are forced to choose between 1) attempting to do the work of many on their own in order to minimize exposure risk, or 2) sacrifice safety in order to get help with caregiving or work to pay the bills. Nursing home placement is not a common option in my community either because of cultural norms, prohibitive cost, or both. My father recently passed away at home due to a heart condition and I had a first-hand glimpse of what caring for him at home would look like under COVID and without a vaccine. Long-term, it would have been overwhelming and unsustainable. The norms that I describe here are common across the other Latino cultures. In addition, similar practices of elder care exist in Asian, Slavic, and likely many other cultures. Conversations with close friends and shared experiences with my significant other have taught me that these practices of elder home care are widespread and providing care under COVID in this manner is becoming unsustainable for many. I request that this group of seniors be distinguished from nursing home residents and the general 65+ population and at that they get prioritized for vaccination appropriately. The omission of this group from the priority list is striking to me. Again, I'm speaking of seniors who are both 1) not independent, and 2) cared for by family at home. Categorizing this group as high priority vaccine recipients will protect them while allowing their families to provide them culturally appropriate care, and the positive outcomes will likely be felt across multiple cultures. Thank you very much for your time and consideration.

Susan Goold, MD, MHSA, MA, FACP
Professor of Internal Medicine, Medical School
Professor of Health Management and Policy, School of Public Health
University of Michigan

Hello. I'm Susan Goold. I'm a Professor of Internal Medicine and Health Management and Policy at the University of Michigan. First, I want like so many others to personally and professionally thank all of you for the clear excellence and commitment you bring to this work. You are thoughtfully balancing risk of exposure, risk of severe infection, and the need to maintain basic social functions, including health care capacity. I hope my comments today, combined with the CDC's long and admirable history of engaging communities in deliberations about resource allocation in case of a pandemic, can contribute to equitable allocation and distribution of COVID vaccines. My own work with community partners of focuses on justice issues in health and on increasing the voice of minority and underserved communities in policy decisions. Years ago working on pandemic preparedness, I struggled with the question not

whether to incorporate concerns for equity, but *how*. We know first-come first-served exacerbates inequity in healthcare and should avoid allocating vaccine that way as you have done. Similarly, allocating solely based on age, while appealing in simplicity, and ordered in the Twittersphere, would worsen inequity due to pre-existing disparities in life expectancy. But how can we improve equity. The National Academies, whose guidance you have often quoted, suggested that equity cut across all phases of allocation, and that that's 1a through everything, and that federal, state, and local authorities could use the Social Vulnerability Index or similar ways to provide a disproportionate share of vaccine to communities that have been disproportionately burdened by COVID. I strongly encourage you to include such a recommendation in your guidance. While as a health services researcher I would welcome the opportunity to compare varied allocation and distribution methods on equity, as an ethicist, I would favor consistent standards. Your guidance can help make that happen. Furthermore, while the phases of allocation you enumerate are morally and intellectually challenging enough, sub-prioritization, which you have talked about a great deal today within phases, would also benefit from your guidance. Perhaps social vulnerability could help providing hospitals in underserved areas with more vaccine for instance or vaccinating staff and residents of long-term care facilities in socially vulnerable areas first. If you want minority and underserved communities to trust in the vaccine distribution process, transparently recommending concrete ways to help them through this pandemic might help. In summary, I strongly encourage more explicit recommendations for both sub-prioritization and how to enhance equity. Thank you for the opportunity to speak.

Christopher Tu
Family Caregiver
Public Educator, San Ramon Valley Unified School District

My name is Christopher Tu. As a public educator in the San Ramon Valley Unified School District (SRVUSD), I've become accustomed to and quite frankly passionate about advocating for marginalized and under-represented populations. But today, instead of talking about my students or my colleagues, I'd like to give voice to a population in my cultural community that will be directly affected by any decisions made in the prioritizing of recipients for forthcoming COVID-19 vaccinations. From historical and cultural perspective, Southeast Asian families have a tendency to lean on one another and not government entities when they have needs. For example, my grandmother does not live in a care home. She lives with my aunt who has made many sacrifices to ensure that my grandmother not only continues to live in good health and safety, but also with a high quality of life for her remaining years. This is the norm for many multi-generational families that live exist across America. What the system cannot provide for them, they provide for themselves, but therein lies the systemic inequity. By not living in a care facility with a licensed nurse, someone such as my grandmother and aunt, who for all intents and purposes live in a care home and in a patient-caregiver relationship, may not check every systemically derived box necessary to be considered high priority for vaccination. This all because they like many of these under-represented families choose to work as hard as they can before becoming a burden to others or to ensure that their appropriate needs are met. Obviously, these communities cannot rely on each other for vaccinations. So, this is a critical moment where they must lean on the government and local agencies for support. In this process, it is imperative that we ensure that the decisions made and any required proverbial check boxes do not lead to further marginalization of this out group. I don't think anyone can disagree that the last 9 months have taken some form of socioemotional toll on everybody. To deprive elderly and a family member caretakers access to a vaccine further separates their level of support compared to the population norm. As one final example, if unvaccinated, these households cannot safely bring in other family members for support like vaccinated healthcare

workers could without putting themselves, others, and those they care for at further risk. As a call to action, I ask that critical reflection be taken to consider whether or not the criteria used to prioritize vaccines are truly equitable. My grandmother represents just one of the many families that consist of the silent minority of elderly who receive long-term care from family members in a private home and their positions need to be considered when further subdividing what specific groups qualify for Phases 1a, 1b, and 1c. Thank you.

Monica Peek, MD, MPH, FACP
Health Disparities Researcher & Bioethicist
Director of Research, MacLean Center for Clinical Medical Ethics

Thank you so much for having me. I am a primary care physician on the Southside of Chicago. I work at the University of Chicago. I'm also a health disparities researcher and a bioethicist. I'm the Director of Research at the MacLean Center for Clinical Medical Ethics. I'm talking today on behalf of myself and also Govind Persad JD, PhD who is a lawyer and legal professor at the University of Denver College of Law. We both are part of the Greenwall Foundation (GF). Our previous work on prioritization of COVID vaccines in the *Journal of the American Medical Association* (*JAMA*) was recently cited by the ACIP and we hope that our further comments today on this topic will be helpful to you. I'd like to first just start by expressing our gratitude and thanks to the ACIP for your thoughtful, extremely helpful deliberations and work this far, and your proposed prioritization of essential workers in Phase 1b and people with high-risk medical conditions for Phase 1c. Our comments today really are expressing concern about the equity and benefit of using a single age threshold, initially 65 and now 75, as a one-size-fits-all population-wide prioritization criterion and particularly how that has impact around equity for many populations, but particularly for a racialized minority population. Because of structural inequities and structural racism in this country, racialized minorities age differently. They physiologically age differently and have as a result shorter lifespans for many reasons, including an increased burden of chronic disease. So if you take a 70 year old white man, that may be the equivalent of a 55 year-old African-American man. We've seen differences in just the distribution curve of COVID play out amongst racial or ethnic minorities so that for white persons, only 13% of COVID deaths have been amongst people who are under 65. So the vast majority have been for people who are 65 and older, but that has not been the case for Latinx people or Black people where 35% and 30% respectively has constituted COVID deaths. So, the burden of COVID mortality that we're seeing in minority communities has shifted to a much younger population that what we are seeing in the non-minority population. So it is important, I think, for us to be thinking not just as age . . . (time expired).