Review Meeting Objectives
- Review ACIP recommendations for allocation of COVID-19 vaccines for Phase 1b and 1c
- Develop AVAAC recommendations for Phase 1b
- Determine how to share with the public final discussion and voting on recommendation

DHSS Presentation (attached)
- Vaccine Allocation Timeline
- Review Alaska Phase 1a Tiers 1, 2, 3
- Public comment summary
- Allocation communications update and upcoming Public Comment opportunities
- Review ACIP framework and recommendations for allocation of COVID-19 vaccines for Phase 1b and 1c
- MMWR published 12-22-20 on ACIP recommendations
  https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_x

AVAAC Phase 1b discussion
Committee member statements on ACIP Phase 1b recommendation for draft Alaska Phase 1b populations. Each committee member has 2 minutes to provide comments:
- Agree with ACIP, big question is how you identify patients with high risk medical conditions [for Phase 1c].
- Agree with ACIP on Phase 1b. Identify which essential workers need it most (where systems have failed) and have had to shut down. Will we have enough to cover all types of essential workers? Which mitigation strategies have worked? Which essential workers would be most important to include? Where has essential functioning failed?
  - From DHSS: Congregate living centers, homeless shelters, outbreaks make it hard to stay open. Those services where direct care and movement required between communities have been impacted heavily such as Office of Children’s Services and law enforcement. When essential services shut down because of outbreaks, some communities are not served.
- ACIP Phase 1b criteria misses congregate living centers – all should be included, both residents and staff.
- Rural priority – should be an emphasis on Indigenous communities. Communities underserved and unserved by sanitation.
- Concerns that Phase 1a Tier 3 includes too many people; recommend we include sub-prioritization criteria
- Workers at severe risk of infection or with chronic conditions who are in the essential worker category.
- Rural priority sub prioritization is essential. Workers in locations with limited access to health care resources. Congregate housing should be included.
• Keep in mind, social justice and health equity. People who don’t have access to modern sanitation or living space that allows them to protect themselves.
• Would like to know the numbers so if we need to make decisions on how to prioritize within a group, for example to prioritize rural communities.
• If we don’t think there will be enough vaccine to reach everyone, we need to provide sub-prioritization to avoid too large of a group in Phase 1b. Don’t want to make too broad a framework.
• Include sub prioritization as part of Phase 1b
• Agree with emphasis on underserved communities without access to sanitation and healthcare. Put on higher tier on this list.
• ACIP guidelines are great, question about allocation to Alaska Native community.
  o DHSS: IHS numbers calculated federally. DHSS is the shipper, not the allocator. State makes no decisions on allocation, divided by THO. No state involvement.
• Agree with prioritizing people without access to care.
• Agree with ACIP in general, break out both elders and critical societal functions. Fully support emphasis on rural and congregate living.
• First responder law enforcement needs to be high priority – critical function we cannot bypass.
• ACIP went with age cut off of 75, does this make sense for Alaska? Could we drop it lower or not?
• Agree with ACIP and rural priority and congregate living.
• Listened to ACIP, I don’t think we could come up with something better.
• It bothers me that we don’t have enough vaccine for everyone, impossible task that we know will create some chaos and high demand
• Agree with “Alaskanizing” the ACIP guidelines.
• Watched ACIP, smart group and like their guidelines. There is an advantage to keeping Phase 1b focused and defined so we can get to Phase 1c. Keep 75 & older. High risk essential workers.
  Add congregate living – but clearly define. Agree with a rural emphasis
• Agree with ACIP, important to focus on some critical infrastructure mentioned: Police and OCS
• Ethics slides – Promote justice and mitigate inequities. Would like an appeals committee or process. Found a process that could be considered for appeals.
• Agree with ACIP a lot, like Canada plan, includes congregate living centers and starts at age 80 and goes down by 5 year increments.
• Rural priority. Make the front-line workers very clear, not too broad or we won’t have enough.
• Congregate living is important. Committee needs to understand the operational impact of our allocation. 20% of vaccine went to people who didn’t fit into 1 a,b,c. Be clear about specifying who gets the vaccine.
• Agree strongly with over 75 and ACIP essential worker category. Would like sub prioritization for communities without piped water, and agree with congregate living settings, to mitigate outbreaks.
• Front line essential workers those with frequent in person contact or transportation.
• Appreciated tuning into ACIP – enlightening. Struggling with same issues. Not perfect but prioritizing rural areas without infrastructure should be called out.
• Rubric around who is front line is essential. Fishing industry huge part of economy and population. Still have seafood workers in close working and congregate living. Call out fishing
industry with essential workers. Seafood industry did ok, they really took responsibility, but they have lots of congregate living and transient housing with fishing.

- ACIP influenced how I feel about this. Keep Phase 1b smaller so we can move on. Mortality numbers useful, 4 times higher for 75+. Look at uniqueness of Alaska landscape. Sub prioritize population 65+ in work force.
- Focus on high risk population in rural areas. Distribution of vaccine distribution in rural areas. Provide some wiggle room to vaccinate people between 1b and 1c in rural areas. In a small village of 200, it is difficult to get there to provide vaccinations. In those settings we need to move through phases at a different pace.
- Include people who are Alaska Native and Native Hawaiian/Pacific Islanders in sub prioritization.
- Podcast link really good. Vaccinating people at most risk for serious illness allows this to be an illness with mild impacts. Marry the two needs. The more high-risk people we get the less this will be a burden on society.
- Police, teachers, etc. have a huge impact on society. Be aware of who else in those categories will take a lot of vaccine without as big an impact.
- Sub-prioritization - how will we do this with so many people clamoring for vaccine?

Summary age breakdown

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<td>70-74</td>
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<td>75+</td>
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Small group breakouts to discuss population groups

Frontline essential workers
- Which, if any, modifications should be made for Alaska?
- Review lists from ACIP, Alaska data

Persons aged 75+
- Which, if any, modifications should be made for Alaska?

Report back on small group discussion

Breakout group 1
- Implementation questions related to frontline essential stratified also by age, risk or other high-risk medical conditions. Seeking balance between morbidity/mortality and societal functioning.
- Ability to leave criteria open to allow local communities to decide.
- Focus on maintaining stability of industry, preservation of societal function.

Where sub-prioritization of frontline essential workers is needed due to limited vaccine supply, consider:
- Workers in locations with limited access to health care resources
- Workers in locations where high rates of transmission and/or outbreaks have occurred
- Workers who are at increased risk for severe illness based on age or underlying medical conditions*

Canadian plan. Discussed adjusting age to 70. However, the burden of disease fourfold higher among individuals aged 75+.

Breakout group 2
Priority populations for Phase 1b:

- Residents in rural communities that are unserved and underserved by sanitation facilities
- Persons residing and workers in congregate living settings including correctional facilities, and shelters for people experiencing homelessness
- Frontline essential workers
  - Use ACIP list and apply the ACIP sub-prioritization (slide 7, Oliver) to all classes of workers on the list
  - Where sub-prioritization of frontline essential workers is needed due to limited vaccine supply, consider:
    - Workers in locations where high rates of transmission and/or outbreaks have occurred
    - Workers who are at increased risk for severe illness based on age or underlying medical conditions*
    - Workers who do not have a history of documented acute SARS-CoV-2 infection in prior 90 days
  - Modify the Food & Agriculture category to prioritize fishing industry and food supply chain

Breakout group 3

- K-12 teachers and daycare – specify and narrow.
- Law enforcement and Office of Children Services – linked together as both travel to rural communities and have high exposure risk. Also include Adult protective services
- Corrections (prisons, jails) – include as congregate setting
- Congregate living setting – workers who go between settings – include domestic violence shelters and homeless shelters
- Food and agriculture - seafood in congregate living
- Transportation – specifically aviation (connected to seafood) and critical for rural communities also include Marine Highway System. Need to define who specifically – just pilots or everyone who works for aviation? Pilots only. Air traffic controllers – small group
- Work down age cohorts and comorbidity for essential workers.
- We must identify the workers who are essential in rural communities; these may be different than in urban communities. For example, grocery store clerks, in urban areas there is redundancy, in a rural community there may only be one or two.
- Define rural as off the road system without redundancy in essential workforce
- Be very clear that every vaccine with allocate to a healthy young person is taking away from a high risk person.
- Lots of workers are essential, could we prioritize those with underlying health conditions or those that are very limited.
- Minimize impact to global system, e.g. law enforcement must respond to calls, rural areas may not have as much option to switch out.
- Postal service – rural impact is much more important.

Overall Group Discussion
• How do we operationalize the 75 and older along with the frontline? Is there an order and who goes first in that group? Do we sub-prioritize those groups?
• The 75+ first and sub-prioritizations from ACIP should be applied to the essential workers at the start.
• Prioritizing 75 and older first, this essentially creates a tier 1 and tier 2
• Corrections and Seafood have both been hit hard.
• Essential workers that have had a lot of outbreaks before those without
• Essential workers without redundancy
• Have tiers within Phase 1b? By age etc. Phase 1b – 75 and above, for frontline essential, at the start prioritize within the group? Like 65 an older teacher etc.
• How do you say 75 and older is more vital than essential worker that can’t isolate, and is underserved?
• How about a tier 1 including age 75 and up, and the frontline essential workers WITH underlying medical conditions (+/- rural location)
• Underserved might jump above others if there is a lack of vaccine, that’s okay.
• Flexibility to apply 1b/1c in smaller communities would help logistics and could help disparities in communities with limited sanitation facilities; maybe topic for next meeting
• Appeals process as part of tiers – add to general section of the allocation document on appeals.
• Operational context – whoever can make the appointment first. Ask people to follow guidelines and determine if they fit into the guidelines, more or less an honor system. This creates a first come/first serve that will mean underserved populations may not have access.
• Challenge – those who are underserved may not have access to the systems to get vaccine; that is by definition what it means to be underserved.
• If we don’t make a recommendation that addresses sub-prioritization within the groups and "equal" access, which means ‘first come first served’, it will result in inequitable access. Those with high social vulnerability index will miss out in an "equal" or ‘first come first served’ access situation.
• I also agree with 75+ first, and then sub-prioritization of ACIP list. Agree that without sub-prioritization risk would be inequitable access.
• Need sub-prioritization list. As well vaccine providers need to sign an attestation that they will follow the phases and tiers. Secondly, DHSS will work with vaccine providers to help them think through access issues to help address the fair and equitable. To address the folks that don’t follow media or use the internet.
• Uncertain on whether we should address race-based disparities specifically but the deaths and hospitalizations among people who are Native Hawaiian/Pacific Islanders is remarkable. Not sure it is right to ignore this group as a priority.
• See links below and look at the relative risk data. Over 75+ have higher risk than ethnic minority groups
• Other info shared: Other essential workers that are critical to this response or functions of government – this would include legislators, governor, and other critical public health staff like epi, etc.
• One suggestion that other states and the Federal government are doing our contingency of operation plans and beginning to work down the contingency of operation schedule for vaccination.
**Resources/articles** – shared to guide thinking


Is It Lawful and Ethical to Prioritize Racial Minorities for COVID-19 Vaccines? [https://jamanetwork.com/journals/jama/fullarticle/2771581](https://jamanetwork.com/journals/jama/fullarticle/2771581)

There is precedent for prioritizing minority groups (AK Natives during H1N1).

COVID-19 Among American Indian and Alaska Native Persons — MMWR on AI/AN mortality [https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a3.htm](https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a3.htm)

**Wrap-up and Preparation for next meeting, 12/29/20**

- Committee decision on public engagement in committee comments and voting for Phase 1b at 12/29/20 meeting

Further discussion is needed on how to promote transparency without having a public vote. Take to the broader team to think through ideas.
Draft/proposed changes to Phase 1b

Phase 1b, includes the following populations.

- Persons aged 75 years and older
- Essential workers
  - Frontline Essential Workers*
    - First Responders (Firefighters, Police) not vaccinated in Phase 1a
    - Education (teachers, support staff, daycare)
    - Food & Agriculture
    - Manufacturing
    - Corrections workers
    - U.S. Postal service workers
    - Public transit workers
    - Grocery store workers
- Workers in health care setters who did not meet the criteria to be vaccinated in Phase 1a.

*Frontline Essential Workers: workers who are in sectors essential to the functioning of society and are at substantially higher risk of exposure to SARS-CoV-2

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Potential edits to Phase 1b

- Focus on 75+ before essential workers. If you put them together in phase 1b it becomes a huge group. Phase 1b – Tier 1
- Native Hawaiian/Pacific Islanders – Consider a focus on a specific ethnicity with high deaths and hospitalizations. Can’t ignore this group. Strong advocates for rural and Alaska Native. Need to focus on the data on disproportionate impact. Deprivation index, underserved workers.
- All adults living in communities that are unserved or underserved with sanitation or health care – off the road system and lack of sanitation. Adults – what ages? 50 and higher? 18 and up? Special consideration for very small communities and efficiency in implementation.
- Adults living in congregate settings and the workers – be specific about which settings are included – corrections, domestic violence, homeless shelters
- Child protective services, adult protective services
- Law enforcement
- Fishing industry priority within food and agriculture
- Transportation – aviation and marine highway system

Sub-prioritization considerations – Apply to all essential worker categories
Where sub-prioritization of frontline essential workers is needed due to limited vaccine supply, consider:
- Workers in locations with limited access to health care and sanitation resources – Rural, off the road system and lack of sanitation
- Workers in locations where high rates of transmission and/or outbreaks have occurred
- Workers who are at increased risk for severe illness based on age or underlying medical conditions
Notes from emails:

The ACIP MMWR says public health should be vaccinated in Phase 1c, but no specific mention of politicians that I could find.

“Essential worker sectors recommended for vaccination in Phase 1c include those in transportation and logistics, water and wastewater, food service, shelter and housing (e.g., construction), finance (e.g., bank tellers), information technology and communications, energy, legal, media, public safety (e.g., engineers), and public health workers.”

Other essential workers that are critical to this response or functions of government – this would include legislators, governor, and other critical public health staff like epi, etc.

One suggestion that other states and the Federal government are doing our contingency of operation plans and beginning to work down the contingency of operation schedule for vaccination.

Of the 190 Alaska Native communities, thirty-two have never been served with piped utilities, and seventeen more are under served, with piped systems never completed. These communities typically have a washeteria building (combination water treatment plant, laundromat, toilets and showers) that the entire community uses. Most of these communities haul their water from the washeteria to their home in a 5 gallon bucket, and haul their sewage from their home in a different 5 gallon bucket. Most of these communities have less per person water availability then recommended by the WHO for refugee camps. This situation is unique to Alaska and not addressed in the national recommendations. The State of Alaska needs to consider these communities and their risk in their allocation.

I also think we should consider congregate housing before expanding to more health care workers. ACIP also included some “sub-prioritization” guidance in their previous slide decks which may be beneficial to include and could help the State when supply is limited. I added language that also recognizes rural Alaska’s limited access to health care resources.

CDC will use its clinical considerations documents to provide extra guidance about sub-prioritizing people within the phase 1b and 1c priority groups.

Estimated numbers of people in unserved/underserved communities

 Unserved communities: Estimated total over 15 = 5206  

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Source: DCCED
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Underserved communities: Estimated total over 15 = 4820

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