Association of Immunization Managers (AIM) Public Comments to the National Academy of Medicine (NAM) Committee on Equitable Allocation of Vaccine for the Novel Coronavirus

September 4, 2020

Good afternoon. My name is Claire Hannan and I am the Executive Director of the Association of Immunization Managers. Our members are the individuals in state and territorial public health agencies that strive daily to ensure the timely vaccination of every child, teen and adult.

Thank you very much for the opportunity to provide comments today and thank you to the Committee for your commitment to quickly develop an overarching framework to assist in planning for equitable allocation of COVID vaccine. Immunization program managers are on the front lines of vaccine distribution planning, and they need evidence-based guidance to assure success.

I would like to share three observations upon reading the draft report, and clearly state that these observations have not been discussed or vetted with my membership due to the short time frame.

First, acknowledgement of COVID Disease Impact: I commend the Committee for thoroughly exploring all aspects of the framework and the principles on which the framework is founded. This approach clearly acknowledges "a significantly higher burden" of COVID-19 infections and deaths among Blacks, Hispanics, American Indians and Alaska Natives. The report also acknowledges that "fundamental health inequities in COVID-19 and in other health conditions are rooted in structural inequalities, racism, and residential segregation." I think this acknowledgment is critical to establishing trust in the vaccine and the public health and provider community who will be encouraging vaccination.

I am concerned, however, that the principle of mitigating health inequities when discussed alongside the principle of equal regard and fairness, may cause confusion and blur the strong acknowledgement of the higher disease impact on certain populations.

The Committee notes a key lesson from the Ebola outbreak in West Africa: "The lack of effective community engagement was among the barriers that delayed a rapid and effective response." State and local Immunization program managers need to engage in these communities where this virus is impacting populations the most. These communities know that the virus is infecting Blacks, Latinos, and Native Americans at higher rates than whites, and that hospitalizations and death rates are higher. They know because they are experiencing it.

State and local public health officials are engaging with these communities, talking with community leaders, church groups, and employers. They need to have clear information to share about the vaccine as it becomes available, and they first need to establish trust. And they need to acknowledge what these communities already know, that they have been hit harder by the disease. And they've got to explain the guidance that's being developed for the vaccine, why certain groups are prioritized to receive the vaccine first. It's very difficult to operationalize the

guidance and logic of the Committee. It is potentially difficult to acknowledge health inequities and a strong association of COVID disease infection with race and ethnicity, but then communicate that with respect to the vaccine prioritization, all individuals are regarded equally.

Second, Specificity versus Flexibility

As the Committee notes, the H1N1 vaccine program allowed state and local jurisdictions the flexibility to developing their own distribution plans. Flexibility is critically important, as workers essential to the function and economy of communities may vary from state to state. And strategies such as drive thru clinics may be great in sunny Florida but not feasible in chilly North Dakota. Flexibility needs to be balanced with the need for consistency. As the report notes, decisions made by states in 2009 around allocation of vaccine within priority groups and when to broaden vaccination efforts beyond initial priority groups led to confusion and communication challenges.

The vaccine supply is likely to be much more limited in the early phase than the populations recommended to receive the vaccine. Without additional guidance on who to prioritize within larger groupings, we could again see variance across states leading to confusion and communication challenges. Our hope is that we learn from the lessons of 2009 to apply any final recommendations with uniformity while allowing appropriate state flexibility.

Third, Translating Priorities into Outreach: While it seems entirely appropriate to prioritize "people of all ages with comorbid and underlying conditions that put them at significantly higher risk" in Phase 1B as the committee recommends, my concern is the challenge to operationalize this. It would be very difficult for public health to find and vaccinate this group with scarce vaccine without the benefit of putting vaccine out more widely in clinics and pharmacies. It could be challenging for front line vaccinators to make the determination of who qualifies in this category and what if any documentation would be necessary to approve their prioritization.

Additionally, I am concerned that millions of people who meet this criterion may not be aware they are prioritized due to the prevalence of undiagnosed chronic conditions among Americans, with the CDC estimating that 11 million Americans have undiagnosed hypertension, and 7.3 million people have undiagnosed diabetes. And regarding obesity, which the committee identifies as an important risk condition, Gallup Poll data indicate that close to half of people who are overweight or obese do not think they are overweight or obese.[1] We are going to need guidance on best ways to reach these populations and make sure the most high risk individuals are not being left behind.

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[1] Gallup, "In U.S., Majority "Not Overweight," Not Trying to Lose Weight." June 10, 2014. Available at https://news.gallup.com/poll/171287/majority-not-overweight-not-trying-lose-weight.aspx

I want to share three additional big picture considerations needed to assure equitable distribution of the vaccine:

- **Accessibility** – States have just received notice about the availability of $200 million in planning grants, which is an essential first step. We also need adequate funding to *implement* these developing plans to assure vaccine accessibility to all communities. As of today, Congress has not appropriated any dedicated funds for actual vaccine distribution, so while plans and guidance are essential, state and local immunization programs will need resources to translate both into action.

- **Affordability** – We appreciate this committee highlighting the importance of making the vaccine free and with no out-of-pocket costs that can create barriers to vaccination, particularly among those in populations suffering disproportionately from COVID. In 2014, the CDC's Community Preventive Services Task Force recommended interventions that reduce client out-of-pocket costs based on strong evidence of effectiveness in improving vaccination rates, and cited eleven studies that showed a median increase of 22 percentage points.[2] We hope that the US government is committed to making the vaccine free to all Americans, but we need to work through the policy details of what that means for vaccinators whose business plan does not allow for free vaccination of individuals who can't pay (i.e. Pharmacies). We don't want a two-tiered system.

- **Acceptance** – Two key factors that need to be built now to enhance widespread vaccine appearance are trust and transparency. FDA needs to check all the boxes in a fully open and transparent way before vaccine is available and anyone is encouraged to get it. Immunization programs are on the front lines of combatting misinformation about vaccines, and we welcome any help from this committee to assure widespread acceptance.

Finally, while we have nothing but respect for the incredible expertise and commitment represented on this committee, I do want to express my concern about the potential confusion in the field if the timing of your guidance were to somehow overlap with ACIP recommendations, or if the general public were to perceive NAM and ACIP as offering potentially disparate or competing recommendations. I would greatly appreciate this committee's attention when messaging your final report to stress and clarify your role in providing *guidance* and *information* to ACIP, while highlighting that the ACIP charter vests them with the responsibility to make formal vaccine prioritization recommendations.[3]

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[2] The Community Guide to Preventive Health Services Findings and Rationale Statement," Increasing Appropriate Vaccination: Reducing Client Out-of-Pocket Costs for Vaccinations." Available at https://www.thecommunityguide.org/sites/default/files/assets/Vaccination-Reducing-Out-of-Pocket-Costs.pdf.

[3] According to the ACIP Charter, "For each vaccine, the committee advises on population groups and/or circumstances in which a vaccine or related agent is recommended." Available at https://www.cdc.gov/vaccines/acip/committee/charter.html.

In closing, I want to comment that we also eagerly await the other aspects of the Committee's task, which will be included in the final report, specifically the guidance on risk communication and steps to mitigate vaccine hesitancy. Thank you again for the opportunity to comment.