

Coronavirus Disease 2019

Los Angeles County Department of Public Health Guidance for the Allocation of Phase 1A COVID-19 Vaccine

Guidance for the Allocation of Phase 1A

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Purpose of this Guidance

These guidelines will assist in the effective and equitable allocation of COVID-19 vaccine in Los Angeles (LA) County.

During the initial phases of vaccine allocation, the supply of vaccine is expected to be limited while the need is high. Until sufficient supply becomes available, vaccine eligibility will be determined by phases of prioritization developed by the Centers for Disease Control and Prevention (CDC) through the Advisory Committee of Immunization Practices (ACIP) as well as guidance developed by the California Department of Public Health (CDPH). Local planning is essential to further refine these broad categories and assist in implementation based on the current status and trends in



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transmission in LA County. This guidance is specific to vaccine doses under FDA Emergency Use Authorization (EUA) and includes those doses made available during the initial allocations of Phase 1A of vaccine roll-out when the supply/demand challenges will be at their highest.

Importance of vaccination against the virus that causes COVID-19

COVID-19 vaccination will be critical in preventing illness and death due to COVID-19 disease. Vaccination will help reduce the disruption to our society and economy, including the maintenance of essential healthcare capacity.

Goals and principles guiding the allocation of vaccine in Phase 1A

The following are goals and principles guiding the vaccine allocation strategy based on CDC, ACIP, and CDPH [recommendations](#):

Goals:

- Decrease death and serious disease.
- Preserve functioning of necessary healthcare services and the larger society
- Reduce the additional burden the disease is having on people already facing healthcare and income disparities.

Principles:

- Maximize benefits and minimize harms — Respect and care for people using the best available data to promote public health and minimize death and severe illness.
- Mitigate health inequities — Reduce health disparities in the burden of COVID-19 disease and death, and make sure everyone has the opportunity to be as healthy as possible.
- Promote justice — Treat affected groups, populations, and communities fairly. Remove unfair, unjust, and avoidable barriers to COVID-19 vaccination.
- Promote transparency — Make a decision that is clear, understandable, and open for review. Allow and seek public participation in the creation and review of the decision processes.

In addition to these guiding values, additional operational considerations are necessary:

- Efficient targeting —criteria to improve implementation feasibility.
- Maximum coverage —criteria that maximizes actual recipients among intended recipients.
- Minimum leakage —criteria that minimizes unintended recipients among actual recipients.

Los Angeles County Specific Considerations

LA County specific data can help ensure the effective and equitable use of the FDA EUA vaccine doses in Phase 1 priority populations. Key considerations include:

1. Epidemiology of cases and deaths among [healthcare personnel \(HCP\)](#)



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- a. Healthcare workers constitute a large, diverse group of occupations and work in a variety of settings. Healthcare worker data is complicated due to the difficulty in determining exact denominators, self-reported roles, self-reported workplace setting, and ascertaining the source of exposure.
 - b. HCP risk of infection due to SARS-CoV-2 varies depending on the availability of adequate personal protective equipment (PPE) and its correct and consistent use.
 - c. The majority of healthcare worker infections occurred among those working in congregate living facilities, acute care hospitals, outpatient settings, and EMS/first response. Adjusted for the estimated number of workers at-risk, HCP working in congregate living facilities and EMS/first response were most affected consistent with the risk of transmission in close, less controlled settings.
 - d. The largest affected group of healthcare workers was nurses consistent with their risk of prolonged, close contact.
2. Death rates for skilled nursing facility (SNF) residents
 - a. In LA County, there are 338 SNFs that house up to 34,223 residents at any one time. The cumulative [mortality](#) rate for residents of SNFs is approximately over 6,000 per 100,000 residents, using certain assumptions, compared to over 60 per 100,000 in LA County [overall](#).
 - b. Experience and outbreak investigations by Department of Public Health (DPH) staff demonstrate a high burden among similar congregate settings including memory care units, assisted living, adult residential facilities, homeless shelters, and residential care facilities.
 3. COVID-19 death rates by area of poverty, geography, and race/ethnicity
 - a. The death rate of all LA County residents, regardless of occupation, by area poverty percentage demonstrates an increasing risk gradient with increasing poverty.
 - b. Case, hospitalization and death rates continue to demonstrate the disproportionate impact of COVID-19 on Latinx, Black, Native Hawaiian and Pacific Islander communities.
 - c. Similarly, the death rates by city/community and health district demonstrate substantial geographic differences in LA County consistent with variations in the social vulnerability index (SVI) which is a comprehensive measure created and used by the federal government that includes variables that make up socioeconomic status (below poverty, unemployed, income, no high school diploma), household composition & disability (aged 65 or older, aged 17 or younger, older than age 5 with a disability, single-parent households), minority status & language (minority, speak English “less than well”), and housing type & transportation (multi-unit structures, mobile homes, crowding, no vehicle, group quarters).¹
 - d. The Healthy Places Index (HPI) is structured to highlight the community conditions shaping health outcomes in neighborhoods across California. The HPI score is the sum of its eight weighted Policy Action Areas: Economic, Education, Transportation, Social, Neighborhood, Housing, Clean Environment, and Healthcare Access.



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- e. The HPI and the SVI outline very similar regions of the County that have the highest areas of vulnerability/highest areas of need.

Phase 1A

Priority Populations

Based on the general definition and rationale for Phase 1A target groups as given in the ACIP phased approach [framework](#) and the CDPH recommendations, COVID-19 vaccine will be offered to:

- a) Persons at risk of exposure to-CoV-2 through their work in any role in direct health care or long-term care settings. This population includes persons at direct risk of exposure in their non-clinical roles, such as, but not limited to, environmental services, patient transport, or language interpretation support.
- b) Residents of skilled nursing facilities, assisted living facilities, and similar long-term care settings for older or medically vulnerable individuals.

Using the above principles and data, CDPH and LA County Department of Public Health (LACDPH) have further defined priorities within the Phase 1A populations under the assumption of a limited initial vaccine supply that does not meet demand.

Between Facility Sub-prioritization

Given limited vaccine supply, the above populations may need to undergo further sub-prioritization. Doses should be prioritized to facilities serving the greatest proportion of vulnerable persons in their catchment area, or having the greatest number of vulnerable staff, as measured by the HPI, local epidemiology, and health department subject matter expertise.

Sub-prioritization of Healthcare Workers

Given limited vaccine supply, the above populations will need to undergo further sub-prioritization. The following considerations should be used to determine which healthcare workers should be prioritized for vaccine during the initial allocations:

- 1) Type of facility
- 2) Location of facility
- 3) Attributes of individuals
 - a. Exposure risk
 - b. Clinical risk

Allocation Guidelines for COVID-19 Vaccine During Phase 1A

CDPH has provided [guidance](#) on allocation during limited dose availability during Phase 1A. COVID-19 vaccines should be directed to as many tiers, and categories in each tier as possible to reach the prioritized populations. The tiers and categories in each tier, are presented in ranked



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order yet allow for re-arrangement and specificity by local health jurisdictions given local knowledge and constraints. In addition, persons immunizing the prioritized populations should be offered immunization during or before the populations they are immunizing. The tiers are outlined below with an annotation * where LACDPH added more specifics to the outlined categories.

Tier 1

- HCP at acute care, psychiatric and correctional facility hospitals
- HCP at skilled nursing facilities, assisted living facilities, and similar settings for older or medically vulnerable individuals
- Residents at LTCF
- Paramedics, EMTs and others providing emergency medical services
- HCP at dialysis centers
- HCP as infusion centers*

Tier 2

- HCP at intermediate care facilities for persons who need non-continuous nursing supervision and supportive care
- HCP at residential Substance Use Disorder (SUD) and Mental Health facilities*
- HCP at Office of Diversion and Re-entry (ODR) and Department of Children and Family Services (DCFS)*
- Home health care and in-home supportive services personnel
- Community health workers, including *promotoras*
- Public health field staff that are part of COVID-19 field response and/or vaccinators
- HCP at primary Care clinics, including Federally Qualified Health Centers, Rural Health Centers, correctional facility clinics, and urgent care clinics

Tier 3

- HCP that work in other health care settings, including:
 - Specialty clinics
 - Laboratory workers
 - Dental and other oral health clinics
 - Pharmacy staff not working in settings at higher tiers

Operationalizing Allocation During Phase 1A

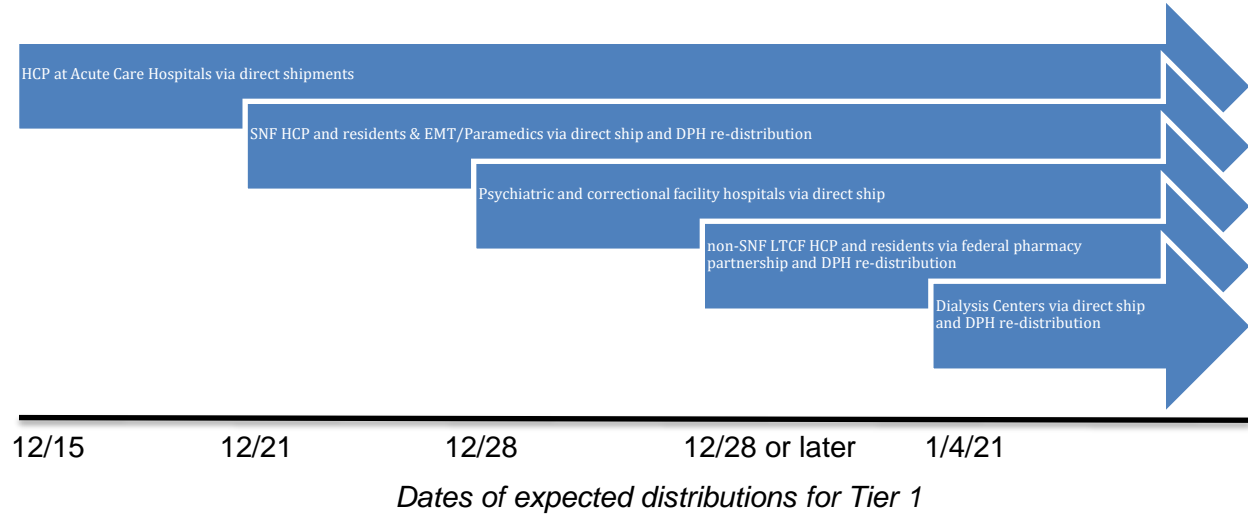
Based on the numerous constraints on the supply of the vaccines we anticipate will receive an EUA during Phase 1A, operationalizing this guidance will be challenging. The CDC agreement to receive and administer vaccine necessitates a process of submission and review into the CDPH COVIDreadi system before a provider can be allocated doses in the CalVax system. Many factors such as cold chain storage, the ability to use the minimum number of doses that can be shipped to a provider at any one time, and the target population will determine the method of distribution.



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LA County DPH will approach the sub-prioritization of tier 1 given the allocation constraints in the following way:



Within Facility Sub-Prioritization

Within a facility, individuals should be designated by exposure risk and by clinical risk assessed by the facility. Within a particular area of exposure risk, if vaccine is limited, healthcare workers who are clinically at high-risk for COVID-19 should be prioritized. (See the definition section below for additional details regarding who is considered clinically at high risk). Given initial vaccine constraints, employees that are classified as low risk for exposure should not be vaccinated in Phase 1A; they will be covered based on, ACIP proposed Phase 1B, essential workers.

Table 2. LA County DPH Phase 1A Within Facility Cascade Based on Exposure Risk

Tier	Order	Composition
I-III	1	Highest-risk units: e.g. ER, COVID designated med/surg, stepdown, ICUs
	2	High Risk Employees (defined as the number of employees who come in direct contact with and/or provide care to patients)
	3	Moderate Risk Employees (defined as number of employees (not counted in the previous question) who have indirect or limited contact with patients in their current job duties and work arrangements)
		Due to no patient contact, Low Risk Employees (defined administrative support staff with no routine patient contact) are to be vaccinated with other essential workers (ACIP Proposed Phase 1b), NOT in Phase 1A.

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Definitions

1. Healthcare and EMS workers are those involved in direct patient care, as well as those working in transport, environmental services, registration, or other healthcare services who risk daily exposure to bodily fluids or aerosols from patients or other individuals. HCP who work in less controlled environments and who have prolonged close exposure are prioritized first.
 - a. Unit wise approaches are preferred for operational ease and to provide equitable opportunity for vaccination to HCPs in different roles. However, a unit may be covered over several days, see clinical considerations below for more information. HCPs' designation to a unit is defined by location of regular work. This may be difficult in certain facilities or among certain categories of staff.
 - b. Limited vaccine will be allocated pro rata by facility size.
 - c. HCPs should not be differentiated by permanent vs contract, or paid vs unpaid, or directly employed vs consulting status if they are providing regular care.
2. Exposure risk refers to high-risk, moderate-risk, and low-risk workplace exposure to SARS-COV-2 by HCP as defined by the CDPH survey to acute care facilities and outlined in the appendix below. Exposure risk may not reflect disease incidence as the latter is modifiable, but not eliminated, by workplace interventions and individual behavior.
3. Clinical risk refers to the risk of severe COVID-19, these individuals are defined as having met two (2) or more criteria defined by CDC based on data from COVID-19 Associated Hospitalization Surveillance Network. These include:
 - Age \geq 65
 - Cancer
 - Chronic kidney disease
 - Chronic obstructive pulmonary disease
 - Immunocompromised state from solid organ transplant
 - Obesity (body mass index \geq 30)
 - Serious heart conditions (e.g., heart failure, coronary artery disease, cardiomyopathies)
 - Sickle cell disease
 - Type 2 diabetes mellitus

Additional Clinical Considerations

1. If supplies are insufficient to fully vaccinate those in a risk subgroup, the facility could consider delaying vaccinating HCPs or LTCF residents with a documented lab positive test for SARS-CoV-2 within the past 90 days. Prior SARS-CoV-2 infection, symptomatic or asymptomatic, is not a contraindication to vaccination and serologic testing for SARS-CoV-2 antibodies is not recommended prior to vaccination.
2. The number of HCP who are pregnant or breastfeeding are substantial. Currently, we do not have vaccine safety and efficacy data in this population, but these women can choose



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to be vaccinated. A discussion with their healthcare provider can aid them in making an informed decision.

3. While no serious adverse events were reported in the large, Phase 3 clinical trials for COVID-19 vaccines, local and systemic symptoms are expected. In Phase 2 and 3 vaccine trials from which detailed data is available, COVID-19 vaccination produced symptoms such as local pain, fatigue, and headache. Other recipients experienced fever, chills or myalgias. Most symptoms were graded as mild or moderate in intensity. Symptoms were more common after the second dose and among younger participants with the Pfizer vaccine. While further data is needed to determine the incidence, timing, and duration of post-vaccination symptoms, facilities should stagger vaccinations so that staff from a single shift, single specialized function, or single unit are not all vaccinated at the same time to mitigate against potential absenteeism due to post-vaccination symptoms. Facilities should plan for personnel to potentially need time off work if they develop post-vaccination symptoms.

Additional Considerations

1. Simultaneous vaccination of priority groups (high and moderate risk groups together for example) should not be conducted if vaccine supply is limited to prevent low coverage of higher priority groups and to facilitate logistics and improvement in the vaccine delivery process as larger group sizes are encountered.
2. Each group should be targeted with sufficient outreach and mobilization before proceeding to the next group. However, exceptions may be made in order to prevent any vaccine wastage. Individuals assigned to a priority group who initially decline vaccination may opt in anytime thereafter.
3. Initial allocation will only be for the 1st dose as planning for 2nd dose for those recipients will be contingent upon the size and timing of subsequent shipments. Second dose of the vaccine must be from the same manufacturer as the first dose.
4. Subsequent shipments of vaccine will undergo the same triage process starting at the group where prior supplies were exhausted or from the beginning of the list if enough time has elapsed for the group to be eligible for the 2nd dose.
5. To support immunization of their staff, facilities should provide extensive information and counseling based on the EUA fact sheets that will be available at the time of immunization.

Vaccine Accountability and Reporting

Vaccine allocation to facilities by DPH is contingent upon the conditions of the federal provider agreement in addition to local expectations of accountability. Key to accountability is timely and complete reporting. All doses administered must be entered into the State Immunization Information System (IIS), named CAIR2, the same day the dose is administered. Daily reporting to LACDPH is also required. Additionally, serious adverse events, must be reported to VAERS. The data elements and workflows for data entry will be communicated fully through other channels.



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Adherence to Recommendations

In addition to reporting, facilities are expected to adhere to the phased guidance provided by DPH. While within facility flexibility exists within this framework, major departures may constitute grounds for cessation of further dose allocations in order to ensure an equitable and transparent allocation process central to public health aims and public trust. Each receiving facility should designate a coordinator for vaccine distribution. This individual should have a clinical background to assess medical history and be involved with COVID-19 control within the facility. They must oversee completion of vaccine recipient lists and be the designated arbiter for review of any vaccination requests or questions to ensure a fair, transparent process.

Footnotes

¹ <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>

Resources

- [National Academies Phased Approach](#)
- [CDC Clinical Considerations for COVID-19 Vaccine](#)
- [CDC COVID-19 Vaccine Recommendations Process](#)
- [CDPH Essential Workforce](#)
- [LACDPH Healthcare Worker Surveillance Report](#)
- [CDPH COVID-19 Vaccine Playbook](#)
- [LAC DPH COVID-19 Surveillance Dashboard](#)
- [ACIP Meeting Slides Dec 3, 2020](#)

Appendices

Appendix 1. Risk Stratification according the CDPH AFL COVID-19 Vaccine Survey

Highest-risk employee: front-line clinical staff who care for patients in high risk settings or for patients with unknown COVID-19 status (e.g. ED, ICU, urgent care, respiratory therapists, anesthesiologists, etc)

High-risk employee: front-line clinical staff who provide direct patient care and support staff with risk of exposure to bodily fluids or aerosols (e.g. EVS staff)

Moderate-risk employee: staff who have indirect or limited patient contact (e.g. food services, medical records, front desk staff)

Low-risk employee: administrative support staff with no routine patient contact.

