



Disability Rights Education & Defense Fund



CALIFORNIA ACADEMY OF FAMILY PHYSICIANS  
STRONG MEDICINE FOR CALIFORNIA



February 19, 2021

Governor Gavin Newsom  
1303 10th Street, Suite 1173  
Sacramento, CA 95814

**Re: Equity Must Drive Vaccine Distribution**

Dear Governor Newsom,

We write today as organizations representing the millions of low-income people of color in California, including those served by community health centers, independent physician practices, and counties - most of whom are on Medi-Cal or uninsured. This is the very population the state is focused on vaccinating in an equitable manner, and significant resources are being spent on combatting fear and hesitancy via trusted messengers and providers. These individuals trust their healthcare providers because these providers understand their patients' unique concerns and needs - all of which will be effectively forsaken due to the state's push for speed and centralization of the vaccine administration in California. **We urgently request the state maintain the current system that has allowed for vaccines to be distributed through counties, while the state works to ensure that community health centers, independent community practices, and counties are all: part of the distribution system; appropriately contracted and onboarded with the new Blue Shield Third Party Administrator (BS TPA); and that the general public understands the new system. There remains much confusion about the vaccination process at both the state and local levels. Furthermore, a complete shift to myTurn should not be made until the system can achieve a series of critical functions.**

We appreciate the vision the state has put forward via the TPA. Creating a statewide integrated data system for vaccines is admirable, and once developed, could help to target and ensure the vaccine is administered appropriately and expediently. However, the speed of the rollout threatens to block safety

net and community-based providers from receiving and administering the vaccine. The Blue Shield TPA has proposed providing financial incentives to providers, should they refer and their patients be vaccinated by other providers that have been onboarded by the TPA. While we appreciate the idea to include all providers, we advise against developing a new referral system instead of simply allowing these providers to continue receiving and administering the vaccine. We also strongly recommend that the state require the TPA to utilize similar strategies to the FEMA sites, allowing community-based organizations to register their members for reserved appointments and soliciting community input regarding the most effective mobile vaccination sites. If the state would simply allow all providers to be onboarded before shutting off the current system, these incentive tools wouldn't be necessary, and patients could receive a vaccine from their already trusted providers.

Furthermore, the current functionality of myTurn is not yet ready. The system is not yet available in all of the threshold Medi-Cal languages, nor is there a clear timeline in place to do so. It also does not have functionality to target the people most in need of the vaccine. For example, there is no way to indicate that an individual registering for a vaccine appointment is homebound, in need of transportation, or needs a specific accessibility or policy modification. The system must be fully operational and easy to use for both providers and patients in order for any county or the state to go live with this tool as the central mechanism to distribute and administer the vaccine. If the state moves too quickly, it will only create more confusion and frustration for Californians seeking to receive the vaccine. **We recommend that no county be moved to the new TPA system until the following is achieved:**

- myTurn is available in all Medi-Cal threshold languages.
  - Currently, the system is only available in English and Spanish. In order for all Californians to access the vaccine via MyTurn, it must be made available in all languages spoken by Californians, including indigenous languages.
- myTurn has both private and public clinic functions.
  - Currently, the site only has the “public clinic” function which means any vaccine clinics scheduled will be publicly viewable through the myTurn appointment site.
  - The public clinic is easily accessible to many individuals and vaccine appointments are not easily saved for those who are most in need - older, brown and black, Native Americans and Native Hawaiians and Pacific Islanders, others at high-risk, and vulnerable populations including agricultural workers, homeless, and essential workers.
- Providers and community-based organizations (CBOs) have resources to help patients navigate the myTurn site.
  - Many of the people most in need of the vaccine cannot navigate the myTurn site. There are digital literacy, reading level, and broadband divides inhibiting easy use of myTurn. We are witnessing these barriers in real time as older adults and those with limited English proficiency (LEP) struggle to navigate the vaccine registration process.
  - Safety net providers, CBOs, and independent physician practices need resources for staff to help their patients and constituents schedule through myTurn.
- Providers have been trained and onboarded to myTurn
  - All current vaccinating providers, particularly the CHCs, independent physician practices, and counties, need to be supported in onboarding to myTurn.
  - The state should focus on building interfaces with all the electronic medical records and prioritize those utilized by the safety net first.

Given the state's announcement that individuals 16-64 years old who are deemed to be at very high risk for morbidity and mortality from COVID-19 are eligible to be vaccinated beginning March 15, we further urge that the state work in an expedited fashion to answer key questions like how the TPA and its network will successfully vaccinate individuals in this population.

**Finally, we recommend that more robust and uniform data on vaccine administration be released regularly in order to make allocation decisions and ensure accountability of the TPA.** The TPA must be held accountable to specific and transparent equity goals. Specifically, we recommend the following:

- Provide a greater level of disaggregation in the race/ethnicity data, including Asian and Pacific Islander subpopulations who have vastly different levels of vulnerability and access to health systems and whose disproportionate impact is often masked by being included in the larger racial category.
- Add sexual orientation and gender identity data in order to accurately assess and address vaccine access gaps for the community.
- Allow for data to be viewed in an intersectional manner. For example, the race/ethnicity breakdown of people 65+ who have received the vaccine.
  - Siloing demographic information ignores the compounding impact of discrimination that COVID-19 has brought to bear and limits our ability to measure the state's progress toward equitable distribution.
  - Furthermore, the state must work with the TPA to report data across other metrics, including for example, whether an individual resides in a congregate setting, or has multiple chronic conditions or a functional limitation.
- Working with CHCs and CBOs to map vaccine distribution using a measure of social vulnerability that includes measures beyond the Healthy Places Index (HPI) to more clearly determine whether the vaccine is reaching the places of highest need or where we need to direct additional outreach and allocation.
  - Composite tools, like the Healthy Places Index, are important, but there is value in augmenting the HPI with additional indices and tools that consider racial equity, language spoken or LEP, multi-generational households, and COVID-19 risk. We recommend that the state, TPA and local health jurisdictions augment the HPI with additional indices, if used. We would recommend exploring other tools, such as the UCLA Pre-Existing Health Vulnerability (PHV) index, created specifically for the pandemic, which captures the risks or severity of COVID-19 infection due to preexisting health conditions.
  - Regardless of the risk/vulnerability index that is used, mapping COVID-19 risk is not the only way to vaccinate against COVID-19 and achieve health equity. In many communities, geography is a far less useful than how people associate. Many communities congregate around churches, CBOs, cultural centers or other central hubs regardless of where they reside. Moreover, dispersed communities will orient around a single church or organization, making that entity the access point. Furthermore, some small, isolated communities have fewer points of access, need culturally or linguistically competent services, and require targeted outreach. Therefore, CBOs, CHCs, and others working with high-risk populations, i.e., racial/ethnic communities, immigrants, LEP individuals, persons with disabilities, etc. should lead the strategy to most effectively reach COVID-19 vulnerable populations.

California cannot achieve an equitable end to this pandemic without all CHCs, independent physician practices, and counties participating. **We respectfully ask the Administration to prioritize and include all CHCs, independent physician practices, and counties to be a part of the Blue Shield TPA, and only once all of these providers are onboarded would the county switch from the current system to the new TPA.** Once this is accomplished and the switch has occurred, we urge you to utilize robust and uniform disaggregated data collection and reporting mechanisms to the TPA accountable to provide equitable access to the vaccine.

We welcome the opportunity to discuss how to equitably vaccinate California to achieve herd immunity. Andie Martinez Patterson, VP of Government Affairs, ([apatterson@cpcac.org](mailto:apatterson@cpcac.org)) can coordinate a follow-up meeting as soon as possible.

Sincerely,

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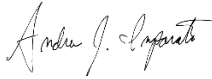
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