

COUNCIL OF THE CITY OF PHILADELPHIA
COMMITTEE ON PUBLIC HEALTH AND
HUMAN SERVICES

Via Microsoft Teams
Philadelphia, Pennsylvania
Thursday, November 19, 2020
1:06 p.m.

PRESENT:
COUNCILWOMAN CINDY BASS, CHAIR
COUNCILWOMAN KENDRA BROOKS
COUNCILMAN ALLAN DOMB
COUNCILMAN DEREK GREEN
COUNCILWOMAN HELEN GYM
COUNCILMAN BOBBY HENON
COUNCILMAN ISAIAH THOMAS

RESOLUTIONS 200403 and 200520

- - -

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2 COUNCILWOMAN BASS: Good

3 afternoon. I understand that state law
4 currently requires that the following
5 announcement be made at the beginning of
6 every remote public hearing as follows:

7 Due to the current public
8 health emergency, City Council committees
9 are currently meeting remotely. We are
10 using Microsoft Teams to make these
11 remote hearings possible. Instructions
12 for how the public may view and offer
13 public testimony at public hearings of
14 Council committees are included in the
15 public hearing notices that are published
16 in the Daily News, Inquirer, and Legal
17 Intelligencer prior to the hearings, and
18 can also be found on PHLCouncil.com.

19 I now note the hour has come.
20 And, Clerk, will you please call the roll
21 to take attendance. Members that are in
22 attendance will please indicate that you
23 are present when your name is called.
24 Also please say a few brief words when
25 responding so that your image will be

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2 displayed on screen when you speak.

3 Madam Clerk.

4 THE CLERK: Councilmember

5 Henon.

6 COUNCILMAN HENON: Good

7 morning, Madam Chair -- or good

8 afternoon, Madam Chair, and good

9 afternoon, colleagues.

10 THE CLERK: Councilmember Oh.

11 COUNCILMAN OH: Good morning,

12 Madam Chair. Good morning -- good

13 afternoon, Madam Chair. Good afternoon,

14 colleagues.

15 THE CLERK: Councilmember Gym.

16 COUNCILWOMAN GYM: Good

17 afternoon, everybody. I look forward to

18 this hearing.

19 THE CLERK: Councilmember

20 Green.

21 (No response.)

22 THE CLERK: Councilmember

23 Thomas.

24 COUNCILMAN THOMAS: Good

25 afternoon. I'm present.

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2 THE CLERK: Councilmember
3 Brooks.

4 COUNCILWOMAN BROOKS: Good
5 afternoon. I'm present.

6 THE CLERK: And Chairperson
7 Bass.

8 COUNCILWOMAN BASS: Good
9 afternoon. I am present. Thank you,
10 Madam Clerk.

11 And a quorum of the Committee
12 is present and this hearing is now called
13 to order. This is a public hearing of
14 the Committee on Public Health and Human
15 Services regarding Resolution No. 200520.
16 Resolution No. 200403 is being held at
17 the request of the sponsor and will not
18 be heard today.

19 Madam Clerk, will you please
20 read the title of the resolution.

21 THE CLERK: A resolution
22 authorizing the Committee on Health and
23 Human Services to hold hearings to
24 evaluate the City of Philadelphia's plan
25 for distributing, tracking, and otherwise

1 11/19/20 - PUBLIC HEALTH - RES. 200520
2 managing the roll out of the COVID-19
3 vaccine.

4 COUNCILWOMAN BASS: Before I
5 hear testimony -- can I ask that if you
6 are not speaking, please mute your phone.
7 Thank you.

8 Before we begin to hear
9 testimony from the witnesses we have for
10 today, everyone who has been invited to
11 the meeting to testify should be aware
12 that this public hearing is being
13 recorded. Because the hearing is public,
14 participants and viewers have no
15 reasonable expectation of privacy. By
16 continuing to be in the meeting, you are
17 consenting to being recorded.

18 Additionally, prior to
19 recognizing members for the questions or
20 comments they have for the witnesses, I
21 will note for the record at this time
22 that we will use the Chat feature
23 available in Microsoft Teams to allow
24 members to signify that they wish to be
25 recognized. In order to comply with the

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2 Sunshine Act, the Chat feature must only
3 be used for this purpose.

4 Madam Clerk, will please call
5 the first panel of witnesses that we have
6 to testify this afternoon. And before
7 they testify, we will hear from the bill
8 sponsor. He has a statement, and other
9 members of Council.

10 Madam Clerk.

11 COUNCILMAN GREEN: Madam Chair,
12 I just wanted to say Councilmember Green
13 here is present.

14 COUNCILWOMAN BASS: Thank you,
15 Councilmember.

16 COUNCILMAN GREEN: Thank you.

17 THE CLERK: The first panel is
18 Dr. Caroline Johnson, Deputy
19 Commissioner, the Philadelphia Department
20 of Public Health.

21 COUNCILWOMAN BASS: Okay. And
22 while we await for the doctor's
23 testimony, I want to recognize Councilman
24 Henon.

25 COUNCILMAN HENON: Thank you,

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2 Madam Chair, and I appreciate this
3 opportunity and thank you for being a
4 co-introducer of this resolution for this
5 extremely important conversation that
6 we're about to have here today.

7 So I want to thank everybody
8 for joining us here today to discuss the
9 COVID-19 pandemic and the COVID-19
10 vaccine. We are joined by doctors,
11 policymakers, infectious disease
12 specialists, and other leaders in the
13 fight against COVID-19 in Philadelphia.

14 We are here today with the hope
15 of understanding at minimum the
16 following:

17 One, what is the process,
18 timeline associated with the development
19 of distribution of the COVID-19 vaccine.

20 Two, what is the process by
21 which the vaccine should be distributed
22 and administered in Philadelphia,
23 including timelines, cost, barriers to
24 effective distribution, and the
25 infrastructure.

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2 Three, how to effectively
3 educate the Philadelphia public about the
4 safety and efficiency of the vaccine
5 administered, especially in communities
6 that have a historically based mistrust
7 of the health system.

8 Four, the role that City
9 government plays in ensuring that
10 Philadelphia gets vaccinated and how we
11 should measure its success of programs
12 aimed at vaccinating the Philadelphia
13 public.

14 In the interest of time, I'm
15 going to limit my comments at this
16 particular moment, except to say that the
17 COVID-19 pandemic has not only resulted
18 in a dramatic loss of life and
19 well-being, it has seriously damaged the
20 Philadelphia economy. It is going to
21 take time, effort, and commitment to
22 rebuild, but the process can't begin
23 until Philadelphians are vaccinated.

24 So thank you for your time,
25 Madam Chair, and you can proceed as you

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2 wish. Thank you.

3 COUNCILWOMAN BASS: Thank you,
4 Councilman, for your statement. I want
5 to, number one, thank you for working
6 with me to be a part of this very
7 important resolution. As someone who
8 knows firsthand the devastation of
9 mistrust, when the people have a mistrust
10 of a medical system or medical community,
11 the effects are devastating. And so
12 while we have this vaccine, it appears,
13 on the horizon, we've heard in the last
14 week or so that there has been two
15 potential candidates to be administered
16 that have an extremely high effectiveness
17 rate, and we want to make sure that
18 people have the information so that they
19 don't fear the vaccine.

20 We want them to make sure that
21 they know exactly what some of the
22 effects would be, what some of the
23 concerns should be, and how it will have
24 an effect on our community, and how do we
25 get it into the communities that have had

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2 concern about the medical community for a
3 very long time. And I'm speaking
4 specifically of the African American
5 community, not just in Philadelphia but
6 just across this nation that hasn't
7 always had positive contacts and outcomes
8 with the medical community.

9 So we want to change that
10 dynamic. This is a great opportunity to
11 do so. And so if we're able to flush out
12 the ways in which we operate and the ways
13 in which we communicate, I think that we
14 can all be very, very successful and have
15 successful outcomes for all of our
16 communities.

17 So I want to thank the
18 Councilman for his forethought and vision
19 on this.

20 And that being said, why don't
21 we hear from our first testifier.
22 Doctor, if you could again state your
23 name for the record and then proceed with
24 your testimony.

25 DR. JOHNSON: Good afternoon.

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2 I am Caroline Johnson and I am actually
3 very thrilled to be here and that we're
4 covering this topic this afternoon. I'm
5 the Deputy Commissioner for the
6 Philadelphia Department of Public Health,
7 and I have been leading the planning
8 process for COVID-19 vaccine distribution
9 in Philadelphia. Thank you for inviting
10 me to testify on Resolution No. 200520,
11 which authorizes the Committee on Public
12 Health and Human Services to hold
13 hearings on the City of Philadelphia's
14 plan for the rollout of COVID-19 vaccine.

15 As you know, COVID-19 is an
16 infectious disease caused by the novel
17 coronavirus SARS-CoV-2. It was first
18 detected in December of 2019, and since
19 then, there have been over 55 million
20 cases worldwide, 11 million cases in the
21 United States, and at least 55,000 cases
22 in Philadelphia.

23 While some people may be
24 asymptomatic or experience only mild
25 symptoms from infection, others,

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2 including seniors and persons with
3 chronic health conditions, are at a
4 higher risk for severe illness and death.
5 Social distancing measures and use of
6 face masks have helped mitigate
7 transmission. However, social distancing
8 measures that require business closures
9 and restrictions on gatherings have also
10 resulted in social and economic strains
11 and hardships for the City and for
12 individuals.

13 Immunization with a safe and
14 effective COVID-19 vaccine is a critical
15 component to the national strategy to
16 control this pandemic. It may be the
17 single most important component of the
18 strategy.

19 Many COVID-19 vaccine
20 candidates are currently in development
21 or under evaluation. In addition, Phase
22 3 clinical trials to determine safety and
23 efficacy of several of the most promising
24 vaccines are very near to completion, and
25 their results should be available soon,

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2 and by "soon," I mean within the next few
3 weeks. Large-scale manufacturing of the
4 COVID-19 vaccine is being done
5 simultaneously with these clinical
6 trials, which will allow for rapid
7 release of the vaccine once it receives
8 the authorization from the U.S. Food and
9 Drug Administration.

10 The Philadelphia Department of
11 Public Health will be the lead agency
12 overseeing distribution of COVID-19
13 vaccines to residents of Philadelphia.
14 Distribution will be different than for
15 other vaccines, in that healthcare
16 providers will not be able to order this
17 vaccine from manufacturers and suppliers
18 directly. All ordering, storing,
19 administration, and reporting of COVID-19
20 vaccines will be managed or overseen by
21 the Health Department, and they must be
22 conducted in accord with rules and
23 practice guidelines established by the
24 Centers for Disease Control and
25 Prevention. This is expected to include

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2 restrictions on the persons who are
3 eligible to receive the earliest doses of
4 vaccine arriving in the City.

5 Since 1994, the Health
6 Department's immunization program has
7 served as one of 64 programs funded by
8 the CDC to control vaccine-preventable
9 diseases and the increased immunization
10 coverage across our city. The program is
11 federally funded to oversee the
12 government purchase and local
13 distribution of vaccines to 70 percent of
14 children in the City and to many
15 vulnerable adults. I point this out
16 because it indicates that we already have
17 experience in managing large-scale
18 immunization programs.

19 The immunization program also
20 manages the local immunization
21 information system, known as PhilaVax,
22 which is the secure data system that
23 allows healthcare providers to access
24 patient immunization records to
25 facilitate vaccination of their patients.

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2 The local immunization
3 program's experience in distributing
4 vaccines working with healthcare
5 providers to assure adequate vaccine
6 storage and handling practices, promoting
7 vaccine administration in accord with
8 established recommendations, tracking
9 uptake of vaccines, and educating the
10 public on the benefits of immunization
11 has positioned the Department well for
12 overseeing distribution of COVID-19
13 vaccines.

14 In mid October, the Health
15 Department submitted a draft COVID-19
16 vaccine distribution plan to the CDC, as
17 it was required to be included in the
18 national strategy. This plan addresses
19 the 15 areas identified by the CDC and
20 their Interim Playbook for Jurisdictional
21 Operations that was issued on September
22 16th. That means we had a four-week
23 turnaround to produce a 150-page document
24 that was going to identify all of our
25 processes.

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2 The local plan was developed by
3 the Health Department, guided by
4 recommendations from the COVID-19 Vaccine
5 Advisory Committee. The Vaccine Advisory
6 Committee is comprised of local
7 stakeholders representing healthcare,
8 vulnerable populations, faith-based
9 organizations, the business sector,
10 insurers, and others in the City affected
11 by the pandemic. Several members of this
12 Vaccine Advisory Committee are going to
13 be testifying to you today.

14 The Vaccine Advisory Committee
15 was established to advise on
16 prioritization strategies for vaccine
17 distribution, to address health equity
18 issues, and to guide communication and
19 community engagement strategies to build
20 trust and promote vaccine uptake.

21 The COVID-19 vaccine
22 distribution plan in Philadelphia covers
23 a variety of topics, including defining
24 critical populations, recruiting and
25 training providers on vaccine use,

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2 storage and handling, models of vaccine
3 distribution, data collection and
4 reporting, public information, and
5 monitoring COVID-19 vaccinations for
6 safety and uptake.

7 Given that vaccine availability
8 is likely to be limited initially,
9 Philadelphia is planning for a phased
10 approach to COVID-19 vaccinations. In
11 Phase 1, vaccine administration will
12 concentrate on populations of high risk
13 of acquiring infection, transmitting
14 infection to vulnerable populations or
15 suffering severe consequences in
16 infection. This phase will likely
17 include healthcare workers with direct
18 patient contact, critical workforce, and
19 persons with defined underlying medical
20 conditions.

21 As the supply of vaccine
22 increases in Phase 2, the Health
23 Department will prioritize vaccinating
24 those persons who were not reached in the
25 first phase and still needed to be

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2 vaccinated, as well as it will expand to
3 include moderate-risk essential workers
4 and additional persons who might
5 experience complications of infection.

6 In Phase 3, COVID-19 vaccine
7 supply will be sufficient for the entire
8 population. The Health Department will
9 create a broad vaccine administration
10 network to achieve sustainable and
11 equitable vaccine access across the City.
12 The network will include private
13 healthcare providers, pharmacies,
14 clinics, hospitals, community service
15 organizations, and several mass
16 vaccination events.

17 There is much we don't know
18 about the COVID-19 vaccine. We don't
19 know if the FDA will find the vaccine or
20 several of the vaccines to be safe and
21 effective and, therefore, issue an
22 emergency use authorization. We don't
23 know which populations the FDA will
24 authorize is eligible to receive the
25 earliest doses of vaccine. We don't know

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2 which product or products Philadelphia
3 will receive, nor do we know how many
4 doses we'll get and when we will get
5 them. We also don't know what the
6 storage requirements will be for the
7 vaccine. I'm sure you're all aware of
8 the requirement for one of the vaccines
9 to be held at what's called ultra cold
10 temperatures, and that's a difficult
11 complication for many people to handle.

12 So a lot of these unknowns
13 really complicate our planning process,
14 but we're taking into account as many
15 possibilities as we can.

16 And that's the end of my
17 testimony. I'm happy to take questions
18 now or at the end of this panel.

19 COUNCILWOMAN BASS: Thank you,
20 Dr. Johnson.

21 Let me defer first to
22 Councilman Henon, if he has questions,
23 and I'll go after him with my questions.

24 Councilman Henon.

25 COUNCILMAN HENON: Thank you,

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2 Madam Chair. I do have some questions,
3 but if I can have a point of order. We
4 have somebody who is testifying on the
5 next panel and I ask the Chair for
6 courtesy for Dr. Rick Nettles --

7 COUNCILWOMAN BASS: I do see
8 that now.

9 COUNCILMAN HENON: -- from
10 Johnson and Johnson, who has got a hard
11 stop and leave. So if that's okay with
12 Dr. Johnson to reserve the questions for
13 the panels, which I do have questions.

14 COUNCILWOMAN BASS: Sure.

15 COUNCILMAN HENON: To give the
16 doctor a chance for Johnson and Johnson.
17 He's the only person that responded from
18 any of the drug companies.

19 COUNCILWOMAN BASS: Absolutely.
20 I would ask that Dr. Caroline Johnson, if
21 you just hang for a moment, and let's
22 bring forward Dr. Nettles, is it?

23 DR. NETTLES: Yes.

24 COUNCILWOMAN BASS: Thank you
25 so much for being here and for

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2 testifying. Please state your name for
3 the record and begin with your testimony.

4 DR. NETTLES: Yes. Thank you
5 very much for inviting us. My name is
6 Rick Nettles. I'm an infectious disease
7 physician and I'm representing Janssen
8 Pharmaceutical Companies of Johnson and
9 Johnson. We have been working on our
10 COVID-19 vaccine beginning in January of
11 this year when the genetic sequence of
12 Coronavirus was released out of China.
13 We are leveraging an adenovirus-based
14 platform that we have used to develop
15 other vaccines, the first of which was
16 approved in Europe this summer. That
17 platform has been used to develop an HIV
18 vaccine, an Ebola vaccine, and an RSV
19 vaccine and has been used in now over
20 110,000 individuals.

21 But specifically for the COVID
22 vaccine, we've moved forward this year in
23 pre-clinical studies in Rhesus macaque
24 monkeys. The trial results are published
25 in the Journal of Nature where we showed

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2 the vaccine was able to induce antibodies
3 fourfold greater than those induced by
4 macaques that have been infected with
5 Coronavirus. Based on this data, we
6 moved forward into a Phase 1/2a clinical
7 trial that has enrolled over a thousand
8 individuals, the safety and
9 immunogenicity of which convinced us and
10 the FDA that we could move forward into a
11 Phase 3 clinical trial.

12 We're now in Phase 3 clinical
13 trials. They're called Ensemble 1 and
14 Ensemble 2. The Ensemble 1 trial is
15 important because it's a single-dose
16 vaccination series, which is different
17 from some of the vaccines that will
18 become available initially. The Ensemble
19 1 trial has two sites in the City of
20 Philadelphia, one at the University of
21 Pennsylvania and one at Temple University
22 that are currently enrolling subjects in
23 it.

24 At J&J, we understand that
25 transparency is critically important

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2 during this period of uncertainty. We've
3 made our full Phase 3 clinical trial
4 protocol available online, and we are
5 committed to publish the results of our
6 trials in peer-reviewed journals, and in
7 the case of the Phase 1/2a trial that I
8 referred to, we've made that available on
9 medRxiv online before it's available in
10 print.

11 We also understand the
12 importance of including a diverse
13 population in our clinical trials and are
14 committed to enrolling a population in
15 our trial that's consistent with the U.S.
16 demographics, specifically focusing on
17 enrolling African American, Hispanic, and
18 Native American individuals in our
19 clinical trial.

20 And, finally, we're committed
21 to safety. We understand that if the
22 general population does not believe in
23 the safety of the vaccines, they will not
24 agree to take it. And so we have signed
25 a vaccine manufacturer's pledge stating

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2 that we will not put forward the vaccines
3 for approval by the FDA until we feel
4 confident that we have achieved safety
5 and efficacy signal in our Phase 3
6 trials.

7 The Ensemble 1 clinical trial
8 will enroll up to 60,000 individuals and
9 the Ensemble 2 clinical trial will enroll
10 up to 30,000 individuals. So these are
11 very large Phase 3 clinical trials.

12 And then, finally, I would end
13 where Caroline Johnson mentioned as well,
14 we have scaled up our manufacturing
15 capability in parallel with conducting
16 the clinical trials. We've signed a
17 manufacturing agreement with the U.S.
18 government to supply 100 million doses of
19 the vaccine in 2021. We're partnering
20 with Operation Warp Speed, so the
21 distribution of the vaccine would flow
22 through the federal government during the
23 pandemic period, and we've agreed to a
24 not-for-profit price for our vaccine as
25 well during the pandemic period.

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2 So I would stop there and take
3 any questions that you have.

4 COUNCILWOMAN BASS: Well, thank
5 you very much for your testimony. I just
6 have one quick question and, that is,
7 when you stated that there were -- you're
8 planning to have over or approximately
9 100 million doses here in the United
10 States. Can you talk about your
11 worldwide vision? Because as we know,
12 this pandemic, it travels, it spreads,
13 it's moving around. And so what does it
14 look like in terms of distribution beyond
15 our borders?

16 DR. NETTLES: Yes. Absolutely.
17 If there's a Coronavirus anywhere in the
18 world, it can get everywhere in the world
19 very quickly. I completely agree. So
20 we've scaled up our manufacturing not
21 just in the U.S. but in Europe and in
22 Asia as well, and we are in discussions
23 with similar advanced purchase agreements
24 that we have for the U.S. government in
25 2021 to supply hundreds of millions of

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2 doses around the world.

3 COUNCILWOMAN BASS: Excellent.

4 Excellent. Okay.

5 Councilman Henon.

6 COUNCILMAN HENON: Thank you,

7 Madam Chair.

8 And, Doctor, I want to thank
9 you for taking your time out today. J&J
10 was the only pharmaceutical company that
11 was able to join us, so we appreciate
12 your presence and your expertise. And I
13 think my two questions you may have
14 answered in your opening statement,
15 reiterating the reasons why people should
16 not be afraid to take the vaccine when it
17 is available. I believe you answered
18 that; is that correct?

19 DR. NETTLES: Well, there's a
20 couple of things. I think we're using a
21 vaccine platform that has been used in a
22 very large number of people, over
23 110,000, to develop other vaccines, but I
24 think the other point is that the Phase 3
25 clinical trials are very large, and so

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2 while we're moving forward rapidly this
3 year in the development of these
4 vaccines, we're not cutting corners with
5 regard to safety or cutting corners with
6 regard to the size of the clinical
7 trials.

8 COUNCILMAN HENON: And that's
9 great to hear. And I know that you had
10 mentioned a pledge about the safety and
11 efficacy of COVID-19 vaccines, so I'm
12 also glad to hear that you have taken
13 that public opinion and you're talking
14 about that and making sure -- and to
15 ensure that the public could be confident
16 of all the hard work that has been done.

17 So I want to thank you for your
18 time and I want to thank you for
19 answering those questions.

20 Thank you, Madam Chair.

21 COUNCILWOMAN BASS: Thank you.

22 And I just wanted to say in
23 closing, because I know that you have to
24 leave, Dr. Nettles, but Councilman Henon
25 was just being way too kind by saying

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2 that you were the only one who was
3 available to testify. I do believe that
4 this is so important that there are other
5 pharmaceutical giants who could have
6 certainly made themselves available. So
7 I certainly want to send a special thank
8 you to Johnson and Johnson for making
9 sure that you had someone here at the
10 table here in Philadelphia where COVID
11 has just been exploding, as we know, as
12 it is around the nation, but really it's
13 been exploding particularly in the
14 African American community.

15 So I really wanted to say a
16 great big thank you, because I do believe
17 that as your time is valuable, you
18 prioritized and made time to come and
19 talk to us, and I think that that just
20 goes a long way in terms of making people
21 feel comfortable and making people feel
22 that this is someone that we can connect
23 to that understands our concerns, that
24 here is what some of the things are that
25 we are worried about and is a voice that

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2 we can connect with. So I just really
3 wanted to say a special thank you for
4 making yourself available.

5 DR. NETTLES: Absolutely. And
6 should the FDA find our vaccine to be
7 safe and effective and it be approved
8 under emergency use authorization, please
9 call J&J whenever you need us to support
10 your implementation of the vaccine around
11 the City.

12 COUNCILWOMAN BASS: Thank you.
13 Thank you very much.

14 Doctor, before you go, I think
15 that we have a question for you
16 actually --

17 DR. STANFORD: From Dr.
18 Stanford.

19 COUNCILWOMAN BASS:
20 Dr. Stanford, generally in hearings the
21 questions are between the panel and the
22 members of Council. So I'm going to ask
23 that you hold your question and we can
24 get it to Dr. Nettles, if that's okay
25 with you. If you don't mind, we're just

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2 going to ask you to hold the question.

3 Okay. One moment.

4 And we're going to rearrange
5 some things here as well. Dr. Nettles,
6 you can be dismissed at this point.

7 We have three testifiers from
8 Jefferson University that have to leave
9 by 2:00 p.m., so we're going to include
10 them to sort of rearrange the schedule
11 and add them to this panel as well.

12 So, Sabrina, can you call their
13 names and have them start their testimony
14 for the record.

15 THE CLERK: Dr. Bon Ku, the
16 Marta and Robert Adelson Professor of
17 Medicine and Design, Director, Health
18 Design Lab, Professor of Emergency
19 Medicine, Thomas Jefferson University;
20 Dr. Rose Ritts, Executive VP and Chief
21 Innovation Officer, Jefferson Health and
22 Thomas Jefferson University; and Dr. John
23 Zurlo, the W. Paul and Ida Havens
24 Professorship of Infectious Diseases,
25 Director, Division of Infectious

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2 Diseases, Chair, Jefferson Enterprise
3 COVID-19 Task Force at Thomas Jefferson
4 University.

5 COUNCILWOMAN BASS: If we could
6 start in that order, with the first
7 individual named to state your name for
8 the record and begin with your testimony.

9 DR. KU: Hi. Good afternoon.
10 I'm Bon Ku from Jefferson Health. I'm an
11 emergency medicine physician. I've been
12 working throughout this pandemic in the
13 emergency room and I'm of the operation
14 team for Jefferson working with the City
15 on COVID -- well, about testing sites.

16 I worked last night in the
17 emergency room, so I apologize if I sound
18 a little bit sleepy. Working last night,
19 I'm concerned about where we're heading
20 this winter. Our emergency rooms are
21 already jammed. We've been on diversion,
22 and it's not even -- the flu season has
23 not even picked up yet. And as you know,
24 we are approaching a near disaster
25 scenario, and a vaccine is not going to

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2 help out with that because it's not going
3 to be distributed in time. So I just
4 want to put that out there.

5 I think a lot about who needs
6 to get the vaccine first, and I think the
7 answer lies in where is currently the
8 community transmission, and it's
9 spreading in households, it's spreading
10 especially in multi-generational
11 households and workers and service
12 industries who can't isolate at home and
13 be on endless Zoom meetings like most of
14 us are.

15 I diagnosed a patient recently
16 with COVID-19 who had literally broke
17 down crying when I told her, because she
18 told me her sister died of COVID in June
19 and she believes she was infected by her
20 son, and she was concerned about her
21 daughter, who is pregnant who lives with
22 her, and her two grandchildren, who also
23 live with her. And I see this narrative
24 being played out a lot in my patients
25 that I treat, that these patients, these

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2 people who live in multi-generational
3 households, there is a high risk for
4 transmission of the SARS-CoV-2 virus.

5 And what also concerns me is
6 that I see a lot of patients not taking
7 the flu vaccine seriously, that a lot of
8 them are not getting the vaccine. So I
9 think we need to be very concerned about
10 the messaging for this new vaccine that
11 is being rolled out.

12 And just a few lessons learned
13 from implementing and launching two COVID
14 community testing sites, one in the
15 Southwest and one in the Northwest, is
16 that it is critical to work with
17 community partners. We have been
18 partnering with the local school and the
19 local church, because it's been constant
20 iteration. We've been having to respond
21 in realtime to a situation that changes
22 on a daily basis.

23 Right now I just got a report
24 that there's cars lining up around the
25 block. We've been treating about 200

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2 patients a day at one of our sites.

3 So as the vaccine distribution
4 is going to be a logistical nightmare,
5 but I think it's critical that we put the
6 distribution sites in neighborhoods, and
7 that's going to require community
8 partners develop trust with the public,
9 and that there's a moral imperative that
10 we prioritize black and brown
11 communities, because they have been
12 disproportionately impacted by the
13 pandemic. And we're going to have to get
14 very creative. We're going to have to
15 iterate and improvise as we all together
16 think about how to best distribute the
17 vaccine.

18 So I'll end my comments there.

19 COUNCILWOMAN BASS: Thank you
20 very much, Doctor.

21 If we could have the next
22 panelist to state your name for the
23 record and begin your testimony. And I
24 did notice that a number of you,
25 Dr. Stanford and some others, have to be

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2 out and have some time constraints. So
3 we'll make sure we get to you as quickly
4 as possible and before you have to
5 depart. So we'll get to you as quickly
6 as possible. Thank you.

7 DR. RITTS: Hi. My name is
8 Rose Ritts. I am the Head of Innovation,
9 Chief Innovation Officer here at
10 Jefferson.

11 My comments really are based on
12 two things. One, my time in the Defense
13 Department in chem bio warfare defense.
14 It's funny, it's the opposite side of
15 this problem, but there's still a lot of
16 moving around of materials that you need
17 in order either to do diagnostics or to
18 do therapeutics with very similar cold
19 chain management challenges, so something
20 I've lived through once and seen done
21 both well and poorly. And also Jefferson
22 does have a vaccine candidate in the mix
23 called CORAVAX that is soon to enter
24 human trials, and one of its key points
25 is its low cost and easy logistics, but

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2 for today, I just want to emphasize a few
3 points that Ms. Johnson did already
4 allude to at a high level.

5 Of course, we've all heard
6 about the importance of maintaining the
7 vaccine quality through the supply chain
8 and ensuring that there are no breaks in
9 the cold chain. That's important because
10 when we get ready to give a dose to
11 somebody, we need to know that it's
12 really a viable dose, and making sure
13 that we understand the providence of
14 where it came from, where it was stored,
15 how it was transported, and the
16 recordkeeping around that are really
17 critical.

18 What we think that we've heard
19 from the Pfizer vaccine is that it has to
20 be stored in a cold chain, but then after
21 you defrost it, you can keep it
22 refrigerated for five days, but that's a
23 pretty short period of time. And one
24 thing I haven't heard a lot of talk about
25 yet that I'm sure is in the planning in

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2 the City but needs to be really thought
3 through is estimating how much you need
4 where, what stocks in what locations, and
5 making sure that you use them. And
6 although we did hear from Johnson and
7 Johnson that they have one vaccine
8 candidate that might be a single dose,
9 their second ensemble requires two doses,
10 and most of the vaccines out there
11 require that two doses be given in a very
12 specific timing sequence. And so an
13 important question to ask, which differs
14 from the different vaccine candidates, is
15 if somebody only gets one dose, is it
16 that they are only minimally protected,
17 not fully protected, or that they're not
18 protected at all? And for the different
19 candidates, some of them the answer is if
20 somebody comes in and gets one dose and
21 they don't come back for the second dose,
22 you just wasted a dose because they're
23 not protected at all after just one dose.
24 Other of the vaccine candidates with one
25 dose you get some minimal protection.

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2 So that's just something else I
3 really want to put in the Council's mind,
4 tracking the timing of when people got
5 the vaccine and when they're going to get
6 their second dose so that we're maximally
7 utilizing every dose that we have.

8 Of course, the prioritization
9 of who gets the dose is first, and I will
10 echo what Dr. Bon Ku said, that it's very
11 clear that we need to prioritize black
12 and brown communities and our front-line
13 health workers, I will say like Dr. Ku,
14 who are doing shifts in the ER and
15 putting themselves on the line. We have
16 to be able to give it to them, but when
17 we get into the communities, we have to
18 know that the person is going to come
19 back for the second dose. That's really
20 important.

21 And leasing vehicles in cold
22 storage and making sure that all of that
23 stuff is ready for the vaccine to be
24 gotten to where it needs to be in a
25 viable way is such a huge part of what we

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2 need to do. And for all of these things,
3 our health systems need staff and we need
4 to be able to keep pace with all the
5 evolving best practices and make sure
6 that the vaccine doses were given are
7 viable, that we understand the priorities
8 that we need to give them, and that we're
9 managing all the information to know how
10 well this works.

11 So glad to take questions, but
12 those are the comments I wanted to offer.

13 COUNCILWOMAN BASS: Thank you
14 so much for your commentary, and I think
15 that we should really underscore your
16 point that the two doses is a
17 requirement. It's not an option. It's a
18 requirement, and that that's something
19 that we really need to pay a lot of
20 attention to make sure that this happens
21 as quickly as possible and that people
22 understand that two doses are absolutely
23 required for the maximum protection from
24 COVID. So thank you very much for your
25 testimony.

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2 If we could have the next
3 person that was called state your name
4 for the record and begin with your
5 testimony.

6 DR. ZURLO: Yeah. Good
7 afternoon. This is Dr. John Zurlo. I am
8 the --

9 COUNCILWOMAN BASS: Good
10 afternoon.

11 DR. ZURLO: Hello?

12 COUNCILWOMAN BASS: Good
13 afternoon.

14 DR. ZURLO: Can you hear me?
15 Good. This is Dr. John Zurlo. I'm the
16 Director of Infectious Diseases here at
17 Thomas Jefferson, and I've been the Chair
18 of the COVID Enterprise Task Force here
19 at Jefferson.

20 So a couple of my comments.
21 Let me start off briefly by mentioning a
22 little bit about where we are in our own
23 institution with the pandemic. Just to
24 give you some perspective, at our peak in
25 May for our enterprise, which includes

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2 hospitals in Philadelphia and the
3 surrounding areas, our peak census was
4 558 patients, of whom 142 were in the
5 Intensive Care Unit. Our nadir in terms
6 of census, we were down to 62 patients
7 across our enterprise, with only 12 in
8 the Intensive Care Unit. And now since
9 sometime in October, late September and
10 October, we've increased, and now just
11 for idea, we're up to 332 patients in
12 census across our enterprise, with 51 in
13 the Intensive Care Unit. So not
14 surprising, we're seeing an increase in
15 our census.

16 On the positive side, however,
17 we've watched -- we compare March from
18 October. Our mortality overall for
19 hospitalized patients in March was 21
20 percent. In October, though it's early
21 still, we still have -- the numbers still
22 may go up. It's down to 7 percent.

23 Our length of stay in March was
24 11 days. Our length of stay now in
25 October was seven days. That's an

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2 excellent trend.

3 The percent of our patients
4 requiring intensive care is down from 38
5 percent in March to 20 percent in
6 October. The length of stay in the
7 Intensive Care Unit is down from 12 days
8 in March to eight days in October. And
9 the percentage of patients who require
10 mechanical ventilation is down from 31
11 percent in March to 9 percent in October.

12 All of those are good trends.
13 The challenge we face is that once
14 patients are on ventilators, they tend to
15 stay on ventilators. That number hasn't
16 changed for a long time.

17 So on the positive side, we're
18 seeing positive trends in terms of the
19 hospitalized patients, but on the
20 negative side, of course, we're seeing a
21 continued rise, and we have not peaked
22 yet in terms of our census among our
23 hospital systems.

24 The next three things to
25 mention, if I might share my screen.

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2 Let's see if that's possible. I just
3 want to show for the -- well, maybe it's
4 not going to work. I'll try it one more
5 time.

6 I don't know if that's working.
7 I wanted to compare the various vaccines
8 that are available, the two vaccines that
9 are available in terms of efficacy, in
10 terms of adverse reactions and so forth.
11 I don't know if this -- can you see my
12 screen? It should say the Comparison of
13 Moderna and Pfizer Vaccines.

14 COUNCILWOMAN BASS: Yes.

15 COUNCILMAN HENON: Yes, we can.

16 DR. ZURLO: Very good. So you
17 see that they're both mRNA vaccines, as
18 we've heard. If you look at the end
19 points reached, there were 95 cases in
20 the Moderna vaccine, 90 in the placebo,
21 five in the vaccine. 170 cases in
22 Pfizer, 162 in the placebo, eight in the
23 vaccine. And they both have equivalent
24 95 percent or so efficacy.

25 If we look at efficacy in older

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2 patients, we see that there were 15 cases
3 in adults above the age of 65, though
4 they did not report efficacy data for
5 this group. The Pfizer reported a 94
6 percent efficacy in patients over 65,
7 which was virtually the same, of course.

8 Other efficacy, if you look at
9 the numbers of severe cases all in the
10 Moderna, they all occurred in the placebo
11 group. There were 20 cases in diverse
12 communities, but they didn't describe
13 whether they were in vaccine or placebo.
14 As for severe cases in Pfizer, there were
15 ten, nine in the placebo and one in the
16 vaccine.

17 For adverse reactions exceeding
18 2 percent of Grade 3, there were only
19 small numbers involved in all of them,
20 things like fatigue and arthralgias and
21 headaches and injection site pain that
22 were all very acceptable, quite frankly.
23 And in the Pfizer group, they noted that
24 older adults tended to report fewer and
25 less serious adverse reactions.

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2 We have heard about the cold
3 storage. It's the Pfizer that's the
4 super cold that's the more challenging.
5 And then the amount of vaccine available,
6 20 million doses of Moderna by the end of
7 2020, enough for 10 million people, 50
8 million doses by the end of 2020 for 25
9 million people.

10 So the last comments that I'll
11 make will be just what we are doing at
12 Jefferson to prepare for vaccination. I
13 head a group that includes individuals --
14 a diverse group of individuals from
15 around our entire enterprise that's
16 preparing for the receipt of vaccination.
17 Just because we can handle the ultra
18 cold, my guess is -- and it's purely a
19 guess -- is that we will get the Pfizer
20 vaccine, but once again, that's just a
21 guess on my part.

22 We are preparing now for
23 prioritization and logistics of
24 vaccination, and those are the two
25 challenges. Prioritization really

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2 involves a very diverse group of people,
3 trying to identify the individuals in
4 Phase 1a who are at greatest risk for
5 exposure to COVID. Hence, it will be
6 individuals, all individuals, not just
7 doctors and nurses but everyone who works
8 in intensive care units, in emergency
9 departments and so forth and so on. And
10 so we're working through trying to create
11 tiers of individuals who will receive
12 vaccine in various orders, and then
13 ultimately trying to put names and
14 numbers to those tiers of individuals.

15 We obviously need to overstate
16 or over-invite ultimately the number of
17 people who will be in that early phase,
18 because we really don't know what the
19 uptake will be. Will 60 percent of
20 people agree to be vaccinated? Will 90
21 percent of people agree to be vaccinated
22 among our employees? The answer is we
23 don't know.

24 On the positive side, we have
25 two excellent vaccines in terms of both

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2 efficacy and adverse reactions. On the
3 negative side, there is a lot of
4 skepticism about vaccinations.

5 As part of our group, we have a
6 broad communications plan, first for our
7 employees and then ultimately working
8 with the City and other entities, a
9 public program of information so that we
10 can really get all the information out as
11 best we can.

12 I think the last piece that I
13 think is going to be very challenging, as
14 has been mentioned, is the logistics of
15 vaccinations, how will we do this, how
16 can we maintain the cold storage and
17 guarantee that that's the case.
18 Obviously we don't want to waste a single
19 dose of vaccine, so we're going to have
20 to -- knowing the amounts of vaccine in
21 the units that are given to us, we need
22 to oversubscribe so we can make sure that
23 we don't waste any of it. We don't want
24 to reach the five-day point, which is the
25 time which the vaccine can be

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2 refrigerated, at least Pfizer, and have
3 vaccine left over because people haven't
4 shown up. So I don't want to understate
5 the challenges of doing this kind of
6 thing.

7 So that's kind of my update and
8 testimony, and I'm happy to take
9 questions, please.

10 COUNCILWOMAN BASS: Thank you
11 so much for your testimony. We greatly
12 appreciate it.

13 I know that Councilwoman Gym
14 had questions for the panel.

15 COUNCILWOMAN GYM: Yes. Thank
16 you so much, Madam Chair, and thank you
17 to you and the Council sponsor for this
18 really important hearing, and we're lucky
19 to have so many illustrious guests on
20 here.

21 A couple questions that I had
22 related back to Dr. Ku, Dr. Bon Ku from
23 Jefferson, if he's still with us, and
24 Dr. Stanford. One of the issues that I
25 think we're dealing with is that -- and I

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2 think Councilman Henon and others have
3 spoken to it before -- that there's a lot
4 of misinformation. So getting advanced
5 notice ahead of time about the kinds of
6 misinformation, how it spreads, would be
7 helpful so that we can counter it.

8 My second question is, and I
9 think Dr. Bon Ku said it earlier and
10 we've talked about it before and,
11 Dr. Zurlo, I think you've made it very
12 clear. We don't need to wait until the
13 vaccine is underway or whatever. A
14 marshaling of this effort in a city of
15 our size where I think -- I read
16 somewhere that the COVID positivity rate
17 was in the double digits in our city.
18 I'm not entirely sure if that's accurate,
19 but New York City is up, what, 3 percent?
20 So we will need to do, a majority of the
21 City, an all-out marshaling effort on a
22 scale of a massive deployment. It's
23 going to go beyond the doctors. It's
24 going to go beyond hospitals and those
25 who have medical care or those who

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2 believe in medical care and treatment.

3 So I think now kind of staking
4 out, as you're doing very clearly I think
5 with all of us, making clear that we
6 would be foolish to be waiting right now.
7 We know a massive deployment is going to
8 happen. It literally probably needs to
9 go block by block, and in certain
10 neighborhoods, as I think Dr. Stanford
11 and, Dr. Ku, you've made such a
12 compelling case for, in our black and
13 brown neighborhoods and immigrant
14 neighborhoods. We will have to go block
15 by block and so there will be -- we are
16 going to have to figure out how to plan
17 that out, because that will take a long
18 time and it is absolutely not reliant on
19 the timing of the vaccine, because the
20 vaccine is coming.

21 So I think the main questions
22 that I have are those areas. Do we feel
23 like from your perspective you have
24 identified the key areas that you would
25 start on a map in terms of vaccinations

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2 that -- you would do your X areas first.
3 Are they based on anything in particular
4 and have they been clearly shared with
5 the rest of the City and is the City in
6 agreement with you? So that would be
7 one.

8 And then, two, like you hear a
9 lot about like why people don't trust
10 medical treatment, why the Coronavirus
11 isn't real, why I'm not going to get my
12 flu shot. And so as you're listening to
13 these, it actually doesn't hurt for you
14 to kind of unpack -- like share them with
15 us, where people hear them from, is it
16 just rumors, is it internet, like how are
17 we dealing with it. And I think, as you
18 said, a counter strategy that is
19 purposeful and widespread on behalf of
20 the City is going to be key for us to
21 make it through.

22 Nothing would be worse than
23 having a vaccine available and having one
24 of America's largest cities either not
25 want it or not be able to access it. But

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2 we have plenty of history that indicates
3 that that is exactly the case, because
4 healthcare is not based on science
5 necessarily. It is based on people's
6 understanding, interpretation, and faith
7 in a scientific medical process and
8 access to it.

9 DR. KU: I'll respond quickly.
10 I'm in 100 percent agreement, this needs
11 to be a citizen-driven effort that we
12 partner with the leadership of the City
13 government. This is going -- this is the
14 largest human vaccination effort in the
15 history that the country is going to
16 undertake, and I get inspiration from the
17 Get Out the Vote campaign that we did.
18 That was a grassroots movement and
19 impacted every neighborhood, and I think
20 that's a mindset that we need to have.
21 It can't be led by the hospitals. It
22 needs to be this grassroots effort and
23 working with community partners, who
24 already have the trust of residents who
25 may have some vaccine hesitancy.

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2 So I think -- I look at this
3 that this is a grassroots effort led by
4 the City, but in similar ways to how we
5 came together as a city and voted in huge
6 numbers.

7 COUNCILWOMAN GYM: Super
8 helpful. Thank you.

9 DR. ZURLO: My only comments
10 I'll add are that we appreciate that it's
11 daunting enough just to get to our
12 employees. I mean, on the positive side,
13 we do flu campaigns every year with our
14 employees and we have a pretty good take.
15 On the downside, there are challenges
16 with the vaccine handling and cold
17 storage that at least make one vaccine a
18 little bit more challenging than perhaps
19 the others. So our group, and I'm sure
20 other groups, are working for our own
21 patient population, but we obviously need
22 a coordinated City response to involve
23 the Health Department along with the
24 healthcare institutions throughout the
25 state.

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2 If I could just put in a plug
3 to the Health Department. They've been
4 great to work with. Philadelphia
5 Department of Public Health has been
6 great to work with.

7 COUNCILWOMAN GYM: Great.

8 Thank you.

9 COUNCILWOMAN BASS: Thank you,
10 Councilwoman Gym.

11 COUNCILWOMAN GYM: Thank you,
12 Madam Chair.

13 Just one other plug that I
14 would say is that I would love if all of
15 our Councilmembers, especially starting
16 with our Health Committee, does a very
17 public kind of let's get our flu vaccine
18 and do it in a videotape or whatever, and
19 if there is -- however we want to promote
20 it, but on video and post it in as many
21 places as we can see so we can normalize
22 the vaccine process in a very difficult
23 time.

24 So thank you very much, and
25 thank you so much to this illustrious

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2 panel. I really appreciate it.

3 COUNCILWOMAN BASS: Thank you,
4 Councilwoman. Believe it or not, it's
5 already in the works. It hasn't been
6 announced just yet, but the effort to
7 make sure that there is education and a
8 plan of distribution and outreach into
9 all of our communities is something that
10 we intend to do, as we did around like
11 Get Out the Vote and masking up and all
12 those kind of efforts. But thank you so
13 much for being on top of that. We really
14 appreciate your ideas, as always.

15 Any additional questions from
16 members of Council?

17 COUNCILMAN HENON: I do, Madam
18 Chair. This is Councilman Bobby Henon.

19 COUNCILWOMAN BASS: Councilman
20 Henon. The Chair recognizes Councilman
21 Henon.

22 COUNCILMAN HENON: So I have
23 some general questions, but I'm going to
24 ask brief specific questions to some of
25 the three panelists now that we just

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2 heard from, and if I could make a
3 recommendation to the Chair, because I
4 know there's time restraints that we are
5 under right now with some of our --

6 COUNCILWOMAN BASS: Sure.

7 COUNCILMAN HENON: And we
8 totally respect that. If there are
9 questions specifically for some of the
10 panelists that will have to leave us, may
11 we submit them to you and we'll make sure
12 that we get them to the panelists,
13 unanswered questions, just due to time,
14 because I don't want to rush this
15 important issue.

16 COUNCILWOMAN BASS: I would
17 agree. This conversation is way too
18 important for us to rush through it. I
19 know that everybody is busy and we have a
20 lot of time constraints. And,
21 Councilman, if we need to, I think that
22 it wouldn't be problematic to reconvene
23 this panel if we need to come back
24 together again, that we could do so
25 within the next few weeks before the end

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2 of this legislative session. I would
3 certainly be open to reconvening and
4 having additional conversation.

5 COUNCILMAN HENON: Well, I
6 think that's probably an appropriate
7 action to have this resolution be at the
8 call -- recess at the call of the Chair.
9 So thank you for that offer.

10 If I can, so I can let the
11 three panelists move on with the day, I
12 got three questions, one for each one of
13 them. Let me start off with Dr. Bon Ku.

14 One, I want to thank you for
15 working nights at the ER and I want to
16 thank you for being awake, that in
17 itself, and certainly appreciate the
18 vintage boom box that you have in your
19 background.

20 But based on your experience
21 treating patients with COVID in the ER
22 and assisting with the operations for two
23 community COVID testing sites, what
24 should the City government be thinking
25 about to make vaccine access and make

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2 sure that the access goes well in the
3 City? That's my first question for you.

4 DR. KU: Great. I think the
5 vaccine is going to get rolled out in
6 different phases, as was stated in the
7 beginning, and who is going to be in that
8 first phase is very critical. And the
9 patients that I'm seeing getting affected
10 are in these multi-generational
11 households, someone lives with their
12 grandmother and they have two grand-kids
13 in the household and they get infected by
14 their daughter or their son and the whole
15 household gets infected. And right now
16 that's a big driver of community spread
17 in Philadelphia and all across the
18 country, that the dinner table is the
19 site of super spreading events, and how
20 do we focus on those sites and thinking
21 about the humans that the people from
22 black and brown communities have been
23 disproportionately impacted throughout
24 this pandemic and what's our role
25 imperative to focus on these communities.

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2 I think these are some maybe guiding
3 principles when we think about who gets
4 the vaccine first in the distribution.

5 COUNCILMAN HENON: Thank you
6 for that.

7 My follow-up question is, can
8 you describe what design thinking in
9 medicine and healthcare means and what
10 kind of design thinking should the City
11 be thinking about to make the vaccine
12 access go well?

13 DR. KU: I think there's going
14 to be a lot of prototyping that gets done
15 in terms of this design approach, that
16 it's a creative one, and we're going to
17 have to really rely upon our imagination
18 and creativity and think outside the box,
19 because this is going to be the
20 nightmares of nightmares in terms of
21 logistics, and we cannot approach this
22 from a mindset of doing business the
23 normal way, because it's a huge effort.
24 We have great leadership, but there are
25 going to be tremendous hurdles and take a

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2 lot of creativity and imagination,
3 iteration throughout this process to roll
4 this out.

5 COUNCILMAN HENON: Thank you,
6 Doctor.

7 My next question is for
8 Dr. Ritts, if you are still with us.

9 DR. RITTS: Yes. I'm here.

10 COUNCILMAN HENON: Thank you.
11 My question to you, and you had touched
12 on it in your testimony, can you talk
13 about the only Philly vaccine that we
14 have here in the City, CORAVAX?

15 DR. RITTS: Yes; the Jefferson
16 vaccine, CORAVAX, C-O-R-A-V-A-X. The key
17 things that this vaccine focuses on are
18 longevity, safety, and cost. So
19 longevity being one that we don't talk or
20 hear talked about too much.
21 Adenovirus-based vaccines, which you
22 heard from the Johnson and Johnson, but
23 others are using too, those are seasonal
24 vaccines. So whatever logistics we come
25 up with, we're going to be doing them

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2 again next year and the year after just
3 like a flu vaccine.

4 The basis of the CORAVAX
5 vaccine is a rabies vaccine that is
6 generally given once every ten years and
7 has long-lived immunity. Of course if we
8 get a vaccine that will help people,
9 we're going to give it to them, but it
10 would sure be great to push through one
11 that you didn't have to give every year
12 because this thing isn't going away so
13 fast.

14 Cost is another key issue. The
15 vaccine, this CORAVAX vaccine, the
16 manufacturing price is so low that even
17 without a subsidy, the cost is in the \$10
18 range, and we're hearing prices -- of
19 course we expect them to be subsidized
20 early on, but some of these RNA vaccines
21 are upwards of \$300 and they're just
22 expensive to make. So that's just
23 another thing to keep in mind as we talk
24 about access and we talk about all these
25 phases, is bearing the burden of the

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2 cost. So that's just another important
3 thing.

4 And safety is another one. A
5 lot of these new vaccines, we have seen
6 them and you hear quotes about how many
7 hundreds of thousands of patients the
8 vaccine has gone into. It's true that
9 CORAVAX is not -- we're entering humans
10 as our phase, we're entering human trials
11 very shortly, but the base vaccine is one
12 that's been in literally billions of
13 people, including pregnant women,
14 children, older people, and has a
15 tremendous record of success across a
16 wide variety of the community. So we're
17 excited about this vaccine.

18 In trying to hit those three
19 key things, which our team felt were so
20 critical, we were a little late to the
21 game, so by the time we went to BARDA
22 looking for funding, it was hard to get,
23 which was a disappointment. We do have
24 some money from the state, from DCED,
25 that we appreciate very greatly, and we

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2 have industrial partners. But we're
3 excited about this, and we'd sure like to
4 bring this thing home for Philly in a way
5 that helps both us and is a beacon for
6 the world. So thank you for asking the
7 question.

8 COUNCILMAN HENON: Thank you so
9 much for being with us here today.

10 Madam Chair.

11 COUNCILWOMAN BASS: Thank you,
12 Councilman.

13 I believe Dr. Stanford -- or
14 actually why don't we have the Clerk call
15 the last panel, Panel 3.

16 THE CLERK: Madam Chair, there
17 are two individuals that do have to leave
18 at 2:15. Is it okay if I call their
19 names along with Panel 3?

20 COUNCILWOMAN BASS: Yes,
21 please. Thank you.

22 THE CLERK: Dr. Charles B.
23 Cairns, Walter H. and Leonore Annenberg
24 Dean, College of Medicine, Professor of
25 Medicine and Emergency Medicine, Senior

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2 Vice President, Medical Affairs, Drexel
3 University; Dr. PJ Brennan, Chief Medical
4 Officer, University of Pennsylvania
5 Department of Medicine; Dr. Ala Stanford,
6 Founder of Black Doctors Consortium; and
7 Andrei Doroshin, Founder, Philly Fighting
8 COVID.

9 COUNCILWOMAN BASS: Thank you.

10 If we could have folks go in
11 the order in which your name was called.
12 Please state your name for the record and
13 proceed with your testimony.

14 DR. STANFORD: I think you said
15 my name first, but honestly I wasn't
16 paying attention. Did you say
17 Dr. Stanford?

18 THE CLERK: Dr. Charles Cairns,
19 followed by Dr. PJ Brennan, then Dr. Ala
20 Stanford, and then Andrei Doroshin.

21 COUNCILWOMAN BASS: Okay. If
22 we can proceed in that order. Thank you.

23 Dr. Cairns, you're muted.

24 Thank you.

25 DR. CAIRNS: Thank you so much.

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2 So my name is Dr. Charles Cairns, and
3 thank you, Chair Cindy Bass, Vice Chair
4 Bob Henon, and your distinguished
5 Councilmember colleagues. It is truly an
6 honor to be providing this testimony. I
7 currently serve as the Walter H. and
8 Leonore Annenberg Dean of the College of
9 Medicine, Professor of Medicine and
10 Emergency Medicine and Senior Vice
11 President of Medical Affairs at Drexel.
12 I also currently serve as the principal
13 investigator for the Bill and Melinda
14 Gates Foundation grant on COVID-19
15 digital platform for patient recruitment,
16 testing, and prediction, as well as
17 serving as the clinical lead investigator
18 for the National Institutes of Health
19 COVID-19 Immunophenotyping study. Thus I
20 am studying the COVID-19 virus, testing
21 people for the virus, promoting how to
22 best care for people with the virus,
23 learning how to promote vaccination
24 against the virus, all the while
25 assessing situational awareness in order

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2 to be prepared to pivot with any new
3 information.

4 Pertinent to the testimony of
5 others today, the recent National Academy
6 of Medicine report for equitable
7 allocation of COVID vaccine states that
8 vaccine hesitancy is on the rise. Thus
9 we need a proactive approach to provide
10 information on the value of vaccination
11 and to address any barriers in receiving
12 a vaccine, including the issues of
13 language access and the importance of
14 providing culturally and linguistically
15 appropriate access to enhance trust among
16 our African American and communities who
17 are suffering the most.

18 At Drexel, colleagues in the
19 Colleges of Medicine, Public Health,
20 Nursing, and Health Professions are
21 working to better understand these issues
22 and address them in communities in West
23 and North Philadelphia.

24 We propose that the PhilaVax
25 system be augmented by incorporating

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2 further proactive community programs to
3 directly support COVID-19 vaccination in
4 these communities which have been
5 traditionally underserved by healthcare
6 and, frankly, have been underrepresented
7 in COVID-19 testing.

8 Currently, we're working with
9 Saint Christopher's Hospital for Children
10 to provide COVID-19 testing to these
11 underserved communities in Philadelphia.
12 We're also using community health workers
13 to assist in the education, awareness,
14 warm handoffs of vaccination to better
15 engage the community and gain trust as a
16 proactive approach to addressing, as
17 already stated, low percentage of those
18 willing to receive the vaccine.

19 Supplementing this with vaccine
20 administration in a mobile unit to
21 communities at highest risk would be
22 ideal.

23 We also propose to utilize
24 COVID-19 information platforms, including
25 mobile and web-based applications, to

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2 facilitate vaccination access, confirm
3 dosing regimens, and provide longitudinal
4 information on efficacy and safety.
5 There are outstanding questions on
6 whether the vaccine protects those who
7 have already had prior exposure to the
8 SARS-CoV-2 virus and, frankly, how long
9 any protection conferred by the vaccine
10 lasts. Thus the system can provide
11 longitudinal information on those two key
12 issues. This information system could be
13 built upon the Drexel Health Tracker for
14 COVID-19, which was developed in
15 conjunction with My Own Med. This is a
16 system currently being utilized in a
17 community interventional project
18 supported by the Bill and Melinda Gates
19 Foundation, the longitudinal study of
20 COVID-19 patients, especially those
21 patient-reported outcomes supported by
22 the NIH and utilizing a version of Health
23 Tracker for the Saint Christopher
24 Hospital for Children COVID-19 testing
25 program. The app provides connections to

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2 a trusted source of information, symptom
3 tracking, linking to nearest COVID-19
4 vaccination sites, and could report
5 post-vaccination outcomes. The system
6 could also link to the PhilaVax system
7 and any applicable programs across the
8 City, state, and the country.

9 Thus I strongly encourage the
10 City to follow a smart, creative, and
11 inclusive approach to COVID-19
12 vaccination, building upon the PhilaVax
13 system and incorporate universities,
14 proactive community programs, and
15 augmented digital platforms. Our goal
16 should be to get at least 80 percent of
17 Philadelphians vaccinated as soon as
18 possible.

19 Thank you for the opportunity
20 to testify before the Council today. I'm
21 happy to address any questions, although
22 thank you for recognizing my time
23 constraint.

24 COUNCILWOMAN BASS: Thank you
25 for your testimony.

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2 If we could have our next
3 panelist state your name for the record
4 and begin with your testimony.

5 DR. BRENNAN: I'm Dr. PJ
6 Brennan. I'm an infectious disease
7 physician and Chief Medical Officer of
8 Penn Medicine. Good afternoon,
9 Chairmember Bass, Councilmember Henon,
10 and members of the Committee. Thank you
11 for inviting me to testify on this
12 important issue.

13 On behalf of Penn Medicine, I
14 would like to thank you for your
15 leadership in addressing the COVID-19
16 pandemic. As you know, the COVID-19
17 pandemic has had a disproportionate
18 impact on economically disadvantaged and
19 minority communities in Philadelphia. In
20 an effort to address this
21 disproportionate impact on our vulnerable
22 communities, Penn Medicine has worked to
23 expand testing in the West Philadelphia
24 community. This spring, Penn Medicine
25 worked with the Philadelphia Department

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2 of Public Health to stand up a community
3 testing site at Sayre Health Center. In
4 its first week, the Sayre site, staffed
5 by Penn Medicine nurses, doctors,
6 physician assistants, and operational
7 supports, saw a volume of 906 patients,
8 more than 88 percent of whom were
9 identified as African American.

10 Testing at Sayre is available
11 to members of the public at no cost
12 regardless of whether they are Penn
13 Medicine patients or have medical
14 insurance. Walk-up tests without
15 referrals are available and the site is
16 open Monday through Friday.

17 The Sayre site has performed
18 19,652 tests since it opened on May 4th.
19 As cases have surged in the City over the
20 past week, Sayre is averaging 350 tests a
21 day and is a beacon of access for West
22 Philadelphia. The Sayre testing site
23 also provides screening and navigational
24 support for mental health and social
25 needs.

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2 The Penn Medicine site at 4040
3 Market Street also provides testing
4 regardless of insurance. To date, 31
5 percent of 18,513 test recipients at 4040
6 Market Street were not Penn Medicine
7 patients. Between our testing sites at
8 Sayre, 4040 Market, and Radnor, we
9 performed 51,138 tests since the
10 beginning of the pandemic.

11 The COVID-19 pandemic has
12 highlighted profound racial and
13 socioeconomic inequities in healthcare.
14 Penn Medicine is committed to addressing
15 COVID-19's disproportionate impact on
16 vulnerable communities in Philadelphia.
17 In response, Penn Medicine launched the
18 Social Needs Response Team, SNRT, a
19 virtual call center powered by
20 interprofessional teams trained in the
21 tenets of crisis intervention. The SNRT
22 screens for distress and social needs;
23 provides supported navigation to food,
24 medication, housing, and other resources;
25 assists in the application for public

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2 benefits; and provides psychosocial
3 support. SNRT provides support for an
4 average of 50 patients and community
5 members per week.

6 Since March, Penn Medicine has
7 been at the forefront of the fight
8 against COVID-19. Our six hospitals have
9 treated 4,575 inpatient COVID-19
10 patients, and our emergency departments
11 have treated 6,044 COVID-19 patients,
12 3,321 of whom were admitted. This spring
13 at the height of the pandemic, our census
14 was about 423 admitted patients, with a
15 ten-day average length of stay, with many
16 admitted patients in the intensive care
17 units.

18 In addition to our efforts to
19 directly treat COVID-19 patients, Penn
20 Medicine has implemented a number of
21 programs to ensure the safety of patients
22 who need medical care unrelated to
23 COVID-19. This includes screening
24 patients for COVID before appointments.
25 To date, we have screened 1,414,764

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2 patients for COVID-19.

3 Throughout the pandemic, we've
4 leveraged our Penn Care at Home service
5 to help decrease hospital stays, reduce
6 readmissions, and free up hospital beds
7 for more serious cases. The Penn Care at
8 Home team supports COVID patients who
9 upon discharge do not have familial or
10 social support at home. To date, our
11 team has served 1,050 COVID-19 patients.

12 Over the past few weeks, we've
13 seen an alarming spike in COVID-19
14 admissions at our hospitals, and we
15 expect that trend to continue as we enter
16 the winter months. We're confident that
17 our health system has the capacity to
18 handle another surge, but we're concerned
19 about the devastating toll this virus
20 takes on its victims.

21 We're pleased to see the
22 encouraging news related to the
23 effectiveness of the COVID-19 vaccines
24 being developed by Pfizer and Moderna.
25 Penn Medicine's own infectious diseases

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2 expert, Dr. Drew Weissman, developed the
3 mRNA vaccine technology that is the
4 foundation of Pfizer and Moderna's
5 COVID-19 vaccines, as well as others
6 being developed globally.

7 Penn Medicine has been working
8 for several months on a plan to
9 distribute the vaccine once it is
10 available. We've established an internal
11 advisory committee consisting of a
12 representative team of clinicians,
13 emergency management professionals,
14 ethicists, and human resource officers to
15 plan for effective, efficient, and
16 ethical implementation of our vaccine
17 distribution plan. The team has
18 incorporated the recommendations of the
19 National Academy of Medicine, the Centers
20 for Disease Control and Prevention, the
21 Pennsylvania Department of Health, and
22 the Philadelphia Department of Public
23 Health into our policy governing how
24 vaccines will be distributed.

25 In accordance with ethical

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2 principles developed by the National
3 Academy of Medicine and CDC, Penn
4 Medicine's distribution policy aims to,
5 one, maximize benefits and minimize harm;
6 two, mitigate health disparities; three,
7 promote justice; and, four, promote
8 transparency.

9 Understanding that supply will
10 be limited for several months, we plan to
11 prioritize the following groups for early
12 vaccination: healthcare personnel,
13 workers in essential and critical
14 industries, people at high risk due to
15 underlying conditions, and individuals 65
16 years and older.

17 Penn Medicine will assign the
18 first priority status to front-line
19 healthcare workers who interact directly
20 with patients who may have COVID-19 and
21 are, therefore, at the highest risk for
22 contracting the virus. Accordingly,
23 clinicians, doctors, nurses, and advanced
24 providers and staff, environmental
25 service, security, transport, and food

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2 service personnel who work in areas such
3 as COVID inpatient treatment, emergency
4 medicine, labor and delivery, trauma,
5 specimen collection, and transplant donor
6 retrieval will receive the vaccine first.
7 Our plan prioritizes all healthcare
8 personnel who work in these high-risk
9 environments, not just licensed medical
10 professionals and clinicians.

11 Our plan assigns second
12 priority to staff involved in specific
13 procedures that present an elevated risk
14 of COVID-19 exposure. This group
15 includes clinicians and staff working in
16 fields such as respiratory therapy,
17 anesthesiology, and otolaryngology.
18 Clinicians and staff in these specialties
19 perform procedures that generate aerosols
20 or otherwise present an increased risk of
21 COVID-19 transmission.

22 We've assigned third priority
23 status to clinicians and staff who
24 routinely work with a patient population
25 that is immunocompromised. This includes

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2 fields such as transplant, oncology, and
3 neonatology.

4 Community-based care teams,
5 including home care, hospice, and
6 community healthcare workers, will
7 receive the fourth priority status.

8 The vaccine will be offered
9 according to the prioritization policy,
10 but not mandated at this time considering
11 its expected emergency use status when
12 first authorized. If the volume of
13 vaccine is lower than the demand amongst
14 eligible staff, we will implement a
15 lottery system to determine distribution.
16 A wait list will be available to all
17 staff who are not eligible according to
18 the priority policy. As the vaccine
19 supply increases, we will begin providing
20 the vaccine to individuals on the wait
21 list. Our occupational medicine team has
22 established a robust tracking and
23 monitoring system for staff who receive
24 the vaccine.

25 The Philadelphia Department of

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2 Health has selected Penn Medicine, along
3 with other citywide leaders, to provide
4 subject matter expertise in the clinical,
5 operational, and emergency management
6 aspects of the vaccine distribution plan.
7 Penn Medicine will utilize a hub and
8 spoke model for storage, distribution,
9 and vaccine operations. Penn Medicine is
10 prepared to support the Philadelphia
11 Department of Public Health in any
12 community-based vaccination efforts for
13 healthcare workers and others outside of
14 the Penn Medicine system.

15 Penn Medicine remains committed
16 to our partnership with the City to
17 address the COVID-19 pandemic and
18 distribute vaccines in a safe, effective,
19 and ethical manner.

20 Thank you for the opportunity
21 to speak with the Committee.

22 COUNCILWOMAN BASS: Thank you
23 so much for your testimony.

24 Do we have the next witness
25 available to testify?

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2 DR. STANFORD: Hello. This is
3 Dr. Ala Stanford. I have three comments
4 and two questions, more for people to
5 think about.

6 I am the Founder of the Black
7 Doctors COVID-19 Consortium, and like
8 you've heard multiple people say on this
9 call, we've been testing about 400 people
10 a day for the past two weeks, and our
11 positivity rates are 17 and 19 percent.
12 And as I heard the Councilwoman say, we
13 need an all-out marshaling effect, but
14 the reality is everyone who needs a test
15 in the City of Philadelphia still cannot
16 get a test. We're not like California or
17 DC or New York where the rates in New
18 York are 3 percent, and the rates in New
19 York are 3 percent because you can walk
20 in any place 24 hours a day and get a
21 test, without a state-issued ID, without
22 any insurance, without an appointment and
23 you can walk in, and that accommodates
24 these face-front employees that are
25 working all day that can't get there

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2 between 9:00 and 5:00 Monday through
3 Friday. They need a nighttime session.
4 They need a weekend session.

5 So when folks finish at Sayre
6 and they finish at Jefferson, they come
7 over to us, which is why we're always
8 slammed and there until 10 o'clock at
9 night, because we're there when people
10 get off work and the other places shut
11 down and on Saturday at the Liacouras
12 Center, which is where we'll be this
13 Saturday from 11:00 to 4:00.

14 And so I'm concerned about the
15 distribution. Why? Because everyone who
16 needs a test in the City, particularly
17 the people who are contracting it the
18 most, dying the most, and spreading it
19 the most, still cannot get a test
20 uniformly.

21 What I wanted to ask
22 Dr. Nettles of Johnson and Johnson is
23 that, again, with these different arms of
24 the vaccine, which I'm excited about,
25 what about the people who have had

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2 Coronavirus and who have antibodies?
3 When we look at our data now out through
4 six months, 85 percent of the people who
5 we tested at three months and now at six
6 months still have IgG antibodies to
7 Coronavirus, and something I would like
8 to know from the Phase 3 data is that did
9 you include people who previously had
10 Coronavirus when you did the study? And
11 the antibodies generated, were they more
12 efficacious if you got the vaccine or was
13 it equal to someone having antibodies who
14 had had SARS-CoV-2 already? Why would
15 that be important? Because the majority
16 of the people who have had Coronavirus
17 are black and Latinx, and as I mentioned,
18 85 percent of them still have antibodies.

19 So if we're going to go out and
20 encourage them to take a vaccine, it
21 would behoove us to be able to say "and
22 it's only going to make the antibodies
23 you have that much more potent" or say
24 "you don't need it." And we know the
25 antibodies are transient, meaning they

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2 don't last forever, but so is the
3 vaccine. It's transient.

4 And so I'm somewhat
5 disheartened. I'm hoping when the data
6 comes out in the evidence-based journals,
7 we're going to know that they looked at
8 an arm with people who had antibodies.
9 However, I know for a fact Moderna
10 excluded all people who had previously
11 been infected. That is a very big
12 concern to me, because it says that at
13 the table when the study was being
14 designed, folks who were already
15 infected, which were primarily black and
16 Latinx in America, were not at the
17 forefront or that would have been
18 included. That's my comment.

19 My concern, as I'm on the
20 Vaccine Advisory Committee with
21 Dr. Brennan and Dr. Johnson, is the Phase
22 1 people that are primarily healthcare
23 workers, people who take care of folks in
24 nursing homes, and folks that are 65 and
25 up. Dr. Farley and I have discussed it.

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2 In the African American community, it's
3 not primarily 65 and up. The people who
4 are contracting Coronavirus are 45 to 54.
5 They're your working-class people.
6 They're 35 to 44, and then we get into
7 the 65 and up, and then we go back to the
8 25 to 34.

9 So, again, the criteria that
10 excluded African American and Latinxes
11 from getting tested are going to be some
12 of the same criteria that exclude them.
13 Also of our data, only 22 percent of
14 people who tested positive had co-morbid
15 conditions. So you're saying I need to
16 be old, I need co-morbid conditions.
17 That makes me high risk. Well, those
18 aren't risk factors that many African
19 Americans and Latinx people have.

20 That is the crux of what I
21 needed to say. And the last thing I'll
22 say about the restrictions, even with the
23 vaccine being 90 percent effective, that
24 means 10 percent of people even getting
25 the vaccine will not have immunity

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2 against this virus, which means we still
3 have to promote wearing your mask, social
4 distancing until everybody gets it.
5 Phase 3, it may not be until summer or
6 even the end of December 2021. So we
7 have to continue to empower folks to know
8 that we could be out of these
9 restrictions just by changing our human
10 behavior and doing what is recommended.

11 And that's all I have, and
12 thank you for your time.

13 COUNCILWOMAN BASS: Thank you,
14 Dr. Stanford.

15 Do we have our next panelist
16 available to testify?

17 MR. DOROSHIN: Yes, ma'am. I
18 believe that's me.

19 COUNCILWOMAN BASS: Please
20 state your name for the record and begin
21 with your testimony.

22 MR. DOROSHIN: Hello. My name
23 is Andrei Doroshin. I'm the CEO of
24 Philly Fighting COVID. So I thank you
25 very much, Councilmembers, and thank you

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2 very much, Councilmember Henon and Chair
3 Bass, for making this hearing happen.

4 As some of you guys know,
5 Philly Fighting COVID was created to help
6 low-income communities with access to
7 free medical care and testing. I was
8 called here to discuss the administration
9 of this vaccine.

10 Now, as some people have
11 mentioned before, this is literally the
12 largest logistical operation of our
13 species. We're all here talking about
14 something that we still know very few
15 details about, but what we can do is
16 create a preemptive strike, and that is
17 what people like Caroline Johnson,
18 Dr. Ala Stanford, and a bunch of us are
19 trying to do.

20 So we know that you guys don't
21 want to put your money into something
22 that has previously been largely behind
23 the scenes, which is what this is. It's
24 a highly scientific effort. Right now
25 the political sentiment behind vaccines,

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2 behind anything healthcare related is
3 actually really poor. So we hope that
4 these hearings help you understand that
5 this is something that's extremely
6 necessary.

7 Now, in terms of what Philly
8 Fighting COVID has been doing, we've been
9 working for four months to ensure that
10 the logistics of what's going on with
11 this vaccine will not hold Philadelphia
12 up to get the vaccines in the first
13 place. We don't want any delays when it
14 comes to we have a vaccine and there is
15 an economic burden going further into the
16 future.

17 So my team has already begun
18 hiring and identifying submitted plans --
19 and submitting plans, rather, for the
20 construction of five major high-purpose
21 sites that can take about 10,000 patients
22 a day. We're also working with many
23 smaller clinics and community
24 organizations to allow for
25 smaller-purpose sites of 500 patients per

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2 day that are mobile and will target
3 populations that don't have access to
4 healthcare, which is something that is a
5 huge issue in Philadelphia, as has been
6 outlined by previous speakers, which is
7 in Philadelphia you have a huge disparity
8 of people that don't have access to
9 healthcare.

10 I'm going to share my screen
11 just for a second, and you will see in
12 this map we have population density. Can
13 everybody see that?

14 (Yes, we can.)

15 MR. DOROSHIN: So here we have
16 population density. Highly dense, as we
17 know, in South Philadelphia. You have
18 bits and pieces here. Philadelphia is a
19 highly partitioned city. But here is
20 income by --

21 COUNCILWOMAN BASS: Can I
22 pause? I'm looking at something else.
23 I'm looking at the Chat room.

24 MR. DOROSHIN: Sorry, guys.
25 Let's see if we can fix this. Thank you.

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2 Can you see it now?

3 COUNCILWOMAN BASS: Yes.

4 MR. DOROSHIN: All right.

5 Thank you very much.

6 So population density, we were
7 talking earlier about where should we be
8 focusing our efforts. This is one of the
9 most important decisions that is going to
10 happen, because we don't want communities
11 to be missing out on medical care.

12 So population density, highly
13 dense in South Philadelphia.
14 Philadelphia is also very known, as we
15 know, for being a highly partitioned
16 city. So you have little bits of density
17 here and there.

18 Income. So this is no surprise
19 to anybody. American healthcare is
20 awesome if you're rich. If you're poor,
21 it's one of the worst in the world. So
22 what we want to focus on is making sure
23 that low-income neighborhoods have access
24 to, first off, testing, as we currently
25 are doing, but later on the vaccine. And

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2 if we look at hospital distribution in
3 Philadelphia, it largely mirrors income,
4 right? Hospitals don't really like to be
5 in places that are poor. Poor people
6 mean uninsured. Uninsured means that
7 hospitals cannot collect.

8 So what Philadelphia is looking
9 at is doing this five main node model of
10 drive-throughs with highly mobile sites,
11 high-frequent sites, meaning they can
12 take about two to ten thousand patients a
13 day. The reason for these high-frequent
14 sites and the fact that they're going to
15 be necessary is when H1N1 came around, we
16 had a huge problem of pharmacies,
17 hospitals who just got overwhelmed. Now
18 with COVID, take the social distancing
19 mandate of six feet and you've just
20 created a, quote/unquote, run-on-the-bank
21 scenario, where everybody is going to
22 want to get a vaccine and it's going to
23 be a huge problem.

24 So what we're currently asking
25 the Council is assistance and guidance in

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2 doing this. So we've currently budgeted
3 internally for Philly Fighting COVID \$2.7
4 million for constructions of these sites.
5 The day requirements are all custom. It
6 all has to be custom fed to the
7 immunization software and the CDC within
8 24-hour requirements, which my team is
9 currently building out from my own
10 personal funding, supplies, PPE,
11 refrigerators, warehouses. We're
12 currently training staff. We're hiring
13 about 500 staff over the next 60 days, as
14 well as an army of educators and a
15 marketing campaign that is going to be in
16 line with the City. This is going to be
17 a big effort, and everybody on this call
18 is going to have to have a part in it and
19 we're all going to have to communicate.

20 The Health Department has been
21 really good in terms of making sure that
22 all these parties are communicating. The
23 conversations that we've been having on
24 the Vaccine Advisory Board have been
25 highly productive, but the reason and the

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2 key takeaway of my testimony is that --
3 I'm sure you hear this all the time,
4 Councilmembers. I'm sure you hear people
5 come in here all the time asking for
6 money, but the Health Department in
7 specific really needs funding, and the
8 reason is is, we need to preempt this
9 attack. We need a preemptive funding to
10 create a preemptive strike. As you've
11 seen hopefully in my presentation, this
12 is a large-scale effort that's going to
13 require thousands of people and millions
14 of dollars of moving parts.

15 The quicker that we can begin
16 the setup, specifically the quicker the
17 Health Department can start working on
18 getting these pieces in play, which they
19 already have been but with limited
20 resources, the quicker that we can get
21 Philadelphia back up and running.

22 Thank you, Council, and I'll be
23 taking questions.

24 COUNCILWOMAN BASS: Thank you
25 so much.

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2 I'm going to pause right here
3 for some questions. I know that members
4 of the Committee have questions.

5 Before I do that, I did want to
6 recognize Dr. Stanford, and I know she
7 has to go soon because she's off to do
8 another testing in West Philadelphia.
9 And so I just really wanted to thank her
10 for all of her work on this issue and for
11 stepping up at a time when it was kind
12 of -- in a lot of our communities, we
13 felt like, well, what to do, what's
14 happening, what's going on, and we didn't
15 have the direction that we were all
16 looking for, and without direction,
17 without a thought, she just put something
18 into place to begin to do immediate
19 testing, and I just really wanted to
20 publicly say thank you so much for all
21 that you've done for our communities,
22 because undoubtedly the testing has saved
23 lives. So I just wanted to put that on
24 the record.

25 Councilman Henon.

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2 DR. STANFORD: Thank you.

3 COUNCILWOMAN BASS: You're
4 welcome.

5 COUNCILMAN HENON: I think we
6 have Dr. Abella. I'd like to hear his
7 testimony before I ask any questions.

8 COUNCILWOMAN BASS: Well, we
9 have two more to testify, so why don't --

10 COUNCILMAN HENON: All right.
11 Then let me ask my quick question.

12 So I only see -- let me check
13 to see who is still on the call here.
14 Dr. Reed, if Dr. Reed is still on the
15 call.

16 DR. REED: Yes, sir.

17 COUNCILMAN HENON: Wonderful.
18 Thank you.

19 Oh, he didn't speak yet? Okay.
20 How about Dr. Cairns or Brennan?

21 DR. BRENNAN: Dr. Brennan is
22 here.

23 COUNCILMAN HENON: Doctor,
24 great. Thank you.

25 COUNCILWOMAN BASS: Dr. Cairns

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2 I believe had to step off.

3 COUNCILMAN HENON: Okay.

4 So, Dr. Brennan, you talked
5 about the Sayre testing site, which is a
6 model site with regards to COVID-19
7 testing. Will that site become a
8 vaccination site?

9 DR. BRENNAN: We anticipate
10 that we will be implementing our
11 community vaccination at our off sites,
12 meaning away from the hospitals.

13 COUNCILMAN HENON: Okay.
14 Great.

15 And you also stated that one of
16 the policy aims of Penn that aims -- the
17 Penn vaccine distribution policy is to
18 maximize benefits and minimize harm. Can
19 you explain what that means?

20 DR. BRENNAN: Sure. We want to
21 give the vaccine to the highest risk
22 individuals and to those who are at the
23 greatest risk of transmitting it to
24 others who would be high risk. So on the
25 one hand, we want to administer it to

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2 everyone who is at the front line in our
3 emergency departments. For example, in
4 obstetrics where through studies that
5 we've done we've identified that nearly 7
6 percent of pregnant women presenting in
7 labor in the first wave of the pandemic
8 were COVID positive. That was a bit of a
9 surprise to us, but with that in
10 information in hand, we want to vaccinate
11 that staff, and that would involve those
12 individuals who were doing triage as well
13 as the obstetricians who are assisting
14 with the delivery of babies.

15 We also want to communicate in
16 a way that helps the community, both at
17 Penn and the broader community,
18 understand the benefits and risks of the
19 vaccine and tries to overcome vaccine
20 hesitancy, if these vaccines are both
21 safe and effective when we have more
22 information about them beyond the news
23 reports that have just come out.

24 So we're working with
25 communications professionals who have

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2 actually done research on vaccine
3 messaging so that we have the best
4 content and methods to talk about this
5 and address the concerns of communities
6 that have had adverse experiences with
7 the medical community and with vaccines
8 specifically.

9 COUNCILMAN HENON: Well, thank
10 you. Thank you so much for that.

11 Last question for Mr. Doroshin.
12 Are you still with us, Andrei?

13 MR. DOROSHIN: Yes, sir. I am
14 here.

15 COUNCILMAN HENON: I got a
16 question about logistics, the logistics
17 of administration and funding of
18 primitive vaccine efforts. We want you
19 to show to us in Philadelphia that you
20 are ready if the call is upon you that
21 you can be there at the time for our City
22 of Philadelphia. Could you talk about
23 that?

24 MR. DOROSHIN: Yes, sir. So
25 currently an effort like this requires a

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2 lot of human capital. With any medical
3 effort, as we've seen with hospitals,
4 with sophisticated procedures, you need
5 mostly equipment, right? You need lots
6 of resources. The only equipment that
7 you really need for a large-scale
8 vaccination effort is the PPE, your
9 warehouses, and refrigerators for the
10 ultra cold chain storage.

11 What we've been focusing on is
12 training, making sure that our staff is
13 trained, but also the data. So you're
14 dealing with about one million patients.
15 That's a million patients of data that
16 you have to collect, transmit to the CDC,
17 and then transmit also to the local
18 health department. So we've been working
19 meticulously in making sure that we could
20 actually move all of this data, and then
21 once people come to these sites, they're
22 in and out within a matter of minutes,
23 and that's the whole point. Because this
24 whole run-on-the-bank situation that's
25 probably going to happen with the

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2 hospitals and pharmacies and the sites
3 that aren't ready, we can't afford that
4 at all.

5 COUNCILMAN HENON: You had
6 mentioned, and you just touched on it
7 now, about PPE. You had manufactured PPE
8 prior to your vaccination efforts.

9 MR. DOROSHIN: Correct.

10 COUNCILMAN HENON: Can you
11 speak a little bit more on those efforts?

12 MR. DOROSHIN: Yeah. So we
13 start off -- I was actually a PPE
14 manufacturing company, where we
15 manufactured face shields. We've done
16 thousands of manufacturing of face
17 shields, and we continue to manufacture
18 face shields, but we also work with mask
19 manufacturers on a personal level. So
20 all of our PPE supply chain is actually
21 off the grid. So we have access to a lot
22 of equipment that hospitals, pharmacies
23 don't have access to, but would be
24 necessary for sites like this, because
25 you have 500 people working in full PPE

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2 every day for 120 days, you're turning
3 over all that PPE, plus accidents. You
4 know, it's a lot, and I'm glad you
5 mentioned that, Councilman.

6 COUNCILMAN HENON: Okay. Thank
7 you.

8 Madam Chair, I have no further
9 questions at this time for the panelists.

10 COUNCILWOMAN BASS: Thank you,
11 Councilman.

12 Councilwoman Gym, and then
13 Councilman Thomas.

14 COUNCILWOMAN GYM: Thank you so
15 much, Madam Chair. I think most of my
16 questions -- first of all, I again want
17 to thank the wonderful panel, including
18 Dr. Brennan and Dr. Cairns, and all the
19 others who spoke today for your insights
20 into this, but I think if Dr. Stanford is
21 still with us, I think some of my
22 questions would be directed towards her
23 experiences.

24 And good afternoon,
25 Dr. Stanford.

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2 DR. STANFORD: I'm in motion,
3 but I'm here, yes.

4 COUNCILWOMAN GYM: Okay. I
5 know you are on your way doing important
6 stuff.

7 I guess you took the words that
8 I had for you out of my mouth. My
9 question is is that if you were to
10 evaluate the City's ability to do COVID
11 testing as a precursor to some extent to
12 the COVID vaccine, right, to COVID
13 vaccinations, what grade would you give
14 us?

15 DR. STANFORD: Well, I'd say
16 it's improving. Okay? I'd say it's
17 improving.

18 COUNCILWOMAN GYM: 17 to 19
19 percent positivity rate.

20 DR. STANFORD: You said
21 testing, though, correct?

22 COUNCILWOMAN GYM: Testing,
23 yes. Correct.

24 DR. STANFORD: Testing, I'd say
25 probably a B minus, but that's better

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2 than it was. So it's better than it was
3 in April and May, and I don't understand
4 this part -- you guys can explain it
5 better -- that how in California and even
6 in Delaware, you can go online, register,
7 you can go down to Dodgers Stadium, you
8 can go down and you can get a test, and
9 it's open to everyone, you know, and you
10 don't need a referral and you don't need
11 all these other criteria, but you can
12 just go and get scheduled. But here we
13 had so many people tell us about Rite Aid
14 and CVS and Walgreens, their doctor, and
15 not being able to get tested and their
16 doctor sent them to us for a test. And I
17 don't understand why we don't have that
18 uniformly in our city and why nine months
19 later we're still working. Like I felt
20 like we would be out of business by now
21 and that we were a bridge until supplies
22 caught up and all these sorts of things,
23 but we're not, and now what we're seeing
24 is it's less African American and Latinx
25 or it's 50/50 and now we're seeing

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2 everybody. We're seeing all ethics. We
3 are seeing police officers coming to get
4 tested and waiting in line, and it's
5 just -- I don't know where the disconnect
6 is. I don't know why we're falling short
7 of being able to test folks. And when
8 our positivity rates are 20 percent, it
9 suggests to me that we're not just
10 testing anybody, but we are testing
11 people who need to be tested.

12 COUNCILWOMAN GYM: So you still
13 only give us a B minus? That's pretty
14 generous.

15 DR. STANFORD: Well, you
16 know...

17 COUNCILWOMAN GYM: No need.
18 I think the other question
19 would be -- and I fully hope that you and
20 many others who have been doing this work
21 in communities are at the table as the
22 planning rolls out or the messaging rolls
23 out on the vaccination front. I think we
24 heard a little bit earlier from Dr. Bon
25 Ku, and I think this speaks to a little

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2 bit of what Dr. Brennan is saying. We
3 can't really rely on -- again, I'm
4 interested in hearing from you,
5 Dr. Stanford, but we can't really rely
6 again on sort of the standard issue kind
7 of messaging that has led to the fact
8 that whether or not we think we're doing
9 a good job or whatever, you're seeing
10 COVID positivity rates of 17 to 19
11 percent. You're testing people who need
12 to be tested, yes, but to a large extent,
13 like we are concerned about the ability
14 to reach people en mass, what's safe,
15 what's not safe, recognizing I think that
16 Dr. Bon Ku said this very clearly. We
17 know our elderly -- and you said this
18 too, Dr. Stanford. We know our elderly
19 and our seniors are more at risk. So if
20 they get COVID, they are in high danger
21 of a health emergency, if not something
22 even more serious, but they may not be
23 getting it from other seniors that
24 they're around. They're very likely to
25 be getting it from younger people who

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2 have engaged with them who fall below the
3 radar.

4 Still to this day even though
5 our COVID deaths -- less than half,
6 granted, it's 49 percent -- are seniors,
7 we still have no analysis of the 51
8 percent of people who also die of COVID
9 who are not older. We don't get that
10 breakdown. I'm saying you have it, I'm
11 sure, but we don't get that breakdown in
12 Council on a regular basis. So the
13 message continues to be sent that it's a
14 seniors, primarily high risk, but seniors
15 are now less than 50 percent of the death
16 rate, and we really do need to be talking
17 about the fact that most seniors aren't
18 getting it from other seniors. They
19 could be getting it from younger people
20 who are either not showing signs or
21 something like that.

22 So I wanted you to talk again
23 about like -- please tell me that you're
24 at the table as we're doing the rollout
25 and as we are talking about messaging. I

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2 think Dr. Bon Ku said a little bit more
3 about how we need to move more towards
4 that Get Out the Vote model that went
5 door to door, tried to hit people, used
6 lots of validators, not just the elected
7 officials who are technically on a
8 ballot, for example, but use a lot of
9 different people to send the message that
10 this has to go and drill down street by
11 street, block by block, neighborhood by
12 neighborhood, community by community.

13 DR. STANFORD: So I think
14 what's interesting and what we're
15 hearing, and I think Dr. Brennan and
16 Andrei could comment on this too, is on
17 the committee, we were doing a lot of
18 things by occupation for Phase 1, and I
19 remember early on we talked about
20 ethnicity, we talked about zip codes, and
21 we kind of steered away from that a
22 little bit. But as I listened to the doc
23 from Jefferson and I'm listening to you
24 now, I think it's something we need to
25 probably revisit, and certainly when the

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2 data comes back from the ACIP and their
3 recommendations, we need to reevaluate
4 that. Because, for example, on my staff,
5 I've got about 5 percent of my staff have
6 been positive in the last month, and it's
7 not from testing. It's because their
8 spouse is a police officer. It's because
9 their spouse is a bartender. It's
10 because their spouse is head of
11 environmental services at a nursing home,
12 right? And I had to say to my staff,
13 well, we are black and Latinx, so it
14 doesn't matter that you are out here
15 testing and we're healthcare
16 professionals, because your family, even
17 if you don't bring it home from work,
18 will bring it home to you, right? And
19 those are younger people.

20 And so now as I think back --
21 and, again, I was talking to Dr. Farley
22 about this recently as we've been
23 evaluating our data now -- is it's not
24 the same demographic that the criteria
25 was set up to test -- to give priority to

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2 65 and older and people with co-morbid
3 conditions, because only 22 percent of
4 our folks had co-morbid conditions and
5 most of them are younger. They're 45 to
6 54 was our highest age of most of our
7 people who tested positive. And I just
8 think we might have to reevaluate that or
9 we're going to miss the mark again like
10 we did with the testing, miss the mark
11 with who gets prioritized with the
12 vaccine.

13 COUNCILWOMAN GYM: I want to
14 let you go, because I know you're
15 driving, and the most important thing is
16 for you to be safe here, but I did want
17 to ask the same question to Dr. Brennan,
18 and I know that your hand is up as well,
19 to see how you might have evaluated the
20 City's COVID testing as a precursor to
21 what it might look like or how you might
22 see differences, and then that same
23 question about messaging and how we're
24 looking at prioritizing of communities.

25 DR. BRENNAN: I think testing

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2 has been a shortfall for Pennsylvania
3 throughout. I concur with Dr. Stanford
4 that we're doing better now. I think
5 there's been an enormous supply chain
6 failure. I think that the Defense
7 Production Act could have been put to
8 better use. The reality is that we
9 haven't had very many tests to be able to
10 run.

11 In the earliest part of the
12 pandemic, in the first wave when we
13 were -- when the City was averaging 500
14 cases a day on a seven-day rolling
15 average, we had about 600 tests that we
16 could do in our health system, just one
17 health system, albeit a larger health
18 system, but lots of people needing
19 procedures and coming to the emergency
20 department, and 400 patients across all
21 of our hospitals, we have 600 tests to
22 perform.

23 So it was very limited, and
24 while we have multiples of that now, it
25 still isn't nearly enough to test

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2 everybody that we want to get back into
3 the economy, get back into school and all
4 of that. So we're developing in-house
5 testing capability that will enable the
6 University to reopen and even go beyond
7 that, I think, in providing broader
8 testing for the community.

9 Regarding the communication
10 issue, I think that this is -- it's
11 challenging. There's a lot of
12 anti-vaccination sentiment to begin with
13 in this nation just regarding flu
14 vaccine, and now we have novel vaccines
15 that have been produced very quickly and
16 have been highly politicized. And so I
17 think it's going to be a challenge to get
18 the message out there.

19 So it's going to be very
20 important -- to me it's going to be very
21 important to see what the Advisory
22 Council on Immunization Practices says
23 about these vaccines. That's an
24 independent group that has strongly held
25 opinions that works from evidence and has

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2 an outstanding reputation and the
3 expertise to address the questions, and
4 their support should go a long way in the
5 medical community in endorsing it, and
6 from there, it's incumbent on the medical
7 community and beyond the medical
8 community to then message support for the
9 vaccine.

10 I just want to say one other
11 thing and, that is, that nursing home
12 outbreaks haven't gone away. While
13 infection in the community has shifted to
14 the 20- to 30-year-old and 30- to
15 40-year-old age groups, our state grant
16 that we're partnering with Temple on and
17 supporting over 300 personal care homes,
18 nursing facilities, and skilled nursing
19 facilities has done over 100 rapid
20 responses to nursing homes that have had
21 outbreaks. This is across Philadelphia,
22 Delaware, Bucks, and Lancaster Counties.
23 And so there's still lots of disease
24 occurring there.

25 So I just wanted to make that

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2 point. But oftentimes success in
3 preventing disease in the elderly,
4 infectious diseases in the elderly is in
5 vaccinating those who are in contact with
6 them, like nursing home workers and
7 younger individuals.

8 COUNCILWOMAN GYM: And I want
9 to make it clear that in no way would I
10 underestimate the seriousness of the
11 impact on the elderly, on our seniors,
12 and very vulnerable people. I think the
13 question is is that we know nursing homes
14 are a site of spread. So there's no
15 question. It is a contained area. You
16 could contact trace if you needed to and
17 all of that. I think the concern is more
18 around the broader community spread and
19 the fact that a greater -- more than 50
20 percent of the deaths are in people who
21 are, at least in Philadelphia, are in
22 people who are not in that senior
23 category. And so have we done enough to
24 do the kind of things that I think
25 Dr. Stanford has raised in much of her

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2 research and who she's seeing in terms of
3 the individuals who are testing at such
4 high positivity rates, 17 to 19 percent,
5 in the communities that she's testing. I
6 think it's at 13 percent citywide or
7 something like that. Is that the
8 numbers?

9 DR. BRENNAN: It's more than
10 that. It's higher than that.

11 COUNCILWOMAN GYM: For citywide
12 positivity?

13 DR. BRENNAN: Yeah.

14 COUNCILWOMAN GYM: I mean, that
15 is like a five alarm. The fact that --
16 for me I'm just saying I know I've been
17 really consumed with like the elections
18 and everything. We're in City Council.
19 But that should be like blasted in our
20 face 24/7. I do not necessarily feel
21 like it has, but that is off the chart.
22 I mean, this is just -- it's
23 unforgiveable to many extents. So
24 anyway, I just wanted to share that.

25 (Two people speaking at the

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2 same time.)

3 DR. BRENNAN: In asymptomatic
4 individuals, it's even higher, but --

5 MR. DOROSHIN: I think it's
6 really, really important as we wrap up
7 the experience that the Council --

8 COUNCILWOMAN GYM: Mr.
9 Doroshin, could you please hold to allow
10 Dr. Brennan to finish. Thank you.

11 DR. BRENNAN: So it's even
12 higher in some populations, Councilmember
13 Gym.

14 So I think that in terms of who
15 we vaccinate, we need to be equitable in
16 the first phase in particular. I believe
17 by the second quarter of the year, we're
18 going to have a lot of vaccine and we'll
19 be able to reach the entire population.
20 And when I say "equitable in the first
21 phase," it shouldn't just be the
22 emergency room docs and nurses, but I do
23 think it should be healthcare workers,
24 just given what they put on the line
25 throughout this whole pandemic, where

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2 they were out there first, they were
3 exposed, and I think that it's essential
4 for our infrastructure that we protect
5 them.

6 But we have security guards in
7 the emergency department and they're
8 greeting people as they come in, and they
9 don't know whether they have COVID or a
10 heart attack. And so they need to be
11 vaccinated, and they're not the licensed
12 professionals. So we should be equitable
13 about that.

14 And then in the Phase 1b, as
15 we've been talking about it on the
16 Vaccine Advisory Committee, we're talking
17 about an array of workers who are
18 essential, the paradoxical essential
19 worker, that individual who has to come
20 to work but is undercompensated and at
21 high risk and is likely to be Latinx or
22 African American. And those are
23 sanitation workers and those are
24 telecommunication workers and those
25 are -- they're essential. And so they're

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2 right behind that first wave.

3 COUNCILWOMAN GYM: Yeah. You
4 know, I won't hold you too much longer,
5 but I just really appreciate both of you
6 and your brilliance and expertise that
7 you're lending to it. I just think we're
8 in a complicated area. I think we have
9 to be very real and honest about what we
10 are able to do. Given the fact that we
11 had constraints, we know that there
12 were -- we have a new President
13 basically, in part because like it's very
14 clear that we have issues, and so -- but
15 it doesn't matter. Like we're still
16 Philadelphia. We are going to have to
17 figure out what we have as strengths
18 locally, but we also -- I think what I am
19 interested in and hearing from and
20 without feeling like I have to be -- for
21 me personally I don't have to feel
22 defensive about is the inability to look
23 back on what did not go as well and make
24 sure that we can make amends as we do the
25 rollout.

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2 But I really appreciate your
3 expertise in this and to all members of
4 the Committee.

5 Thank you very much, Madam
6 Chair.

7 MR. DOROSHIN: May I quickly
8 make a statement?

9 COUNCILWOMAN BASS: Yes.

10 MR. DOROSHIN: If I can just
11 make a suggestion, because there's so
12 much information that's being transmitted
13 within our Vaccine Advisory Committee
14 that Council actually has a biweekly
15 meeting or something with the Health
16 Department and with key people on the
17 vaccine. As we can see now, this is such
18 a large effort, I think that everyone's
19 constituents are going to want to know
20 every detail about this and have a say in
21 what goes on.

22 COUNCILWOMAN BASS:
23 Mr. Doroshin?

24 MR. DOROSHIN: Yes, ma'am.

25 COUNCILWOMAN BASS: I'm sorry.

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2 I think I lost you for a second. Were
3 you finished with your testimony?

4 MR. DOROSHIN: Yes, ma'am. I
5 was just saying I think we should have a
6 biweekly meeting with the Health
7 Department and with all the key players
8 so all the constituents know what's going
9 on.

10 COUNCILWOMAN BASS: I think
11 that's an excellent idea, and if it's
12 okay with Councilman Henon, I think that
13 that's something that we'll follow up on,
14 and I'm sure he will be in agreement with
15 that.

16 COUNCILMAN HENON: That sounds
17 like a smart idea to collectively check
18 in with everybody, but I'm pretty sure
19 we'll hear from the Health Department
20 soon and I'm sure they would have some
21 information that they can relay and they
22 can get out to everybody and make that
23 happen.

24 COUNCILWOMAN BASS: Thank you,
25 Councilman.

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2 I know we're short on time
3 because our next panelists, I think that
4 they have to speak briefly and leave.
5 They've been trying to get on for a
6 moment now.

7 Can we have the Clerk call the
8 next witnesses to testify.

9 THE CLERK: Dr. Tony Reed,
10 Chief Medical Officer at Temple
11 University Health System, and
12 Dr. Benjamin S. Abella from University of
13 Pennsylvania.

14 COUNCILWOMAN BASS: If we could
15 have the two of them please in that order
16 state your name for the record and
17 proceed with your testimony, that would
18 be great.

19 DR. REED: Yes, of course. My
20 name is Dr. Tony Reed. I'm the Executive
21 Vice President and Chief Medical Officer
22 here at Temple University Hospital and
23 Temple University Health System. I want
24 to thank all of you, the Council and the
25 Committee and others who here are to

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2 testify, for the opportunity to speak
3 here this afternoon. And one of the
4 beauties of being in the final panel is
5 that a lot of what I have in the prepared
6 statement has already been discussed and
7 addressed, and so in the interest of
8 time, I'm not going to read from what
9 you've received, because you probably
10 have already read it and/or can read it
11 on your own time. What I'm really just
12 going to do is summarize the salient
13 points of that. And before I do that,
14 just some numbers that we're all aware of
15 but that really are particularly
16 important here.

17 The City of Philadelphia has
18 had 57,000 cases, with 2,000 deaths. The
19 black and brown rates are 300 per 10,000
20 versus 160 to 190 per 10,000 in
21 white/Caucasian. When it comes to
22 deaths, 14 per 10,000 versus 6 per
23 10,000. And so those are stark
24 differences.

25 What we have noticed is that

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2 we're getting a lot of differential
3 response in our conversations with
4 vaccination. And I want to start by
5 saying we're part of that initiative that
6 we've been discussing all along, the
7 phased approach. Secretary Levine was on
8 at 12:30 talking about what the
9 Pennsylvania approach looks like. You've
10 heard from Dr. Johnson as to what the
11 City approach looks like and that staged
12 push. You heard from Dr. Brennan as to
13 kind of the conversations that are
14 happening in the who and in what
15 sequence.

16 At the same time here inside of
17 the health system, we have our close
18 point of dispensing process ready to go,
19 ready to receive the vaccine when it gets
20 here, and are standing ready and willing
21 to help with the open point dispensing,
22 whether that be use of Liacouras, whether
23 that be other space or whether that be
24 canvassing the neighborhoods to go and to
25 help convey the idea of vaccine and

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2 preparedness.

3 But that gets me to the issues
4 at hand. For flu vaccination, not COVID,
5 flu, 40 percent rates of vaccination in
6 eligible Americans. Minority and low
7 socioeconomic status have lower rates.
8 And that's a vaccine that's been around
9 for a while. There are a lot of
10 structural factors that happen, access,
11 fragmentation to care, insurance
12 limitations, there's social and cultural
13 factors at play, fear, the unknown
14 contents of what's in a vile, the unknown
15 process of how it comes to be. And then
16 there are always the active
17 misinformation and disinformation
18 campaigns, the so-called anti-vaxers and
19 others that will have us believe that
20 vaccines are scary.

21 The conversation we've had
22 around COVID in the last ten months has
23 worsened these issues, and that's been a
24 national conversation. We're part of
25 that in what's happening here in the

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2 City, to the point that there is a 20
3 point gap in black and brown person
4 willingness to receive vaccine versus
5 white. It's made the disparity worse.

6 And so there's a handful of
7 solutions that are out there, things that
8 we talk about here between the University
9 and the health system, things that we're
10 ready to deploy and have out on the
11 streets. It's the use of trusted
12 sources, credible messengers, whether it
13 be our community healthcare workers,
14 whether it be the community leaders who
15 partner with us, whether they be you, the
16 elected officials partnering with us side
17 by side in helping to educate the
18 community, as I said, neighborhood by
19 neighborhood.

20 We have a series of focus
21 groups, community steering committees
22 helping to understand what are the gaps,
23 what are the knowledge limitations, what
24 are the emotions, what do we need to work
25 through as a community to help push the

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2 message and to help drive forward the
3 cause of reducing COVID.

4 And we need to seek continuous
5 feedback. We need to remain transparent
6 about the side effects, about the
7 efficacies, about the outcomes, and
8 everything else related to how this
9 vaccine process moves forward.

10 And then the last thing I'll
11 say, we really need to consider what kind
12 of framework we're putting this in. I
13 would suggest a trauma-informed
14 framework. Again, that goes back to the
15 credible messengers. It goes back to the
16 empathy and understanding of what's
17 happening. And it really gets at that
18 root of the underlying cause and fear of
19 vaccination.

20 I'm going to stop there. As I
21 said, my testimony had a lot more in it,
22 but it was all stuff that we've talked
23 about already, and I am here for
24 questions at the end.

25 COUNCILWOMAN BASS: Thank you

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2 very much for your testimony.

3 Our next witness to testify,
4 who I believe is our last witness for
5 this panel. Please state your name for
6 the record and begin your testimony.

7 DR. ABELLA: Yes. First off,
8 can everybody hear me?

9 COUNCILWOMAN BASS: Yes. We
10 can hear you well.

11 DR. ABELLA: Terrific. So my
12 name is Dr. Benjamin Abella. I'm an
13 emergency physician at the University of
14 Pennsylvania, where I've been for the
15 last 15 years, and I'm Vice Chair for
16 Research and run the mobile COVID testing
17 center.

18 And I think much like the
19 previous speaker, given the lateness of
20 the hour, I'm not going to just read my
21 testimony. It's a little on the dull
22 side at this -- you've had a lot to hear
23 today. You can read it at your leisure.
24 I think I just want to make a few sort of
25 brief points that will sort of

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2 extemporaneously build off of my prepared
3 comments, if that's okay.

4 So one of the reasons I think I
5 was asked to speak today is that we've
6 had a unique experience of both doing a
7 set of COVID research studies that have
8 never been published and then also
9 running a COVID testing center, which has
10 been a mobile platform for COVID testing.
11 And so I just want to speak a little bit
12 from some of the lessons we've learned
13 and some thoughts and suggestions.

14 So one point I make is, I do
15 think that whatever Philadelphia decides
16 will be its multi-pronged strategy, it
17 should definitely include some mobile
18 testing component. I think the concept
19 of neighborhood by neighborhood, street
20 by street may be very important for a
21 variety of reasons, access, mobility,
22 crowds gathering with high infectivity
23 rates and concerns about that sort of
24 thing. So I think the one thing I've
25 learned is that this concept of bringing

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2 testing or a vaccination, for that
3 matter, to the people through a mobile
4 approach is going to be very important.

5 That's one point I'd make. The
6 other point is, we've been working in
7 partnership with Prevention Point, and
8 one of the lessons we've learned there --
9 Prevention Point, of course, as you know,
10 does a lot of work with those who are
11 suffering with drug addiction and
12 recovery -- is that there are important
13 reservoirs of potential COVID disease
14 that we need to think about in our
15 multi-pronged Philadelphia approach. So
16 certainly healthcare workers, nursing
17 homes, these are all important places,
18 but I think the folks who are in the
19 margins of society that we have to think
20 about as well, immigrants and poorly
21 documented immigrant communities, the
22 homeless, those who are shelter insecure.
23 The concern, of course, is they could
24 fall through the cracks and serve as an
25 ongoing reservoir for disease that could

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2 then infect our communities. So just I
3 want to make a plea that we keep them in
4 mind, and any strategy we come up with
5 should include those communities as well.

6 I also want to echo some of the
7 points made by prior speakers that I
8 think that to do this effectively and
9 efficiently, coordination across all of
10 our various groups is so important, which
11 is why I certainly applaud the formation
12 of the Vaccine Advisory Committee. I
13 think that we don't want to duplicate.
14 We have limited resource settings. And
15 also given the expediency in which we
16 want to approach this problem, we want to
17 make sure that we coordinate our efforts.

18 I think there's another piece.
19 So what I said I know is obvious to this
20 group, but another piece of communication
21 is communication outward towards the
22 public. I think there's going to be a
23 lot of trepidation from the public about
24 who is getting it first, who is getting
25 it second, how are we thinking this

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2 through. And so I think we can set a
3 really good example of transparency if we
4 build an arm for communication to the
5 public about how we're thinking about
6 this. And of course there's some things
7 that may be more or less appropriate to
8 directly share with the public, but I
9 would just advise this group and the
10 Vaccine Advisory Committee to think about
11 having a public-facing reporting to the
12 public on its thinkings and proceedings,
13 so that no one feels incorrectly like
14 they're being advantaged or disadvantaged
15 and that there is a methodical system
16 that's above board and transparent.

17 And then the final point I'd
18 make from my learnings in the mobile
19 testing is data. I think it's going to
20 be really important given that these
21 vaccines both, A, require another dose,
22 so we have to track who has gotten the
23 first dose and so forth and, B, there may
24 be side effects and other issues that we
25 want to track is that the City really

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2 think carefully about how it's going to
3 collect data, especially for the people
4 who get vaccinated outside of healthcare
5 systems, outside of conventional lists,
6 because we'll want -- you want to
7 basically build a dashboard of that
8 information. I think that will be very
9 important. And I think, along the lines
10 of my public-facing comments, a
11 public-facing dashboard showing Philly's
12 progress will be so important to engender
13 public trust, but this is also just so
14 that we know where we stand from moment
15 to moment. To Councilwoman Gym's point
16 of having a report card, we want to be
17 able to have a report card for our own
18 progress so we know we can achieve
19 metrics.

20 So I think I'll stop there.
21 Those are just some overarching points
22 from the things that I've learned. I've
23 tried to do that in a quick fashion to
24 get us all moving along today. I hope
25 that was okay. Certainly we've made

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2 comments as well, and am happy to take
3 questions.

4 COUNCILWOMAN BASS: Well, thank
5 you so much for your testimony. I think
6 one of the most important things that's
7 been said all day is about emphasizing
8 the fact that people are going to have
9 some concern and some suspicion, and it's
10 inevitably going to be some thought that
11 the order in which people receive the
12 vaccine has been unfair or that it's been
13 out of the natural order in terms of what
14 it should be. And I think that as much
15 as we can possibly do to get in front of
16 that is incredibly important. So I just
17 really wanted to thank you for making
18 that point, because we want to get in
19 front of it. We want to, number one,
20 make sure it doesn't happen. Number two,
21 we want to dispel any notion that it's
22 happening and in terms of making sure
23 that people are being treated fairly and
24 that those who are most affected and who
25 have the health disparities and who have

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2 been adversely affected and have really
3 taken a hit from the virus, that they are
4 at the front of the line.

5 So I thank you so much for
6 making that point and suggestion, and
7 that's certainly something that needs to
8 be done.

9 I see Councilman Henon and then
10 Councilwoman Gym. Just because
11 Councilman Henon is the sponsor,
12 Councilwoman Gym, if you don't mind
13 holding for just a sec.

14 Councilman Henon, did you have
15 a question?

16 COUNCILMAN HENON: Thank you,
17 Madam Chair.

18 I have a question for
19 Dr. Abella. First, I just want to thank
20 him for his long history of his community
21 involvement in educating regarding CPR
22 through the Mobile CPR Project, and that
23 project, as the doctor knows, I am
24 personally committed to and we worked a
25 lot throughout communities in the City of

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2 Philadelphia. Educating citizens related
3 to cardiac arrest in some ways is a
4 model, I would imagine, for COVID-19.

5 So, Doctor, can you identify
6 some of the ways that you are suggesting
7 that Philadelphia could educate the
8 public, what works and what doesn't work
9 in terms of educating people on
10 health-related issues since you have had
11 that longstanding, trusted education
12 commitment to the City.

13 DR. ABELLA: Yeah. And you
14 raise, of course -- first of all, thank
15 you for your kind remarks, Councilman
16 Henon, and we appreciate your support as
17 always.

18 I think you raise really
19 crucial points about communication, and
20 some of the things we've learned -- and,
21 by the way, I would agree with you. I
22 think many of the lessons of our Mobile
23 CPR are very analogous, getting out in
24 the community, working with community
25 groups, and I think partnership is one of

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2 the keys here. I think one of the themes
3 we've heard throughout today's testimony
4 has really focused on partnerships with
5 community groups, and community groups,
6 our trusted community groups, have their
7 own sort of spheres of communication and
8 networks, and I think that's going to be
9 really important. So I think identifying
10 community leads and then partnering with
11 them and making sure they're part of the
12 solution. So that's not just sort of
13 like a telegraphing from City Hall and
14 here are our proclamations.

15 That being said, I do think
16 there needs to be some central either ad
17 campaign, internet campaigns, other sorts
18 of things. I think an interactive
19 dashboard that the public could access on
20 where we're at, how many vaccinations
21 have we given, what -- I envision a map
22 with communities turning shades as we
23 sort of hit those things where they can
24 see progress.

25 First off, I think that would

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2 be a really terrific example of
3 transparency and also accountability,
4 because we can all look and see how we're
5 doing. But then also it brings people
6 back, and by bringing people back, you
7 can have messages portrayed there, you
8 can have videos and physicians speaking
9 about the importance of vaccination or
10 PPE. So it can basically become a
11 resource hub. So I think -- and then, of
12 course, we have an internet site. You
13 can build out apps that can access that
14 site as well.

15 So I think using technology,
16 very important and should be an
17 ingredient of this. Partnering with
18 community groups in a smart way is very
19 important, and then letting them respond.
20 So I would suspect, for example, that you
21 might want a community coalition to
22 report into the Advisory Committee with
23 community opinions and have them sort of
24 have interchange back and forth would be
25 important.

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2 So those are some thoughts, but
3 I do think that we really need to be
4 mindful of communication around this.

5 COUNCILMAN HENON: Doctor, I
6 think you're right. Mobile units could
7 be a critical part in the vaccination
8 process. If you were to say at a
9 snapshot, like how many units would you
10 deploy and have you thought about the
11 cost analysis, making sure that we're
12 educating, we're reaching those
13 communities with trust in a
14 cost-effective way.

15 DR. ABELLA: Yeah. I had a
16 couple of thoughts about
17 cost-effectiveness. You know, one thing
18 that I think this city is blessed with is
19 a tremendous number of health
20 institutions with schools, and the spirit
21 of volunteership in our medical schools
22 and nursing schools is tremendous, and I
23 suspect one could rouse a volunteer corps
24 to offset a lot of these costs. I think
25 nothing would be more exciting than

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2 for some of our nursing students and
3 medical students, who have really been
4 sidelined largely in this pandemic, and
5 the ones I work with are just so eager to
6 get involved and so eager to help to help
7 maybe -- I'm not an expert at
8 credentialing for who is allowed to give
9 vaccines, but certainly to be assistance,
10 to get the data collection, to work with
11 the people delivering vaccines, and if
12 credentialing allows, even to give the
13 vaccines.

14 So I think we can leverage
15 perhaps a lot of free sources in our
16 schools and basically build a volunteer
17 corps. That would be one way to offset
18 it.

19 Now, as far as the vehicles,
20 that's a challenging thing, because of
21 course we're a large city with a lot of
22 geographic areas. So one thought on
23 doing this in a way that may be
24 cost-effective -- and I almost hesitate
25 to say this because I'm not an expert on

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2 City politics, but certainly the Fire
3 Department has this very large network of
4 vehicles, and there's this concept out
5 there of community para-medicine where
6 often paramedics can serve as community
7 ambassadors.

8 Now, I suspect the Fire
9 Department would tell us that they are
10 cash strapped and over-tapped as it is.
11 So as I say, I almost hazard to suggest
12 this, but they have been excellent
13 partners with us in a lot of things and
14 certainly they know the neighborhoods and
15 they have vehicles and firehouses, and
16 maybe the firehouses themselves could
17 serve as community hubs for vaccinations
18 and enlist EMS and Fire Department help
19 there.

20 Those are some thoughts, but I
21 do think there's a lot of resources that
22 could be leveraged. This doesn't have to
23 be solely a new budgetary expenditure.

24 COUNCILMAN HENON: Thank you,
25 Doctor.

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2 Is Dr. Reed still with us?

3 DR. REED: Yes, sir.

4 COUNCILMAN HENON: You had
5 indicated that the Liacouras Center would
6 make an ideal vaccination site for mass
7 public vaccinations or a mass vaccination
8 event. Are there examples of this type
9 of effort that we can look at, and how
10 many people do you think we'd be able to
11 vaccinate per day in a safe way?

12 DR. REED: For examples I would
13 have to do some research around the
14 country to give you some, but what I can
15 tell you in the way we do our flu
16 vaccination campaign is designed in a
17 manner similar to that. We have 10,000
18 employees, and in our first day of the
19 campaign, we'll get somewhere near 3,000
20 done, and that's just using two sites.
21 One is our auditorium where we hold grand
22 rounds and one is a large conference room
23 up at our other campus. And so you can
24 flow through fairly effectively.

25 The one thing that we have to

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2 be careful of is congregate settings.
3 And so it's got to be an efficient flow.
4 And so think of our testing tents and the
5 drive-through testing scenarios and those
6 kind of things. I would almost look
7 towards that scenario as a first choice
8 and an indoor venue as a second choice,
9 depending on the time of the year and
10 just how cold it is and how much snow is
11 out there.

12 All of that said, I agree with
13 Dr. Abella. Our first choice by far and
14 wide has got to be to go to the
15 communities, because I don't think we're
16 going to be able to get a large volume of
17 North Philadelphia to come down to
18 Liacouras Center on set times, on set
19 days, at set programs. I'm not sure we
20 can get them to come to a van at a set
21 time and a set day and a set program. So
22 I think we're going to need to be out
23 with frequency and regularity, and much
24 like Dr. Abella, we have that similar
25 kind of spirit amongst our students and

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2 we have vans in the street, some work
3 happening on a regular basis. And so I
4 think any one of a number of those can
5 occur, but I will see what I can find for
6 you about large indoor venues like that.

7 COUNCILMAN HENON: Thank you.

8 Thank you, Dr. Reed.

9 Back to you, Madam Chair.

10 COUNCILWOMAN BASS: Thank you,
11 Councilman.

12 Councilwoman Gym, thank you so
13 much for your patience.

14 COUNCILWOMAN GYM: No; of
15 course.

16 Again, I want to thank
17 Dr. Abella and Dr. Reed for your
18 tremendous work. I don't really have a
19 lot of questions. I do think that I'm
20 certainly deferring to both of you on the
21 direction of which we're going, but I do
22 think, Dr. Abella, you raise a couple of
23 good points.

24 I think there's a difference
25 with messaging. Clearly internally we

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2 know where our private areas -- our
3 priority areas are. There was a question
4 that Dr. Stanford had raised earlier,
5 like does it help to do by occupation
6 when we know that that just -- people
7 start sorting themselves out. Especially
8 when so much of the public does not have
9 a job right now, it is really alienating
10 to identify priorities as people who are,
11 quote/unquote, working and with so many
12 people laid off, but I do think that the
13 dashboard is really helpful, and I think
14 the idea and as you are all discussing
15 messaging, I think you're going to be at
16 more tables than we are on Council.
17 We'll certainly be at some place, but as
18 medical professionals, you'll be at a lot
19 more tables.

20 I mean, I would encourage you
21 to always say that the idea is towards
22 universality as opposed to priority,
23 because I think in priority, especially
24 when it comes to like medicine or things
25 that seem inconvenient or require wait

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2 times, people do sort themselves out.
3 Like they're like let me just take myself
4 out of that voluntary flu vaccine. Let
5 me take myself out of this and that.

6 So the more it moves towards
7 universality and implication that this is
8 by -- you can do it in big areas, but is
9 clear that it embraces everybody within
10 that area. And then of course internally
11 you're going to be able to do it -- you
12 have a priority list anyway. There's no
13 way to not have one. But the messaging
14 has to always be towards universality.

15 I'm curious about whether and
16 how you see schools, elementary schools,
17 right, functioning within your network of
18 either outreach or destination. I mean,
19 we're likely not to be in session,
20 understandably, but I'm curious about how
21 you see that, just because we know
22 schools pull in 130,000 of our young
23 people, plus their families. They will
24 hit everybody. Some schools have a 100
25 percent low-income household rate. They

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2 will reach everybody, plus their family
3 members.

4 So I'm curious about how you
5 see that working and the complexities of
6 the fact that we're in virtual learning
7 right now.

8 DR. REED: Is that for Dr.
9 Abella or for me?

10 COUNCILWOMAN GYM: Both of you.

11 DR. REED: Well, I'll start and
12 then I'll turn it over to Ben.

13 Before I was here at Temple, I
14 was in Delaware, and I'm an adolescent
15 medicine physician. I do school work.
16 In Delaware, our community health centers
17 were right in the public schools. We
18 were in the high schools, in the middle
19 schools. It was a convener. That's also
20 where the elections occurred. Our
21 schools in those neighborhoods were used
22 as a place to gather and congregate.

23 If we have schools of that
24 nature here in Philadelphia, I would
25 consider using that. Our people, from

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2 Scott Charles in the trauma program to
3 Dr. Kathy Reeves in our community
4 programs, are out in the schools on a
5 regular basis and have established that
6 relationship and that work. My question
7 and where I think it takes community
8 input is, is that a place of trust, is
9 that a place where people feel safe, is
10 that a place where we can have those kind
11 of conversations. And it may be a
12 neighborhood-by-neighborhood decision.
13 It may be a regional decision, but I
14 think that's certainly something worth
15 exploring.

16 DR. ABELLA: You know, I defer
17 to Dr. Reed, because I am not an
18 adolescent physician and I've not done a
19 lot of work with schools, but I would say
20 this: We have done some training work
21 with schools, and I do feel at the very
22 least, at a minimum, the schools would be
23 a fantastic point of communication. Much
24 like schools are a touch point for the
25 Fire Department or Police Department or

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2 in safety and community policing and
3 various things, schools could be an
4 excellent touch point for family
5 education and the importance of education
6 for our people, because I think we have
7 to take a step back and appreciate that
8 do we even know -- in a lot of
9 communities, do they understand how these
10 vaccines work or what a vaccine even is.
11 After all, I get this a lot at Penn where
12 we'll have patients -- the
13 misunderstandings around illness and
14 disease are more profound than we
15 realize. I've had not -- one not too
16 many times patients say, I don't want to
17 get COVID testing because it will give me
18 COVID. I've had people say, I don't want
19 the flu shot because it gives me the flu.
20 So I think if nothing else,
21 using the schools for their central --
22 what they do centrally, which is
23 education, to get information out there
24 that kids can bring to their families.
25 Especially middle school and high schools

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2 can ask questions and we can make sure
3 they understand, so we can use this as a
4 teachable moment around health literacy.

5 COUNCILWOMAN GYM: Absolutely.

6 A couple of things to keep in
7 mind is that schools, for what it's
8 worth, schools are compulsory. People
9 have to attend. It's required. I mean,
10 obviously in a world of virtual learning,
11 one of the things that becomes really
12 hard is that compulsory education is now
13 very difficult to determine, and we want
14 to reach all students who could be
15 dropping out, vulnerable communities, et
16 cetera, et cetera. But for right now,
17 schools are compulsory, so people do go
18 there. Whether you have a feeling about
19 it or not, the young people who show up,
20 plus their family members, they hear it
21 from teachers and educators.

22 We fought really hard to get a
23 nurse in every single Philadelphia public
24 school. It would probably be worthwhile
25 to ask or be able to have a conversation

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2 with the School District and the School
3 District's health director about getting
4 information out there to the nurses to be
5 able to have a chance to drop in,
6 quote/unquote, to every virtual classroom
7 that they have in their field to be able
8 to communicate healthcare needs and/or
9 healthcare availability to each and every
10 young person and/or family member, in
11 addition to doing like parental type of
12 work.

13 But I just want to emphasize
14 that while I think it's very difficult
15 because we're in a virtual world right
16 now, try to deploy the things that we do
17 have at our resource and then keep going
18 from there. But I do think that schools
19 are a good way at normalization, at what
20 you are saying, Dr. Abella, about health
21 literacy and all that, and that we do
22 have personnel deployed within them,
23 healthcare professionals and personnel,
24 who can and should be partners, and so an
25 ability to see how that can be more

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2 responsibly utilized or aided. Certainly
3 partnerships or anything like that that
4 can go on between the medical community
5 and other schools would go a long way
6 towards being able to build out a more
7 universal approach for its vaccination
8 and healthcare and self-care overall.

9 So I want to thank both of you
10 for all of your work, and it's a pleasure
11 to spend an afternoon with people who are
12 here just to like save lives in our city.
13 So thank you very much.

14 Thank you, Madam Chair.

15 DR. ABELLA: Thank you.

16 COUNCILWOMAN BASS: Thank you.

17 Thank you, Councilwoman.

18 And I think next we are going
19 to call back Dr. Caroline Johnson. I
20 know that Councilman Henon had some
21 questions for her, representing the
22 City's Health Department.

23 Dr. Johnson, are you still
24 here?

25 DR. JOHNSON: I am here. I've

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2 enjoyed it.

3 COUNCILWOMAN BASS: Fantastic.

4 Fantastic. Councilman Henon had some

5 questions and I'm not sure, maybe

6 Councilwoman Gym and maybe Thomas, but I

7 did want to just quickly just mention, I

8 know that there's a lot of balls up in

9 the air right now. There's a lot of

10 unanswered questions, but I wanted to

11 just dig back down into your statement

12 that all distribution is really going to

13 be managed by the City Health Department.

14 So there's a lot of conversation, but we

15 have to recognize that all of this, all

16 of it will flow through the City's Health

17 Department.

18 And so one of the questions I

19 had is, as you talked about, that there

20 would be different phases, and so I'm

21 wondering -- and also recognizing that

22 there is a lot of -- there are a lot of

23 unknowns right now. We don't have a lot

24 of information on some of these things.

25 So if you don't have the information on

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2 this, I certainly do understand, but I
3 wanted to ask you in terms of the
4 different phases, if you had any sense of
5 what the numbers were. So example, in
6 Phase 1 we're going to be doing X, Y, and
7 Z. We're going to be covering healthcare
8 workers and those with disproportionately
9 bad outcomes and this group and that
10 group, and what are the numbers behind
11 the phases and also the timelines between
12 the phases. Do we have any sense of what
13 that looks like or is it too early? Can
14 you give us some idea.

15 DR. JOHNSON: So we do have
16 some rough ideas of how many people would
17 be eligible in Phase 1 and in Phase 2,
18 and then of course Phase 3 is the entire
19 City being eligible. So in Phase 1, the
20 healthcare workers that are defined as
21 eligible -- and we have a very, very
22 broad definition of healthcare workers.
23 For example, we include the people who
24 are staffing our behavioral health
25 treatment facilities, because we've seen

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2 so many problems with COVID occurring
3 there. So we have what I would call a
4 generous definition of healthcare worker.
5 That number is 68,000 in the City of
6 Philadelphia. And we also know if we add
7 onto that long-term care residents, home
8 health aide workers, and some of the
9 other vulnerable jobs that we've
10 identified, we are talking about the
11 possibility of needing to cover somewhere
12 around 125,000 people in just Phase 1,
13 which is the highest risk.

14 So doing the math, the problem
15 is the number of doses we expect to
16 receive for Phase 1 or sort of in Phase 1
17 I don't think is going to be higher than
18 50,000. Now, I'm hoping I'm wrong and
19 it's going to be more, but practically
20 speaking, when you see what the numbers
21 are that they're telling us are in the
22 stockpiles right now, if we take our
23 proportion, we may be seeing about 50,000
24 doses of vaccine to cover a much larger
25 eligible population. So that's why this

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2 priority scheme becomes so critical to us
3 and that's why -- Dr. Brennan talked
4 about how they had already thought
5 through of their 20,000-plus employees,
6 they've identified a subset of that that
7 said even greatest risk. And that's
8 what's going to happen, is people are
9 going to have to make some tough choices
10 in letting this vaccine be administered
11 to their staff and to high-risk
12 individuals.

13 So anyway, that's the number.
14 We do not know how fast it will come in
15 after that. I mean, I think it would be
16 fair to say by the summer of 2021, we
17 will see a very steady flow of vaccine in
18 here to cover the entire population, but
19 those first few months are going to be
20 tough.

21 COUNCILWOMAN BASS: Well, thank
22 you. And we expect -- listen, it hasn't
23 been easy thus far, but if we're going on
24 our way to making sure people are
25 protected and we can do something about

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2 this terrible virus, we can do something
3 about COVID, then I think it just
4 behooves all of us to be patient and just
5 wait until we could actually get the
6 vaccine and then enough people have it so
7 that it's effective. So thank you so
8 much --

9 DR. JOHNSON: Of course.

10 COUNCILWOMAN BASS: -- for
11 answering those questions.

12 Councilman Henon.

13 COUNCILMAN HENON: Thank you,
14 Madam Chair.

15 And, Dr. Johnson, thank you for
16 your patience. I hope you will
17 understand there's no disrespect intended
18 to having these questions at the end, and
19 also want to remind you and others that
20 questions that haven't had the chance to
21 get asked because of time, because of
22 Channel 64 and us being available to
23 broadcast live, we will get questions as
24 a Committee and as a Council over to you
25 as quickly as we possibly can.

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2 I also want to remind everybody
3 about the good work that the Health
4 Department is doing and give you credit,
5 Dr. Johnson, on the PhilaVax. PhilaVax
6 is 95 percent accuracy for all of our
7 vaccinations in the City of Philadelphia,
8 which is an incredible network, hopefully
9 which will be utilized when we distribute
10 and administer the vaccines. Hopefully
11 I'm correct in making that statement.

12 DR. JOHNSON: Yes. And if I
13 can jump in and just comment something
14 about how important this is. The flow of
15 the vaccine is coming from the CDC.
16 They're not the manufacturers, but
17 they're the ones who will be releasing it
18 to the Health Department and their
19 partners. And if we do not successfully
20 report to them the administrations, they
21 don't replace the doses of vaccines so we
22 can vaccinate even more. So let's say
23 they do give us 50,000 doses to start off
24 with. If I don't report back 50,000
25 administrations to the CDC, we do not get

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2 our next batch of 50,000. So this idea
3 of the data connectivity and having the
4 accurate, reliable data that we can turn
5 around quickly is essential to us even
6 participating in this program.

7 So PhilaVax turns out to be
8 maybe the single most important thing
9 that we can have going for us in
10 launching the program. So I'm excited
11 that we're in good shape with that.

12 COUNCILMAN HENON: I'm glad
13 we're making that point now in advance to
14 further conversations, especially when
15 you talk about possibly, and you don't
16 know for sure, only 50,000 being released
17 from the national CDC.

18 Now, that being said, I guess
19 it really doesn't matter how many
20 pharmaceuticals have been approved if
21 they're releasing in part a little at a
22 time; is that correct?

23 DR. JOHNSON: That's right. I
24 mean, we get a -- we will get a
25 proportion of the total amount available

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2 on any particular day. So I think it
3 just depends on how much they have in
4 their stockpile, and we get our
5 proportion of that.

6 Now, when there are multiple
7 different vaccines, it will be
8 interesting to see if they choose to send
9 all of one type to Philadelphia and
10 another type to New York or how that's
11 handled. We don't have any advanced
12 information on that. But we're preparing
13 for the possibility of having multiple
14 different products in this city at the
15 same time.

16 COUNCILMAN HENON: So just to
17 add to that and some of my questioning
18 is, will Philadelphia receive direct or
19 will it come from the state? Like who
20 would be the centralized -- would
21 Philadelphia be the centralized
22 distribution, and are we prepared
23 infrastructure-wise with either storage
24 freezers and coolers in, of course,
25 undisclosed locations for that purpose so

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2 we can distribute appropriately when we
3 receive them from the CDC?

4 DR. JOHNSON: So we are
5 independent from Pennsylvania. Our dose
6 allocation will be determined based on
7 the population size of Philadelphia, and
8 we are accountable only for immunizing
9 Philadelphia residents.

10 The vaccine will be stored --
11 at a national level there are a couple of
12 major depots that will house all of the
13 vaccine, and when we submit an order to
14 the CDC, the depot then will ship the
15 vaccine to whomever we determine will
16 receive it.

17 Now, depending on what the
18 storage requirements are for that
19 vaccine, that might be the Health
20 Department itself. It might be some of
21 the occupational health departments in
22 hospitals may be direct recipients. So
23 some of the flow of vaccine could go
24 directly to the person or groups that are
25 administering the vaccine or they may

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2 come to the Health Department who will
3 still handle re-dispensing.

4 One of the reasons it's not all
5 worked out yet is because of this issue
6 of the storage temperatures and the size
7 of the distribution boxes. I'm probably
8 getting into way too much detail for you,
9 but some of the vaccine is actually
10 packaged in very large quantities, like a
11 thousand doses, and they will only ship
12 in that large quantity. So we would not
13 want to waste any vaccine by sending a
14 thousand doses to a provider who is only
15 going to use a hundred. So that probably
16 means that all of the vaccine for the
17 smaller providers' hands will pass
18 through the Health Department.

19 And to get back to your
20 original question about storage
21 facilities and refrigeration is, the
22 Health Department has just very recently
23 brought up capacity to store the ultra
24 cold vaccine, and we do believe that
25 we're going to have capacity to support

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2 the amount of vaccine that we're going to
3 get. We will be partnering with some of
4 the big universities who also have these
5 ultra cold storage devices. So our
6 capacity can be supplemented by theirs as
7 well.

8 COUNCILMAN HENON: Now, Doctor,
9 just going off of this conversation, but
10 we're less than 5 percent, right, from
11 our population on the amount of
12 distribution of vaccines in Phase 1. I
13 mean, below 4 percent, I would imagine.
14 Is that going to be universal across the
15 country?

16 DR. JOHNSON: Yes.

17 COUNCILMAN HENON: Like a 3.5
18 percent or less?

19 DR. JOHNSON: For the initial
20 shipment, yes. I mean, Philadelphia is
21 not going to be treated any better or
22 worse than any other jurisdiction.
23 They're going to do this on a straight
24 per capita basis. So I think as a city,
25 we'll be treated fairly, and that's how

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2 vaccines have been handled historically.
3 It's always been done on a per capita
4 basis.

5 The only thing that's a little
6 bit different is that the federal
7 government is making some arrangements
8 for federal institutions that are outside
9 of our jurisdiction, which I mean, for
10 example, the federal prison and some of
11 the federal agencies like the FBI and at
12 the federal building. They probably will
13 have a direct arrangement with CDC to
14 receive vaccine and we will not be
15 accountable for any of their doses. But
16 apart from that, it's a straight per
17 capita level distribution or assignment.

18 COUNCILMAN HENON: And I
19 understand that. It's a little
20 concerning for an urban city like this
21 that is so dense and close together and
22 has a lot of challenges, I think more so
23 than other cities, but I guess we'll have
24 time to continue to fight for that.

25 You had mentioned that the CDC

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2 required that the City Health Department
3 and other government agencies submit a
4 plan for distribution of the vaccine.
5 Can you share that plan? Is that public
6 or is that something that we could
7 distribute to members offline or at least
8 highlight on some of the distribution
9 plans that you submitted to the CDC?

10 DR. JOHNSON: Sure. So that is
11 actually an opportune comment. So I can
12 just announce that we did today open our
13 first public, I guess, presence about
14 COVID-19 vaccine on the City's COVID
15 website. So if you go to the base or the
16 COVID-19 website that we're hosting,
17 there's now a tab there for vaccine, and
18 we have our first sort of basic
19 information there and are building out a
20 series of FAQs.

21 One of the links that's
22 available on that website is the
23 executive summary for the plan. It is
24 basically a two-page summary that the CDC
25 had asked us to construct. The CDC has

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2 that posted publicly on their website and
3 it's on ours as well.

4 We're happy to share the full
5 plan with all the members of Council or
6 whoever you'd like to have it. The full
7 plan will also be made available on the
8 public website within probably a couple
9 of weeks. We wanted to get more
10 information built into the plan about the
11 actual vaccines so that people, if they
12 were going to read this in detail, would
13 understand what products we're working
14 with and what the safety and efficacy is.
15 So we were not quite ready to put it out
16 publicly, but we're certainly happy to
17 share this, and I can make sure that you
18 get a copy.

19 COUNCILMAN HENON: I think
20 that's a great sign of transparency and a
21 symbol for the City of all the hard work
22 that we're doing and especially in a time
23 when people are either curious and
24 concerned at the same time on what the
25 vaccine does, is it safe, is it going to

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2 be able to get out, how do I get it, and
3 what is the timeline, are we allowed to
4 walk outside our house. So I want to
5 thank you for all your efforts in that.

6 I have one last question and
7 I'll submit everything else in writing.
8 I didn't get a chance to ask this
9 question to all of the other panelists
10 that joined us here today. And the
11 question is, is there a benefit of
12 offering multiple vaccines at the same
13 time that we are vaccinating people for
14 COVID-19, since we're using basically the
15 same infrastructure that has been
16 described throughout all platforms and
17 all of the fantastic institutions that we
18 have and non-profits of people that have
19 been charged with dealing with COVID-19.
20 So is there a benefit of offering
21 multiple vaccines such as flu shot and
22 anything else at the same time of the
23 COVID-19?

24 DR. JOHNSON: Absolutely. I
25 love that idea, and I think by the time

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2 we are in the Phase 3, which is the open
3 access for everyone in the City, we would
4 like to see that providers who are
5 immunizing with COVID-19 vaccine are also
6 taking that opportunity to update all of
7 the other vaccines that a person might be
8 eligible for.

9 We're hoping that COVID-19
10 vaccine becomes integrated into normal
11 medical practice, so when you go in for
12 your annual physical, if there's an
13 indication to get this vaccine every
14 year, every five years or whatever it
15 turns out to be, that that would be the
16 opportunity to do that.

17 I don't think in the earliest
18 phase that we will be able to address the
19 other vaccine requirements of the
20 individuals, partly because of the timing
21 and the population that we're dealing
22 with, but it's an overall good strategy.

23 Can I also -- I did forget to
24 mention something earlier in the
25 testimony, and that was about cost, and I

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2 thought it would be good for everyone to
3 understand that there will be no cost to
4 the residents for this vaccine, either
5 for the vaccine itself or for the
6 administration charge. So anyone who is
7 to receive this vaccine has to sign an
8 agreement with the City and with the CDC
9 that says they will not charge the
10 recipient of the vaccine any co-pays or
11 any deductibles or any other kind of fee.
12 Providers are allowed to bill insurance
13 companies, and the federal government has
14 set up a supplemental sort of uninsured
15 client reimbursement mechanism that the
16 providers can go after. So there is
17 going to be no cost to anyone in
18 Philadelphia to receive this vaccine.

19 COUNCILMAN HENON: I'm glad to
20 hear that, and thank you for your hard
21 work.

22 Madam Chair.

23 COUNCILWOMAN BASS: Thank you.

24 And you know what's so funny, I
25 can't believe we didn't ask that question

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2 all along about cost. I'm so excited to
3 hear that there's not going to be a cost
4 associated with it. I think that this is
5 just going to be phenomenal in terms of
6 making a difference in communities where
7 people just really don't have it. And to
8 be honest, right now nobody has it.

9 So, again, we thank you and we
10 thank the Health Department for
11 everything that you're doing.

12 Any additional questions from
13 members of the Committee?

14 (No response.)

15 COUNCILWOMAN BASS: Any
16 additional witnesses to testify?

17 (No response.)

18 COUNCILWOMAN BASS: Anyone?
19 Anyone?

20 (No response.)

21 COUNCILWOMAN BASS: Okay.

22 Well, seeing none, this is going to
23 conclude our hearing for the Committee on
24 Public Health and Human Services. We're
25 going to hold this resolution until the

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2 call of the Chair. I'm sure we'll be
3 revisiting it likely in the near future,
4 before the end of the year.

5 So I want to thank everyone for
6 being here today, and I will reconvene
7 and connect with the resolution sponsor
8 so that we can follow up on some of the
9 recommendations on this very timely and
10 important health issue.

11 Thank you very much, everyone,
12 for being here.

13 (Committee on Public Health and
14 Human Services adjourned at 3:50 p.m.)

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