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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COUNCILWOMAN BASS: Good afternoon. I understand that state law currently requires that the following announcement be made at the beginning of every remote public hearing as follows:

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

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

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displayed on screen when you speak.

Madam Clerk.

THE CLERK: Councilmember Henon.

COUNCILMAN HENON: Good morning, Madam Chair -- or good afternoon, Madam Chair, and good afternoon, colleagues.

THE CLERK: Councilmember Oh.

COUNCILMAN OH: Good morning, Madam Chair. Good morning -- good afternoon, Madam Chair. Good afternoon, colleagues.

THE CLERK: Councilmember Gym.

COUNCILWOMAN GYM: Good afternoon, everybody. I look forward to this hearing.

THE CLERK: Councilmember Green.

(No response.)

THE CLERK: Councilmember Thomas.

COUNCILMAN THOMAS: Good afternoon. I'm present.

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THE CLERK: Councilmember Brooks.

COUNCILWOMAN BROOKS: Good afternoon. I'm present.

THE CLERK: And Chairperson Bass.

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

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

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

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

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managing the roll out of the COVID-19
vaccine.

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

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

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

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

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

Madam Clerk.

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

COUNCILWOMAN BASS: Thank you, Councilmember.

COUNCILMAN GREEN: Thank you.

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

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

COUNCILMAN HENON: Thank you,

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

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

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

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

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

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

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

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

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

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wish. Thank you.

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

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

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

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

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

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

DR. JOHNSON: Good afternoon.

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

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

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

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

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

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

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

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

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

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

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

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The local immunization program's experience in distributing vaccines working with healthcare providers to assure adequate vaccine storage and handling practices, promoting vaccine administration in accord with established recommendations, tracking uptake of vaccines, and educating the public on the benefits of immunization has positioned the Department well for overseeing distribution of COVID-19 vaccines.

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNCILWOMAN BASS: Thank you, Dr. Johnson.

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

Councilman Henon.

COUNCILMAN HENON: Thank you,

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

COUNCILWOMAN BASS: I do see that now.

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

COUNCILWOMAN BASS: Sure.

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

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

DR. NETTLES: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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doses around the world.

COUNCILWOMAN BASS: Excellent. Excellent. Okay.

Councilman Henon.

COUNCILMAN HENON: Thank you, Madam Chair.

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

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

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

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

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

Thank you, Madam Chair.

COUNCILWOMAN BASS: Thank you.

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

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

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

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

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

COUNCILWOMAN BASS: Thank you. Thank you very much.

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

DR. STANFORD: From Dr. Stanford.

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

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going to ask you to hold the question.

Okay. One moment.

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

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

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

THE CLERK: Dr. Bon Ku, the Marta and Robert Adelson Professor of Medicine and Design, Director, Health Design Lab, Professor of Emergency Medicine, Thomas Jefferson University; Dr. Rose Ritts, Executive VP and Chief Innovation Officer, Jefferson Health and Thomas Jefferson University; and Dr. John Zurlo, the W. Paul and Ida Havens Professorship of Infectious Diseases, Director, Division of Infectious

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

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

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

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

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

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

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

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

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

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

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

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patients a day at one of our sites.

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

So I'll end my comments there.

COUNCILWOMAN BASS: Thank you very much, Doctor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNCILWOMAN BASS: Good afternoon.

DR. ZURLO: Hello?

COUNCILWOMAN BASS: Good afternoon.

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

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

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

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

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

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excellent trend.

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

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

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

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

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

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

COUNCILWOMAN BASS: Yes.

COUNCILMAN HENON: Yes, we can.

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

If we look at efficacy in older

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I know that Councilwoman Gym had questions for the panel.

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

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

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

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

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believe in medical care and treatment.

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

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

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

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

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

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

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

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

COUNCILWOMAN GYM: Super helpful. Thank you.

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

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

COUNCILWOMAN GYM: Great. Thank you.

COUNCILWOMAN BASS: Thank you, Councilwoman Gym.

COUNCILWOMAN GYM: Thank you, Madam Chair.

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

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

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panel. I really appreciate it.

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

Any additional questions from members of Council?

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

COUNCILWOMAN BASS: Councilman Henon. The Chair recognizes Councilman Henon.

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

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

COUNCILWOMAN BASS: Sure.

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

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

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

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

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

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

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

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

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

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

COUNCILMAN HENON: Thank you for that.

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

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

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

COUNCILMAN HENON: Thank you, Doctor.

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

DR. RITTS: Yes. I'm here.

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

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

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

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

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

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cost. So that's just another important thing.

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

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

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

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

Madam Chair.

COUNCILWOMAN BASS: Thank you, Councilman.

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

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

COUNCILWOMAN BASS: Yes, please. Thank you.

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

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

COUNCILWOMAN BASS: Thank you.

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

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

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

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

Dr. Cairns, you're muted. Thank you.

DR. CAIRNS: Thank you so much.

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

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to be prepared to pivot with any new information.

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

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

We propose that the PhilaVax system be augmented by incorporating

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

Currently, we're working with Saint Christopher's Hospital for Children to provide COVID-19 testing to these underserved communities in Philadelphia. We're also using community health workers to assist in the education, awareness, warm handoffs of vaccination to better engage the community and gain trust as a proactive approach to addressing, as already stated, low percentage of those willing to receive the vaccine. Supplementing this with vaccine administration in a mobile unit to communities at highest risk would be ideal.

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

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

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

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

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

COUNCILWOMAN BASS: Thank you for your testimony.

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

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

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

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

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

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

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

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

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

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

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

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patients for COVID-19.

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

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

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

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

Penn Medicine has been working for several months on a plan to distribute the vaccine once it is available. We've established an internal advisory committee consisting of a representative team of clinicians, emergency management professionals, ethicists, and human resource officers to plan for effective, efficient, and ethical implementation of our vaccine distribution plan. The team has incorporated the recommendations of the National Academy of Medicine, the Centers for Disease Control and Prevention, the Pennsylvania Department of Health, and the Philadelphia Department of Public Health into our policy governing how vaccines will be distributed.

In accordance with ethical

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

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

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

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

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

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

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fields such as transplant, oncology, and neonatology.

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

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

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

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

Thank you for the opportunity to speak with the Committee.

COUNCILWOMAN BASS: Thank you so much for your testimony.

Do we have the next witness available to testify?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNCILWOMAN BASS: Thank you, Dr. Stanford.

Do we have our next panelist available to testify?

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

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

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

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

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

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

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

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

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

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

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

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

(Yes, we can.)

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

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

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

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Can you see it now?

COUNCILWOMAN BASS: Yes.

MR. DOROSHIN: All right. Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

COUNCILWOMAN BASS: Thank you so much.

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

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

Councilman Henon.

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DR. STANFORD: Thank you.

COUNCILWOMAN BASS: You're welcome.

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

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

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

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

DR. REED: Yes, sir.

COUNCILMAN HENON: Wonderful. Thank you.

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

DR. BRENNAN: Dr. Brennan is here.

COUNCILMAN HENON: Doctor, great. Thank you.

COUNCILWOMAN BASS: Dr. Cairns

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I believe had to step off.

COUNCILMAN HENON: Okay.

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

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

COUNCILMAN HENON: Okay. Great.

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

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

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

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

So we're working with communications professionals who have

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

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

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

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

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

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

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

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

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

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

MR. DOROSHIN: Correct.

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

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

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

COUNCILMAN HENON: Okay. Thank you.

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

COUNCILWOMAN BASS: Thank you, Councilman.

Councilwoman Gym, and then Councilman Thomas.

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

And good afternoon, Dr. Stanford.

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

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

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

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

COUNCILWOMAN GYM: 17 to 19 percent positivity rate.

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

COUNCILWOMAN GYM: Testing, yes. Correct.

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

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

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

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

DR. STANFORD: Well, you know...

COUNCILWOMAN GYM: No need.

I think the other question would be -- and I fully hope that you and many others who have been doing this work in communities are at the table as the planning rolls out or the messaging rolls out on the vaccination front. I think we heard a little bit earlier from Dr. Bon Ku, and I think this speaks to a little

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

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have engaged with them who fall below the radar.

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

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

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

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

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

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

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

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

DR. BRENNAN: I think testing

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

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

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

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

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

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

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

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

So I just wanted to make that

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

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

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

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

COUNCILWOMAN GYM: For citywide positivity?

DR. BRENNAN: Yeah.

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

(Two people speaking at the

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same time.)

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

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

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

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

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

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

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

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

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right behind that first wave.

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

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

Thank you very much, Madam Chair.

MR. DOROSHIN: May I quickly make a statement?

COUNCILWOMAN BASS: Yes.

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

COUNCILWOMAN BASS: Mr. Doroshin?

MR. DOROSHIN: Yes, ma'am.

COUNCILWOMAN BASS: I'm sorry.

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

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

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

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

COUNCILWOMAN BASS: Thank you, Councilman.

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

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

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

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

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

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

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

What we have noticed is that

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

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

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preparedness.

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

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

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

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

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

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

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

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

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

COUNCILWOMAN BASS: Thank you

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very much for your testimony.

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

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

COUNCILWOMAN BASS: Yes. We can hear you well.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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comments as well, and am happy to take questions.

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

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

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

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

Councilman Henon, did you have a question?

COUNCILMAN HENON: Thank you, Madam Chair.

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

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

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

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

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

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

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

First off, I think that would

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

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

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

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

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

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

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

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

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

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

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

COUNCILMAN HENON: Thank you, Doctor.

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Is Dr. Reed still with us?

DR. REED: Yes, sir.

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

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

The one thing that we have to

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

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

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

COUNCILMAN HENON: Thank you. Thank you, Dr. Reed.

Back to you, Madam Chair.

COUNCILWOMAN BASS: Thank you, Councilman.

Councilwoman Gym, thank you so much for your patience.

COUNCILWOMAN GYM: No; of course.

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

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

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

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

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

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

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

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will reach everybody, plus their family members.

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

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

COUNCILWOMAN GYM: Both of you.

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

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

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

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

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

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in safety and community policing and various things, schools could be an excellent touch point for family education and the importance of education for our people, because I think we have to take a step back and appreciate that do we even know -- in a lot of communities, do they understand how these vaccines work or what a vaccine even is. After all, I get this a lot at Penn where we'll have patients -- the misunderstandings around illness and disease are more profound than we realize. I've had not -- one not too many times patients say, I don't want to get COVID testing because it will give me COVID. I've had people say, I don't want the flu shot because it gives me the flu.

So I think if nothing else, using the schools for their central -- what they do centrally, which is education, to get information out there that kids can bring to their families. Especially middle school and high schools

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

COUNCILWOMAN GYM: Absolutely.

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

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

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

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

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

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

Thank you, Madam Chair.

DR. ABELLA: Thank you.

COUNCILWOMAN BASS: Thank you. Thank you, Councilwoman.

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

Dr. Johnson, are you still here?

DR. JOHNSON: I am here. I've

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enjoyed it.

COUNCILWOMAN BASS: Fantastic. Fantastic. Councilman Henon had some questions and I'm not sure, maybe Councilwoman Gym and maybe Thomas, but I did want to just quickly just mention, I know that there's a lot of balls up in the air right now. There's a lot of unanswered questions, but I wanted to just dig back down into your statement that all distribution is really going to be managed by the City Health Department. So there's a lot of conversation, but we have to recognize that all of this, all of it will flow through the City's Health Department.

And so one of the questions I had is, as you talked about, that there would be different phases, and so I'm wondering -- and also recognizing that there is a lot of -- there are a lot of unknowns right now. We don't have a lot of information on some of these things. So if you don't have the information on

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

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

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

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

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

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

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

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

DR. JOHNSON: Of course.

COUNCILWOMAN BASS: -- for answering those questions.

Councilman Henon.

COUNCILMAN HENON: Thank you, Madam Chair.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. JOHNSON: Yes.

COUNCILMAN HENON: Like a 3.5 percent or less?

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

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

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

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

You had mentioned that the CDC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Madam Chair.

COUNCILWOMAN BASS: Thank you.

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

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

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

Any additional questions from members of the Committee?

(No response.)

COUNCILWOMAN BASS: Any additional witnesses to testify?

(No response.)

COUNCILWOMAN BASS: Anyone? Anyone?

(No response.)

COUNCILWOMAN BASS: Okay. Well, seeing none, this is going to conclude our hearing for the Committee on Public Health and Human Services. We're going to hold this resolution until the

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

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

Thank you very much, everyone, for being here.

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

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CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the foregoing matter, and that this is a true and correct transcript of same.

MICHELE L. MURPHY
RPR-Notary Public

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