

# Prioritization Guidelines for Allocation of Personal Protective Equipment

## Introduction

The emergence of COVID-19 variants, the increased vaccination rates, and the evolution of the public health response to COVID-19 requires an update to this document.

The on-going need for Personal Protective Equipment (PPE) caused by the COVID-19 pandemic is currently causing spot shortages of PPE, which has posed challenges to the stressed healthcare system, congregate living facilities, and many other patient-care and public service facilities and organizations. Since the beginning of Washington State's response to COVID-19, requests to the State Emergency Management Division (EMD) for PPE has far outpaced the ability to source and fulfill orders given the lack of product availability. While some PPE items continue to be a scarce resource and difficult for some agencies to source across the country, and internationally, the supply chain has improved.

## Purpose

This document is intended to guide state and local emergency management agencies (EMAs) on how to prioritize the fulfillment of personal protective equipment (PPE) during a shortage of PPE supplies. This prioritization document does not guarantee fulfillment of every order that meets priority criteria, nor does it ensure fulfillment of complete orders. Orders may be partially filled due to limited stock. It also does not guarantee that requestors will receive PPE that is their normal type or brand therefore they need to ensure they have a mechanism to fit test staff their staff to the type/brand/size of respirator that becomes available.

## Scope

This document is specific to PPE in the context of the COVID-19 pandemic to ensure good infection prevention control practices and disease containment.

## The state's role in PPE

To address the COVID pandemic, the state of Washington initiated Medical Surge-Area Command to direct pandemic response. As the complexity of the pandemic grew exponentially, the state of Washington established a Unified Command-Area Command incident management structure. Area Command directed the medical response through its health regions, local health jurisdictions, its State Laboratory, its Isolation & Quarantine Task Force, and its collaboration with medical hospitals, clinics, affiliated state agencies. Unified Command directed State Emergency Operations Center (SEOC) activities encompassing operations, advanced planning, the Joint Information Center (JIC), and logistics operations

including DES contracting/procurement, warehousing/distribution. The state enterprise, acting at the direction of Unified Command- Area Command, serves a unique role in the acquisition, storage, and distribution of PPE to state agencies and to tiered stakeholders in emergent circumstances where the normal supply chain cannot meet demand. These efforts created a state backstop for emergent needs for government or tribal operations in the COVID-19 Pandemic.

As the COVID pandemic evolved through multiple waves and the medical front-line entities (Tier 1) were fully provisioned with surge capacity, the Unified Command-Area Command adapted PPE provisioning to meet Safe Reopening through Tier 2-4 entity provisioning. A complex situation given unprecedented wildfire activities occurring at the same time as a 5<sup>th</sup> wave surge, the state enterprise working in collaboration with SEOC Logistics and WA DOH PPE Coordinator, adapted existing ordering (WebEOC) and points of distribution (PODs) protocol to meet the local health jurisdictions, emergency management agencies, and Tier 2-4 entities needs.

### Non-Governmental Response Partners' Role in PPE

Non-governmental response partners include, but are not limited to, partners such as dental clinics, ambulatory surgical facilities, behavioral health, social service, volunteer, and non-profit organizations. These organizations are to work with the state of Washington, local EMAs, and key stakeholders to build systems for providing certain PPE to key healthcare and social service organizations that require PPE but are not traditional users or have very limited access to required PPE. Additionally, non-governmental response partners can connect PPE distribution channels to organizations or healthcare providers that must maintain their operational effectiveness in order to reduce the likelihood of patient surge in our hospitals, to reduce the spread of COVID-19 in our communities, and protect groups of people most vulnerable to COVID-19.

### Prioritization and Allocation Strategies

All entities, including governmental (city, county, state, and tribal) requesting state provided PPE will pursue options to obtain PPE through their normal supply channels. Organizations that are part of a larger health systems are expected to engage their regular ordering and procurement process when they anticipate PPE shortages. When PPE supplies are limited, organizations are expected to practice PPE conservation strategies per [Center for Disease Control and Prevention \(CDC\) strategies](#)<sup>1</sup>. As it becomes necessary to engage additional supply channels, organizations should contact their regional Healthcare Coalition (Northwest Healthcare Response Network and REDi Healthcare Coalition), and/or the local EMA. Some organizations may be eligible to access current master contracts available through the State of Washington Department of Enterprise Services (DES). If those channels are not able to meet the requirement, entities should submit a resource request to their Local EMA. Organizations must also comply with the Division of Occupational Safety and Health (DOSH), Labor and Industry (L&I), CDC, and healthcare requirements in order to request PPE.

As COVID-19 variants are emerging organizations are also eligible to request PPE for the purpose of replenishing their pre-COVID backstop (prior to January 20, 2020) and able to order up to a 90-day supply. Fulfillment of these requests are subject to PPE availability.

## Prioritization Protocol

1. **Conventional (steady state):** Organizations are able to order/maintain levels of PPE for current operations and have enough on hand for a possible surge event. Current facility strategies are in place as part of general infection prevention and control. Organizations can maintain a 30-day supply of PPE.
2. **Contingency:** Organizations have anticipated PPE shortages and/or have 7-14 days of PPE supplies on hand. Those organizations begin to implement strategies to obtain additional PPE through available channels and prepare for conserving PPE.
3. **Crisis (Emergency):** When demand is exceeding supply, and facilities use their operations cache and have less than 7-14 days of PPE on hand and/or face a surge in COVID-19 cases. In crisis, facilities and organizations have implemented PPE conservation strategies as appropriate.
  - a. Organizations may request an emergent shipment of PPE to meet their needs for up to 7 days.

*Note: The state recommends that all health care facilities maintain at least a 7-day supply of necessary PPE. State and county EMAs will aim for short, rapid deployment of supplies [(state response goal from request to shipment: <24 hours) dependent on type of PPE and availability in the warehouse, quantities requested, and shipping location in the state].*

## COVID-19 disease control strategy

Governmental agencies, health care facilities, and non-governmental organizations managing congregate living facilities serving vulnerable populations or providing an emergency shelter, must maintain their operational effectiveness in order to reduce the likelihood of patient surge in our state's health care system, detect cases of COVID-19, reduce the spread of COVID-19 in our communities, and protect groups of people most vulnerable to COVID-19. Universal masking is the most proven approach for stemming the spread of COVID in LTCFs and within other congregate living facilities and shelters.

## Factors to consider in defining the prioritization of PPE:

1. Protecting health care providers treating urgent and emergent patients with known or suspected COVID-19.
  - a. Ability of health care professional to comply with the Division of Occupational Safety and Health (DOSHS), Labor and Industries (L&I) and CDC recommendations and healthcare requirements for treating patients.
  - b. Likelihood of performing aerosol generating procedures (highest priority for N95s).
  - c. Degree of contact between staff and patients, ability to implement engineering controls and social distancing, and the likelihood that patients are infected with COVID-19.

2. Controlling the spread of the disease and “boxing in the virus” particularly among vulnerable populations living in congregate settings (e.g. long-term care facilities, homeless shelters, etc.).
  - a. Surgical masks will be available to all long-term care facilities, home health, homecare, hospice, hospice care, and supported living agencies as part of the universal masking mandate in order to prevent the spread of COVID-19 within these settings.
  - b. PPE required as a public health emergency protective measure to prevent and mitigate the spread of the disease for populations where spread of the disease will place an increased burden on the health care system.
  - c. Need for PPE in testing and containment operations.
  - d. Sufficient and appropriate PPE for facilities that are providing vaccinations.
3. Protecting those that are disproportionately impacted by COVID-19 (e.g. essential workers).
  - a. Risk of disease spread to other vulnerable people in a congregate setting, or from setting to setting by health care workers and others.
  - b. Role of asymptomatic spread in severe outbreaks.
  - c. Essential nature of the service or support provided by the requesting organization.
4. Organizations having limited ability to access PPE through normal supply chains.
  - a. Availability of PPE in the global and US marketplace to entities/requestors.

## Definitions

**Backstop:** Supporting or augmenting, but not the primary provider of PPE to entities in the Tiered prioritization guidelines.

**Response:** Actively engaging with patient populations or community populations to identify and treat persons with suspected or confirmed COVID-19, protect the people in our communities who are most at risk of infection and may face disproportional impacts from the disease, and to control the spread of COVID-19.

**Operational Cache:** A staged supply of equipment or supplies that is available for rapid deployment to organizations responding to the impacts of COVID-19.

**Urgent and Emergent Care:** Care provided to a patient for which a delay would result in worsening a life-threatening or debilitating prognosis.

## Tiers for PPE Allocation

The following tiers may not capture all facilities or individuals that request or need access to PPE. Emergency management agencies need to use their best judgement around how to prioritize other facilities and individuals not listed. Facilities in all tiers can request PPE from Emergency Management Agencies when they are not able to maintain a 14-day operational supply of PPE. When PPE availability decreases, the state will prioritize filling orders based on this tier structure. This document may continue to change as necessary based on the needs of

the state and the situation as the response to COVID-19 progresses.

Tiers	Organizations
<p><b>Tier 1</b> – Facilities with confirmed/suspected COVID-19 case(s) with limited ability to social distance and apply engineering controls.</p> <p><i>Note: Facilities in this tier with confirmed cases, no PPE, and those practicing extreme <a href="#">CDC’s PPE conservation strategies</a><sup>2</sup> will be recognized as a higher priority</i></p> <p><i>Additional Note: Nitrile gloves will be available for organizations within this tier, as supply is available.</i></p>	<ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient facilities providing care of an urgent or emergent nature. (Including but not limited to ambulatory surgical facilities, Urgent Care Centers, Dental Clinics, etc.)</li> <li>• Outpatient facilities performing aerosol generating procedures for routine care</li> <li>• EMS Services and First Responder licensed or recognized in Washington and other first responders such as Law enforcement agencies, fire and other designated responders not necessarily licensed or recognized as EMS services</li> <li>• Long term care facilities/home health/home care/hospice/hospice care centers and supported living agencies <ul style="list-style-type: none"> <li>○ Surgical masks will be available to all long-term care facilities, home care providers, and supported living agencies in support of the universal masking mandate</li> </ul> </li> <li>• Alternate care facilities and COVID-19 Isolation facilities and COVID-19 Quarantine facilities* <ul style="list-style-type: none"> <li>○ *COVID-19 Quarantine facilities that are co-located with isolation facilities and share staff and resources.</li> </ul> </li> <li>• Medical examiners, coroners</li> <li>• Behavioral Health Residential Programs</li> <li>• Regulatory agencies required to complete onsite inspections and investigations in facilities with residents and patients with COVID-19.</li> </ul>
<p><b>Tier 2</b> – Facilities with confirmed/suspected COVID-19 case(s) but able to implement social distance and apply engineering controls.</p> <p><i>Note: Vinyl and Vinyl/Nitrile blend gloves will be available for organizations within this tier, as supply is available.</i></p>	<ul style="list-style-type: none"> <li>• All public health agencies for outbreak investigations and testing/lab operations</li> <li>• Outpatient clinics providing routine care without conducting aerosolizing procedures</li> <li>• COVID-19 test sites</li> <li>• Designated crisis responders</li> <li>• Congregate living facilities with confirmed/suspected COVID patients</li> <li>• Quarantine facilities with asymptomatic but exposed individuals</li> <li>• Immunization / Vaccination clinics serving asymptomatic individuals.</li> </ul>

<p><b>Tier 3</b> – Facilities that are critical for providing social and behavioral health services to vulnerable populations and may encounter people suspected of having or confirmed to have COVID-19.</p> <p><i>Note: Vinyl and Vinyl/Nitrile blend gloves will be available for organizations within this tier, as supply is available.</i></p>	<ul style="list-style-type: none"> <li>• Licensed pharmacies providing testing or immunization services</li> <li>• Families of patients with confirmed COVID-19 who are at home</li> <li>• Adult day health, Adult day care providers, and Community based providers</li> <li>• Opioid treatment programs</li> <li>• Funeral homes</li> <li>• Mental health promotion, substance abuse, domestic violence and child abuse prevention programs (or similar social service prevention provider)</li> <li>• Equity outreach organizations</li> <li>• Educational agencies and organizations</li> <li>• Childcare centers and facilities</li> </ul>
<p><b>Tier 4</b> – Facilities and organizations that are critical for providing services to the public</p> <p><i>Note: Vinyl and Vinyl/Nitrile blend gloves will be available for organizations within this tier, as supply is available.</i></p>	<ul style="list-style-type: none"> <li>• Faith-based organizations</li> <li>• Volunteer-based organizations</li> <li>• Congregate settings providing shelter due to other emergencies (i.e. wildfire, floods)</li> <li>• Private non-profit partners</li> </ul>

*Note: These tiers may not capture all facilities or individuals that request or need access to PPE. Emergency management agencies need to use their best judgement around how to prioritize other facilities and individuals not listed.*

\*Many adult family homes and skilled nursing facilities have connections to local pharmacies. Pharmacies, in some communities could serve as a hub or connecting point for these types of facilities.

\*\*General practice medical offices or medical specialists should attempt to use their health care network(s) for PPE. In the event that a health care network cannot meet requirements, they should submit a resource request to their local emergency management agency. The request will be evaluated on a case-by-case basis.

## More COVID-19 Information and Resources

Stay up-to-date on the [current COVID-19 situation in Washington](#), [Governor Inslee’s proclamations](#), [symptoms](#), [how it spreads](#), and [how and when people should get tested](#). See our [Frequently Asked Questions](#) for more information.

A person’s race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data are revealing that communities of color are being disproportionately impacted by COVID-19. This is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer opportunities to protect themselves and their communities. [Stigma will not help to fight the illness](#). Share only accurate information to keep rumors and

misinformation from spreading.

- [WA State Department of Health 2019 Novel Coronavirus Outbreak \(COVID-19\)](#)
- [WA State Coronavirus Response \(COVID-19\)](#)
- [Find Your Local Health Department or District](#)
- [CDC Coronavirus \(COVID-19\)](#)
- [Stigma Reduction Resources](#)

**Have more questions about COVID-19?** Call our hotline: **1-800-525-0127**, Monday – Friday, 6 a.m. to 10 p.m., Weekends: 8 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language**. For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).