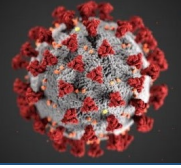


# Interim COVID-19 Vaccination Plan

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WASHINGTON STATE

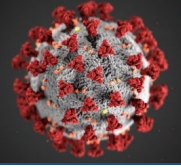
Washington State Department of Health  
OCTOBER 2020 | VERSION 1



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## Executive Summary:

On September 16, 2020, the Centers for Disease Control and Prevention (CDC) released the [“COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations.”](#) This document outlined the federal strategy for delivering and administering COVID-19 vaccine once one is approved, and it requested state and territorial health departments to answer questions and outline their plans for vaccine distribution. The jurisdictional plans were due to the CDC by October 16, 2020. This plan is Washington State’s response to this request. It describes how we will approach the work of planning for and distributing a safe and effective COVID-19 vaccine. It will be updated over time as additional planning occurs and as CDC updates guidance for jurisdictions.

Overall, Washington State is well positioned to receive, handle, distribute, and administer COVID-19 vaccine to its residents once a safe and effective vaccine is available. The Washington State Department of Health has started its planning by coordinating with tribal nations, state agencies, local government, community leaders, health care providers, neighboring states, and other partners.

## Preparation Method

The department is using project management best practices to plan for and execute this work. We are gathering and analyzing the work requirements for a successful vaccination program while also executing the plan. The planning team will add detail and make changes to the plan as more information becomes available. We also used project management best practices to respond to the CDC’s request and write this plan.

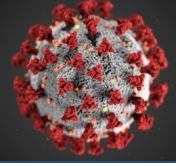
The department involved partners and governmental entities throughout the process. Appropriate committees and subject matter experts wrote or contributed to each section to make sure the plan is thorough and accurate.

Crucial lessons learned from the H1N1 pandemic vaccine distribution in 2009 informed our COVID-19 vaccine plan.

## Areas of Action

The plan itself outlines specific action steps the department will take. Major areas of action include:

- Develop an equitable vaccine allocation framework that identifies critical populations to receive vaccine in each phase of the COVID-19 vaccination response.
- Identify and recruit COVID-19 vaccination providers.
- Support distribution of the vaccine in phases according to the allocation framework.
- Gather feedback from communities that are disproportionately affected by COVID-19 or at higher risk of contracting the disease.

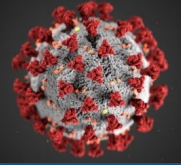


- Conduct outreach and education in an equitable way. Ensure our materials are appropriate for communities that are disproportionately affected by COVID-19.
- Train enrolled providers on proper vaccine storage, handling, and administration.
- Train enrolled providers on reminder/recall techniques and effective vaccine promotion.
- Build vaccine confidence and trust within Washington communities.
- Provide timely, accurate, and credible information to the people of Washington on COVID-19 vaccine, including safety information.
- Promote COVID-19 vaccination to everyone who qualifies to receive it in each phase.
- Gather and monitor vaccine administration data and provider enrollment data.

## Expected Outcomes

- People in Washington will understand the phased approach to vaccination and know when they may receive their vaccination.
- Vaccine providers will properly offer and administer a safe and effective COVID-19 vaccine as it becomes available.
- COVID-19 vaccine will be distributed equitably and ethically to people in Washington following national ethical frameworks.
- People in Washington will receive a safe and effective vaccine during the appropriate phase to protect them against COVID-19.

A great deal of work has been completed and there is still more that needs to be done to accomplish the goals set forth in the Washington COVID-19 vaccination plan. The department is committed to continuing the work necessary and when a vaccine is ready, we will be prepared to deploy it in a way that is equitable, safe, and timely for the people of Washington.



## Section 1: COVID-9 Vaccination Preparedness Planning

- A. Describe your early COVID-19 vaccination program planning activities, including lessons learned and improvements made from the 2009 H1N1 vaccination campaign, seasonal influenza campaigns, and other responses to identify gaps in preparedness.*

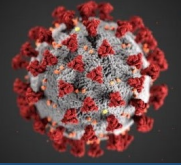
### Organizational Structure and Partner Involvement

The Washington State Department of Health has established an internal COVID-19 Vaccine Planning and Coordination Team within the state's COVID-19 response structure, which is guided by the State Health Officer, Secretary of Health, and Deputy Secretary for COVID-19 Response. This team is under the direction of the Deputy Secretary for COVID-19 Response, and includes representatives from across the agency: Office of Immunization and Child Profile, Division of Emergency Preparedness and Response, Center for Public Affairs, and the Public Health Outbreak Coordination, Informatics, and Surveillance Office. Together they represent subject matter experts in immunizations, public health preparedness, equity, and health communications. Additional staff have been hired to support COVID-19 vaccination operations. The work has been divided into nine areas:

1. Systems readiness
2. Data and program monitoring,
3. Allocation and prioritization
4. Distribution and logistics
5. Provider network
6. Legal and policy
7. Vaccine administration and clinical guidance
8. Engagement
9. Education and communication

This fall, the department has used government, partner, and community engagement to identify members of an External Implementation and Coordination Committee. Committee members will include local health jurisdictions (LHJs), statewide health care coalitions, health care system representatives, pharmacies, business and industry representatives, long-term care representatives, education liaisons, religious leaders, and community organizations that serve Washington's diverse population. This External Implementation and Coordination Committee will review the department's engagement and implementation strategies to identify gaps and challenges in plans and advise on potential solutions. The department will continue to inform, discuss, and collaborate on vaccination planning with many different governmental entities, organizations, coalitions, and other partners.

The department will solicit nominations and recommendations for the committee in October and November, and we plan to launch the committee in December. There may be cross-over representation with people who sit on other committees but do not find that an existing committee meets the need for a community-informed approach. The overarching focus for these internal and external groups are to ensure vaccine uptake, provide guidance on messaging to build vaccine confidence and trust within Washington communities, and ensure we use successful partnerships to



fill gaps in resources and information. The department is also collaborating closely with LHJs to identify additional community partners.

### Materials and MOU Review

The department has reviewed and is currently updating the state's pandemic influenza and medical countermeasures distribution plans. We are reviewing the current planning assumptions, action items, planning scenarios and state After-Action Reports (AAR) from immunization-related emergencies. The main lessons learned from the 2009 H1N1 response include:

- Address internal and external communications challenges.
- Ensure consistent distribution and administration of vaccine across target groups.
- Track doses administered.
- Coordinate with tribal nations.

Washington's statewide pharmacy memorandum of understanding (MOU) is under review. We are collaborating with the Washington State Pharmacy Association to identify areas for improvement and develop action plans, and we have encouraged LHJs to review their pharmacy MOUs.

We have encouraged partners to review their AARs from previous immunization-related incidents and responses, pandemic influenza, and Point of Dispensing (POD) plans, and work to identify any planning gaps.

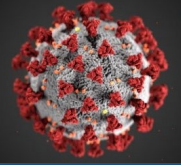
### Equitable Allocation

The department has reviewed and plans to use the ethical considerations outlined by the Advisory Committee on Immunization Practices (ACIP) and the National Academy of Medicine. These national ethical frameworks will inform how the state prioritizes and allocates COVID-19 vaccine. The department's Center for Public Affairs has identified staff that will lead engagement activities to help partners understand the frameworks and gather feedback on detailed vaccine prioritization. Sample population estimates ([Appendix A](#)) are based on U.S. Census and labor data.

Our primary priority is ensuring that a consistent approach is used across the state. H1N1 after-action reports identified the need to have consistent guidance across local jurisdictions and between neighboring jurisdictions. During that pandemic, variations in local guidance or how vaccine recommendations were implemented created confusion and eroded public trust across the state. To address this, we are working for consistency within the state, and we are also talking with our neighboring states, Idaho and Oregon, to ensure that Washington's guidance is similar to theirs.

### Provider Outreach and Enrollment

The Office of Immunization and Child Profile already allows for ongoing provider enrollment in our existing adult and childhood vaccine programs. The department has established an internal workgroup to focus on expanding provider outreach and enrollment. We will reach out to providers not traditionally part of the existing state immunization programs on several fronts, including



providers identified by local health jurisdictions, pharmacies, equity partners, professional health care associations, coalitions, and community organizations.

For the earliest phase of vaccine distribution, the department will prioritize identifying, engaging, and enrolling providers that both:

- a) Can support high-throughput (hundreds of doses a day) vaccination services.
- b) Have access to the initial prioritized groups to receive the vaccine.

The department is developing an electronic registration process through a REDCap survey, which will be ready by early November. To prepare for provider enrollment, we created initial [guidance for providers](#). We also will develop and disseminate materials to assist providers in enrolling in the program. These materials will include a preparation checklist and enrollment overview, walkthrough guide, and frequently asked questions.

The department will create additional materials and trainings to assist providers in following program requirements for vaccine administration, storage, handling, education, communication, and other needs identified in the planning process. We will post materials and trainings on our website for easy access, and send them to providers through partners, medical associations, and a GovDelivery newsletter and listserv, along with any related updates.

The department created an effective foundational framework under the Enhanced Influenza grant that covers flu vaccine distribution, education, promotion, and communication. We will further develop that and adapt it for COVID-19 vaccine.

Preparedness planning for COVID-19 vaccination will include the use of CDC's PanVax Tool. The planning information from the tool provides estimated vaccination capacity and projected need for the number of sites and vaccinators needed in order to vaccinate varying percentages of a given population. We will use this information to make sure our recruitment strategies cover identified gaps.

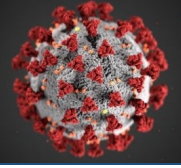
### Immunization Information System (IIS)

Since the 2009 H1N1 flu pandemic, U.S. immunization programs have made significant investments in immunization information systems. Washington's IIS is a lifetime registry that keeps track of immunization records for people of all ages. It is a secure, web-based tool that connects people who receive, administer, record, and order vaccines in Washington.

Providers use tools in the registry to track and improve their immunization work. The department currently works with over 1,000 providers for the state's Childhood Vaccine Program. For the 2009 H1N1 pandemic, we worked with over 2,500 providers. We anticipate a similar, if not larger, increase in provider enrollment for a COVID-19 vaccine.

The department has identified system capacity for the IIS and reporting needs based on CDC guidance and is working with the vendor (STC) to ensure the system can meet the needs in a timely manner. We are exploring contingency options for enrollment, ordering, and information capture in





case the registry is unable to meet these needs initially. We are also exploring how mass vaccination programs may interface with the system to make reporting to the CDC a smooth process.

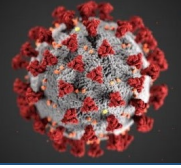
*B. Include the number/dates of and qualitative information on planned workshops or tabletop, functional, or full-scale exercises that will be held prior to COVID-19 vaccine availability. Explain how continuous quality improvement occurs/will occur during the exercises and implementation of the COVID-19 Vaccination Program.*

We currently have four planned workshops and exercises for Phase I:

Event	When	Who	Topic/goal
Seminar on the vaccine plan	October	Internal and external partners	Help partners understand the plan and solicit feedback from them
Tabletop exercise	November	Agency leadership	Phase I policy
Tabletop exercise	November	Department staff	Operationalizing and testing the plan
Tabletop exercise	November	External partners, including health care coalitions, local health jurisdictions, and health care	Leveraging external partnerships to address gaps identified within exercise. Clarifying roles and responsibilities.

Additional exercises may be planned to focus on Phase II of the vaccine campaign.

We will follow the traditional plan improvement cycle. Each exercise will have an After-Action Report to identify corrective actions. We will document those corrective actions and incorporate them into the plan. Additionally, we will share any tabletop exercise materials we develop with partners for them to conduct exercises in their jurisdictions.



## Section 2: COVID-19 Organizational Structure and Partner Involvement

### **Instructions:**

#### *A. Describe your organizational structure.*

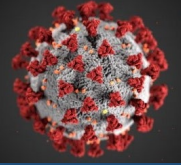
The Washington State Department of Health consists of five programmatic divisions and several centralized offices that provide shared services and resources. The programmatic divisions are Health Systems Quality Assurance; Disease Control and Health Statistics; Prevention and Community Health; Environmental Public Health; and Emergency Preparedness and Response.

In response to the COVID-19 pandemic, we activated an emergency management response structure where staff from across the agency and state participated in various operational and programmatic positions needed to address the pandemic. Since the initial activation of the Incident Management Team, we have begun to transition COVID-19 response roles back into our divisional structure. We have developed a cross-divisional COVID-19 response program that allows priority work areas from across the agency to continue to align efforts in addressing all aspects of the virus and ongoing response.

The COVID-19 Response Program is under the oversight of the Deputy Secretary for COVID-19 Response and consists of the following priority work areas.

- Testing
- Contact Investigation and Contract Tracing
- Outbreak Response
- Surveillance and Informatics
- Immunizations and Vaccine
- Home Isolation, Quarantine, and Care Coordination
- Medical and Health Care Surge
- Medical Countermeasures and Materials
- Emergency Medical Services
- Public Affairs
- Guidance and External Engagement
- Behavioral Mental Health
- Volunteer Management
- WA HEALTH (a data system)

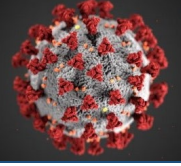
The leads of these priority work areas meet throughout each week to provide situational and operational updates, align efforts, receive feedback, and gain strategic direction from COVID-19 program leadership. The COVID-19 Vaccine Director meets regularly with the Secretary of Health and State Health Officer, and regularly provides updates and solicits feedback from the state's Unified Command Group guiding all of government response to COVID-19.



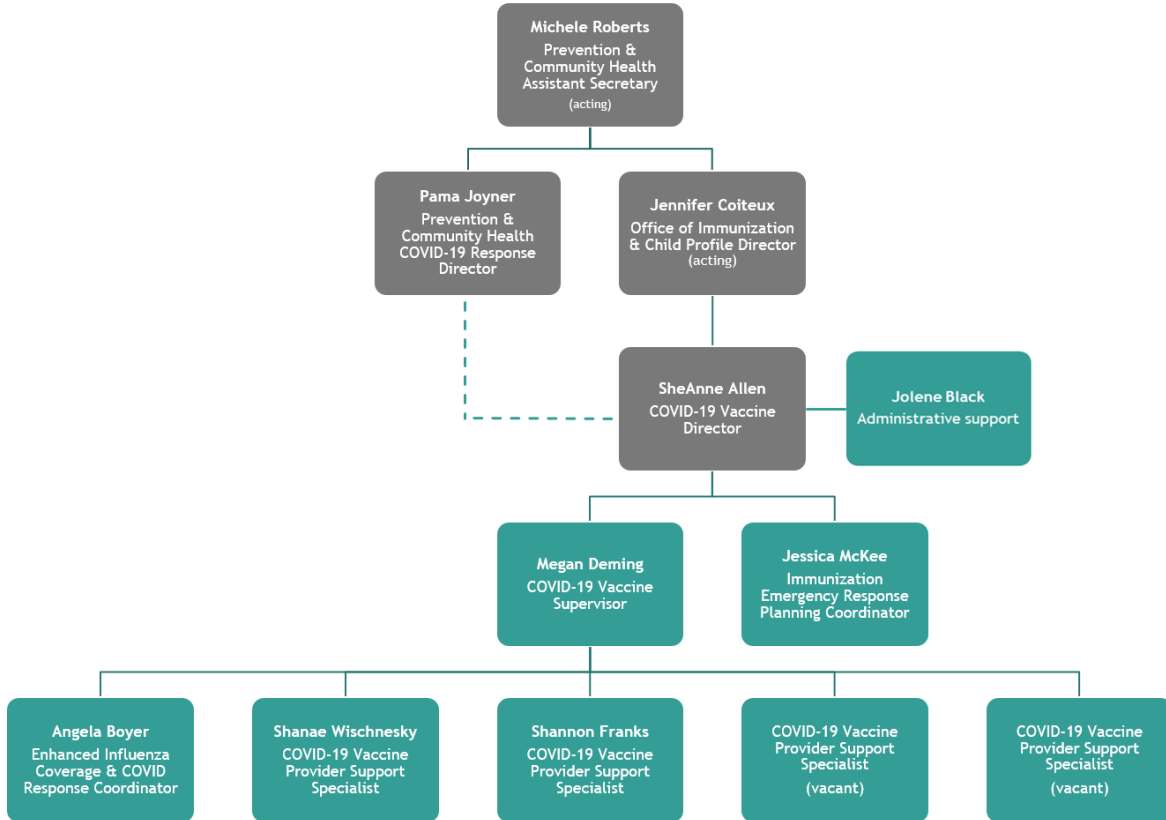
- B. *Describe how your jurisdiction will plan for, develop, and assemble an internal COVID-19 Vaccination Program planning and coordination team that includes persons with a wide array of expertise as well as backup representatives to ensure coverage.*

The department has assembled an internal COVID-19 Vaccine Planning and Coordination Team that includes people with a wide array of expertise. The team has representatives from the department's division of Prevention and Community Health to include both the Office of Immunization and Child Profile as well as the Office of Policy and Strategy. Additionally, the team has representation from the division of Emergency Preparedness and Response, the Center for Public Affairs, People and Performance, and the COVID-19 Guidance External Engagement team. The COVID-19 Vaccine Director leads this team and acts as a liaison to the larger COVID-19 Response Program to provide the COVID-19 vaccine efforts with strategic direction that aligns with the rest of the department's COVID-19 response.

The COVID-19 Vaccine Planning and Coordination Team has identified key initiatives to plan for and operationalize the allocation, distribution, and administration of COVID-19 vaccine strategies. These include systems readiness, data and program monitoring, allocation and prioritization, distribution and logistics, provider network, legal and policy, vaccine administration and clinical guidance, engagement, education, and communication. Each week leads talk with various experts in the department and the state to progress toward key milestones and deliverables within their initiatives. The leads from the COVID-19 Vaccine Planning and Coordination Team meet weekly to align across initiatives and receive strategic direction from the COVID-19 Vaccine Director based on their expertise. They work with all COVID-19 Response Program leaders as well as executive and other agency leadership.

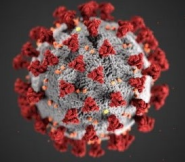


## COVID-19 Vaccine Prevention & Community Health Divisional Team



## COVID-19 Program Vaccine Leads Team

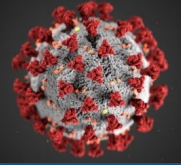
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Washington State Department of Health COVID-19 Vaccination Planning and Coordination Team

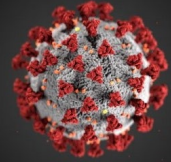
Name	Position Title	DOH Division, Office	Project Responsibilities & Expertise
Amy Sullivan, PhD, MPH	Senior Epidemiologist (Non-Medical)	Prevention & Community Health, Office of the Assistant Secretary	Provides general scientific and operational public health subject matter expertise and strategic guidance
Angela Boyer, MPH	Enhanced Influenza Coverage & COVID-19 Response Coordinator	Prevention & Community Health, Office of Immunization & Child Profile	Provides public health subject matter expertise including; vaccine ethics in phased approach, provider network building, provider training and enrollment, and distribution & logistics
Blair Hanewall, MBA, MPH	<i>Consultant</i>	Independent Consultant	Provides public health subject matter expertise and consultation regarding vaccine ethics, critical population analysis, and allocation and prioritization

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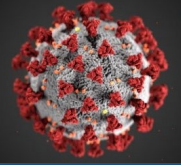
Colleen Thompson	Policy, Rules, and Legislative Affairs Director	Prevention & Community Health, Policy & Strategy	Provides subject matter expertise and consultation regarding vaccine policy, rules, and legislative affairs
Mary Daniel	Health Educator	Center for Public Affairs, Health Promotion & Education	Provides vaccine health promotion, education, and communications material development and navigation
Danielle Koenig	Health Promotion Supervisor	Center for Public Affairs, Health Promotion & Education	Provides vaccine health promotion, education, and communications supervision and consultation
Greg Endler, MA, MFT	Deputy Director of Health Promotion and Education	Center of Public Affairs, Health Promotion & Education	Leads COVID-19 Vaccine Response Team's "Health Promotion, Education, and Communication" initiative and liaises between COVID-19 Vaccine Response team and the Center for Public Affairs
Hannah Febach, MPA	Senior Policy Analyst	Prevention & Community Health, Policy & Strategy	Leads COVID-19 Vaccine Response Team's "Legal & Policy" initiative; ensures policies, data sharing agreements, MOUs, etc. are aligned for COVID-19 Vaccine program implementation
Jennifer Coiteux, MPA, LSSBB	Immunization Information System Manager	Prevention & Community Health, Office of Immunization & Child Profile	Leads COVID-19 Vaccine Response Team's "Systems Readiness" initiative. Ensures IIS is enhanced, back-up plans are in place, and long-term provider enrollment, ordering, inventory and administration systems are implemented and integrated as necessary
Jessica Baggett, MPH	COVID-19 Guidance & External Engagement Manager	COVID-19 External Engagement	Provides COVID-19 guidance and external engagement consultation

# WASHINGTON STATE COVID-19 VACCINATION PLAN



Jessica McKee, MPH	Immunization Emergency Response Planning Coordinator	Prevention & Community Health, Office of Immunization & Child Profile	Provides public health subject matter expertise, including vaccine provider capacity evaluation, medical countermeasures, mass vaccination planning, distribution and logistics, and preparedness planning
Jolene Black	COVID-19 Vaccine Administrative Assistant	Prevention & Community Health, Office of Immunization & Child Profile	Administrative support
Judy Hall, Ph.D., LSSBB, CCP	Performance Officer	People & Performance	Supports outcome and programmatic success metrics development
Justine Miracle, MPH	Senior Project Manager	People & Performance, Project Management Office	Supports COVID-19 Vaccine Director in developing COVID-19 Vaccine Response team structure; charters and tracks project goals, deliverables, and tasks; facilitates team meetings; and documents risks, issues, and decisions
Kathleen Meehan, MPH, CHES	Equity & Social Justice Manager	Center of Public Affairs, Community Relations & Equity	Leads COVID-19 Vaccine Response Team's "Partner Engagement" initiative and ensures equity and social justice approach
Kathy Bay, RN, CENP	Doctorate Nursing Practice Clinical, Quality, Epidemiology, and School Section Manager	Prevention & Community Health, Office of Immunization & Child Profile	Leads COVID-19 Vaccine Response Team's "Vaccine Administration & Clinical Guidance" initiative, ensuring trained workforce and external clinical relationships and expertise inform work; provides clinical expertise for adverse event management
Mary Huynh, MPH, MPP	Deputy Director   CDC Public Health Advisor	Prevention & Community Health, Office of Immunization & Child Profile	Provides public health subject matter expertise across entire project; co-leads COVID-19 Vaccine Response Team's "Allocation and Prioritization" initiative

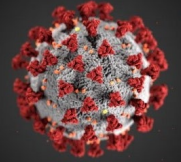
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Megan Deming	COVID-19 Vaccine Supervisor	Prevention & Community Health, Office of Immunization & Child Profile	Co-leads COVID-19 Vaccine Response Team’s “Provider Network” and “Distribution and Logistics” initiatives; works to expand, prepare, and support provider network and ensure distribution and logistics processes are in place  Provides provider enrollment, IIS, and VTrckS subject matter expertise; assists in ordering, distribution, and logistics plans development
Misty Ellis, MPH	CDC Public Health Advisor	Prevention & Community Health, Office of Immunization & Child Profile	Co-leads COVID-19 Vaccine Response Team’s “Provider Network” and “Distribution and Logistics” initiatives; offers general public health expertise and strategic planning and implementation support
Rebecca Baron	Medical Countermeasures Administrator	Emergency Preparedness & Response	Provides public health, planning, medical countermeasures, and materials guidance; acts as liaison to emergency preparedness response teams
Shanae Wischnesky	COVID-19 Vaccine Provider Support Specialist	Prevention & Community Health, Office of Immunization & Child Profile	Provides provider support for enrollment, vaccine and ancillary supply ordering, vaccine distribution and logistics, and technical assistance expertise
Shannon Franks	COVID-19 Vaccine Provider Support Specialist	Prevention & Community Health, Office of Immunization & Child Profile	Provides provider support for enrollment, vaccine and ancillary supply ordering, vaccine distribution and logistics, and technical assistance expertise
SheAnne Allen, MPH, MCHES	COVID-19 Vaccine Director	Prevention & Community Health, Office of Immunization & Child Profile	Provides strategic direction, tracks progress against goals, ensures alignment with COVID-19 response. Co-leads COVID-19 Vaccine Response Team’s “Allocation and Prioritization” initiative



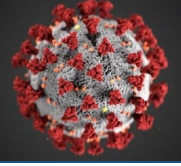
# WASHINGTON STATE COVID-19 VACCINATION PLAN



Pama Joyner	COVID-19 Prevention & Community Health Division Response Director	Prevention & Community Health, Office of the Assistant Secretary	Provides operational and strategic guidance based on the Prevention & Community Health division's direction
Teal Bell, MPH	Epidemiologist, Assessment Supervisor	Prevention & Community Health, Office of Immunization & Child Profile	Leads COVID-19 Vaccine Response Team's "Data and Program Monitoring" initiative, ensuring data flows and program reporting capabilities are planned for and established
Vacant	COVID-19 Provider Support Specialist	Prevention & Community Health, Office of Immunization & Child Profile	Provides provider support for enrollment, vaccine and ancillary supply ordering, vaccine distribution and logistics, and technical assistance expertise
Vacant	COVID-19 Provider Support Specialist	Prevention & Community Health, Office of Immunization & Child Profile	Provides public health subject matter expertise, including vaccine storage and handling, temperature excursion management, provider network building, provider training and enrollment, and distribution and logistics
Vacant	COVID-19 Vaccine Supervisor	Prevention & Community Health, Office of Immunization & Child Profile	Co-leads COVID-19 Vaccine Response Team's "Provider Network" and "Distribution and Logistics" initiatives; works to expand, prepare, and support provider network and ensure distribution and logistics processes are in place

- C. *Describe how your jurisdiction will plan for, develop, and assemble a broader committee of key internal leaders and external partners to assist with implementing the program, reaching critical populations, and developing crisis and risk communication messaging.*

The department will plan, develop, and assemble a broad external COVID-19 Vaccination Implementation Committee. Over the course of October 2020, we will ask partners and communities for committee member recommendations and nominations. The department will communicate formally with tribal nations regarding any anticipated impacts from the planned activities. The department will work government to government with tribal nations and tribal organizations on activities they deem appropriate for their nations.



The goal is to build a diverse committee that reflects trusted representatives of the communities, sectors, and industries most affected by COVID-19. The committee will be focused on COVID-19 vaccination implementation and will serve as the sustainable engagement and advisory structure for this work through 2021. All members are expected to:

- Hold the knowledge, skills, and experience (lived and professional) to effectively represent their respective community.
- Lead with equity and be committed to equitable and just distribution of COVID-19 vaccine.
- Listen to and engage their community, industry, or sector.
- Serve as a trusted messenger for relaying timely, meaningful, accurate, and relevant information.

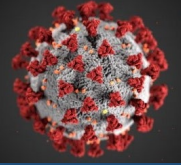
The Washington State Department of Health’s Center for Public Affairs has staff experts on Crisis and Emergency Risk Communication (CERC), Community Engagement, and Social Justice and Equity. These staff will work collaboratively with the external COVID-19 Vaccination Implementation Committee to review developed messages and communications that align with risk communication principles. A critical component to risk communications is reaching the intended audience, which is most likely to happen when the messenger is trusted, and when the message is culturally relevant and responsive to the audience’s needs and questions. By building the members of this committee based on trusted messengers, the department will effectively establish CERC messaging to reach critical populations and to share with partners for adaption for local use.

**D. Identify and list members and relevant expertise of the internal team and the internal/external committee.**

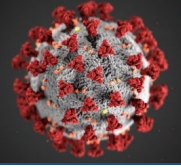
The COVID-19 Vaccination Implementation Committee will be built following a participatory model and will be determined through the current comprehensive engagement effort via formal communication and collaboration. At a minimum, the committee will include representation in the following areas, with exact roles and numbers of representatives determined through engagement efforts. Representation may be cross-cutting and intersectional. Additional members and representation needs will be determined through the department’s conversations with partners and communities. All members will be nominated or recommended by their own respective communities, industries, or sectors. There will be intentional focus to ensure geographic representation, and a balance of representatives from both urban and rural areas. The final language and titles will be determined by the members as well.

Anticipated members	Who this member represents	Expertise needed
Individual(s) at higher risk: Older adult, person with co-morbidities, person with disabilities, or pregnant person	People at higher risk for severe illness	<i>Minimum:</i> <ul style="list-style-type: none"> <li>• Lived experience</li> <li>• Health equity</li> </ul>
Health care provider(s) who serves people at higher risk for		<i>Minimum:</i> <ul style="list-style-type: none"> <li>• Professional experience</li> </ul>

# WASHINGTON STATE COVID-19 VACCINATION PLAN



severe illness: Primary care provider, geriatrics provider, home care aide, doula/birth worker, navigator, community health worker, etc.		<ul style="list-style-type: none"> <li>Health equity</li> </ul>
High-risk worker in a health care facility	People at higher risk for exposure because of occupation	<i>Minimum:</i> <ul style="list-style-type: none"> <li>Professional experience</li> <li>Health equity</li> </ul>
Essential worker at high risk for COVID-19: grocery store worker, migrant farm or factory worker, etc.		
Educator: teacher, school staff, early learning provider, etc.		
Long Term Care Facility staff member		
Community advocate for people in congregate settings: people experiencing homelessness, people who are detained/incarcerated, etc.	People at higher risk because of living situation	<i>Minimum:</i> <ul style="list-style-type: none"> <li>Trusted community connection</li> <li>Health equity</li> </ul> <i>Additional:</i> <ul style="list-style-type: none"> <li>As determined by community represented</li> </ul>
Community leader serving/representing immigrant communities	People at higher risk because of access barriers	<i>Minimum:</i> <ul style="list-style-type: none"> <li>Trusted community connection</li> <li>Health equity</li> </ul> <i>Additional:</i> <ul style="list-style-type: none"> <li>As determined by community represented</li> </ul>
Community leader serving/representing individuals with disabilities		
Community leader serving/representing people who are uninsured		
Community leader serving/representing rural communities		
Local health jurisdiction	Public health and health care infrastructure for vaccine dissemination	<i>Minimum:</i> <ul style="list-style-type: none"> <li>Professional expertise</li> <li>Health equity</li> </ul>
Accountable Communities of Health		
Immunization coalition		
Health system or hospital		
Community health center		
Pharmacy		
Emergency management agency		



Community leader serving/representing the African American/Black community	People at higher risk because of systemic racism	<i>Minimum:</i> <ul style="list-style-type: none"> <li>Trusted community connection</li> <li>Health equity</li> </ul> <i>Additional:</i> <ul style="list-style-type: none"> <li>As determined by community represented</li> </ul>
Community leader serving/representing the Asian American community		
Community leader serving/representing the Latinx community		
Community leader serving/representing the Native Hawaiian and other Pacific Islander community		

**E. Describe how your jurisdiction will coordinate efforts between state, local, and territorial authorities.**

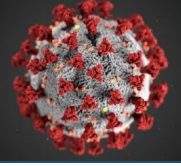
The department plans to use existing systems and communications channels to complete this mission. We will work with the preparedness, immunization, and communications teams at all 35 local health jurisdictions in Washington to plan for the allocation and distribution of COVID-19 vaccine. Additionally, we have developed an engagement strategy to seek input and participation from the following partners:

- Local health officers and administrators via the Washington State Association of Local Public Health Officials (WSALPHO)
- Governmental partners (state agencies and commissions that serve priority populations)
- Health care system partners
- Community groups and organizations
- Statewide associations and advisory boards

We have established the following coordination opportunities:

- Weekly internal planning and coordination calls
- Survey of local health jurisdictions to identify local capacity and planning gaps
- Weekly calls with local health officers
- Weekly department check-ins with local health jurisdiction administrators on WSALPHO calls
- Two calls per month with local health department planners to provide updates and plan next steps

**F. Describe how your jurisdiction will engage and coordinate efforts with leadership from tribal communities, tribal health organizations, and urban Indian organizations.**



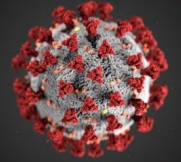
Tribal nations and tribal health organizations are also working hard to respond to the pandemic and support their community members. We are continuing our agreement to working with them government to government as we make plans for a COVID-19 vaccine. The department will follow its Collaboration/Consultation Procedure, a formal agreement that promotes public health partnership between the department and tribal nations and tribal health organizations. The agency may host workgroups, roundtables, consultations with elected tribal leaders and tribal health and clinic directors and program representatives. The agency will fulfill its statutory obligation to communicate with tribal governments by consistently sending Dear Tribal Leader letters to the tribal nation chairs.

- G. *List key partners for critical populations that you plan to engage and briefly describe how you plan to engage them, including but not limited to:*
- *Pharmacies*
  - *Correctional facilities/vendors*
  - *Homeless shelters*
  - *Community-based organizations*

The department is planning a mixed-methods approach to engaging key partners, communities, and critical populations. This approach will include focus groups, community conversations, interviews, partner meetings, and a public survey. Whenever possible, we are working with a trusted internal or external partner to organize and facilitate these conversations. Whenever appropriate and needed, the department will conduct engagement activities in-language (via a dual-language or multilingual speaker), arrange interpretation services, and secure Communication Access Realtime Transcription (CART) services. The communities, groups, and planned engagement activities listed below are a starting place. We will evaluate these efforts and may reach out to other groups not sufficiently represented through these activities. The engagement team will ensure meaningful access to feedback opportunities by utilizing a variety of platforms including phone, video chat, socially distanced in-person interviews, community meetings, and outreach through partner organizations and groups.

**Communities disproportionately affected by COVID-19.** Purpose is to directly engage communities who are at higher risk for COVID-19 and the partner organizations who serve/represent these communities. This will include, but is not limited to, the following communities and groups.

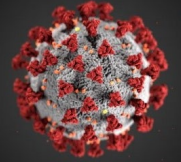
Community/Group	Method of Engagement
African American	Focus group
African Diaspora	Focus group
Asian Americans & Asian Diaspora	Focus group
Latinx	Focus group
Native Hawaiian and other Pacific Islanders	Focus group
Individuals with disabilities	Focus group



Refugees and immigrants	Community conversation with partners
Farm workers	Focus group (in Spanish)
Pregnant people	Community conversation with partners
Older adults	Community conversation with partners
People with underlying health conditions	Community conversation with partners
People experiencing homelessness	Community conversation with partners

**Health care partners.** Purpose is to directly engage partners within the health care and public health system both as individual members of priority groups for vaccination (e.g., high-risk health care workers) as well as partners in vaccination dissemination. This will include, but is not limited to, the following health care partners.

Partner	Method of Engagement
OB and family medicine providers	Key questions Survey
Community Health Workers	Focus group
Pharmacies	Survey Partner meetings as requested
Health insurance companies	Survey Partner meetings as requested
Emergency medical services	Survey
Health care associations	Survey Partner meetings as requested
Health care unions	Survey Partner meetings as requested
Psychiatric hospitals	Email survey
Health care Coalitions	Partner meetings
State and Agency Advisory Committees and Workgroups	Committee or workgroup meetings
Nutrition services partners and providers	Webinar Survey
Community Health Centers	Survey - disseminate to CBO contacts
Accountable Communities of Health (ACHs)	Survey - disseminate to CBO contacts
Birth centers	Key informant interview Survey
Blood banks	Survey
Diabetes education centers	Survey
Dialysis centers	Key informant interview Survey
Hospice homes	Key informant interview Survey

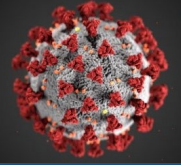


Imaging and radiology centers	Survey
Mental health and addiction treatment centers	Survey
Rehabilitation centers	Survey
Dental and specialty offices	Key informant interview
Physical therapy offices	Survey
In-home health (home care aides, nurse visiting programs, etc.)	Key informant interview Survey
Mobile clinics	Key informant interview Survey
Academic medical centers	Survey
Children’s Hospitals	Survey
Veterans Affairs Hospitals	Survey
Long-term care facilities and nursing homes	Survey Community conversation
Pediatric medical offices	Survey
Free clinics	Key informant interview
Urgent clinics	Survey
Travel clinics	Survey
Ambulatory surgical centers/outpatient settings	Survey
Chiropractor and massage offices	Survey

**Essential workers.** Purpose is to directly engage workers, businesses, and industries who are deemed [essential by the State of Washington’s Safe Start guidance](#) and are at higher risk for COVID-19 exposure. There are 15 sectors identified as essential:

1. Health care/public health
2. Emergency services
3. Food and agriculture
4. Energy
5. Water and wastewater
6. Transportation and logistics
7. Communications and information technology
8. Community-based governmental operations and essential functions
9. Critical manufacturing
10. Hazardous materials
11. Financial services
12. Chemical
13. Real estate and mortgage
14. Mortuary, funeral, embalmer, and cemetery services
15. Defense industrial base

This engagement approach will include a combination of key informant interviews, focus groups, and surveys.



**Governmental partners.** Aside from formal communication, collaboration, and consultation with tribal nations, the department will also consult and collaborate with the following governmental agencies through partner meetings as needed and requested.

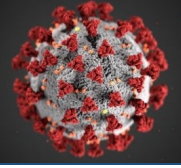
- Local Health Jurisdictions
- Governor's Office
- Department of Corrections
- Health Care Authority
- Office of the Insurance Commissioner
- Department of Children, Youth, and Families
- Department of Social and Health Services
- Department of Commerce
- Commission on Hispanic Affairs
- Commission on Asian and Pacific American Affairs
- African American Commission
- LGBTQ Commission
- Women's Commission
- Governor's Interagency Council on Health Disparities
- Office of the Superintendent of Public Instruction
- State legislators and staff
- Federal delegation
- Local elected officials
- U.S. Customs and Border Protection
- U.S. Coast Guard
- State and local emergency management agencies
- Washington State Patrol

**General.** The department recognizes that COVID-19 vaccine efforts affect everyone. The department has purposefully planned for more general public engagement opportunities to ensure the department is connecting with other affected communities and sectors.

- **Focus groups:** The department is planning focus groups and community conversations with parents, youth, and college students.
- **Public survey:** The department is planning a public survey that will be promoted through existing partner channels and will also be publicly available on the department's website. This survey is a chance for any interested community member, business owner, or other sector representative to provide feedback on the department's proposed plans.

**Leveraging committees.** In addition to direct outreach and engagement to key partners and groups, the department will leverage existing committees related to immunizations and the COVID-19 response. These committees include broad professional expertise and community experience and are naturally in alignment with the goals of this work.





## 1. Public Health and Health Care System Community Leaders Group

The Public Health and Health Care System group is looking at broadening testing efforts, preparing for a second wave and preparing for treatment or vaccine distribution. The group has members representing various sectors and communities of the health care system.

Members include:

- Brian Cladoosby, Swinomish Tribal Leader, Anacortes (Group Lead)
- Ben Danielson, clinic chief and senior medical director, Odessa Brown Medical Clinic, Seattle Children's Hospital, Seattle
- David Fleming, vice president, Global Health Programs, PATH, Seattle
- Jane Hopkins, executive vice president, SEIU Health care 1199NW, Renton
- Hiroshi Nakano, vice president of value-based initiatives, Valley Medical Center, Renton
- Carlos Olivares, CEO, Yakima Valley Farm Workers Clinic, Yakima
- Alison Poulsen, executive director, Better Health Together, Spokane
- Mary Selecky, former Washington state secretary of health, Colville
- Sabine von Preyss-Friedman, medical director, Issaquah Nursing & Rehabilitation Center; president, Washington State Society for Post-Acute and Long-Term Care Medicine, Issaquah

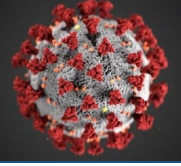
## 2. The Safe Work and Economic Recovery group

The Safe Work and Economic Recovery group advises on recovery plans, guidance for maintaining health standards during re-opening and assistance to Washington's businesses and workers.

This group includes representatives from essential business and critical workforce sectors whose workers are disproportionately affected by COVID-19 and likely will be a higher priority for COVID-19 vaccine.

Members include:

- Jessyn Farrell, senior vice president, Civic Ventures, Seattle (community member lead)
- Jesus Alvarez, president, Southeast Central Labor Council; Teamsters Local 839, Kennewick
- Anthony Anton, president and CEO, Washington Hospitality Association, Olympia
- Larry Brown, president, Washington State Labor Council, AFL-CIO, Seattle
- David Giuliani, CEO Washington Business Alliance; Sonicare inventor, Friday Harbor
- Latisha Hill, vice president for community and economic vitality, Avista, Spokane
- Junus Khan, founder, Carbitex, Kennewick
- Dominique "Dom" Morel, director of retail operations, REI, Seattle
- Tina Morrison, secretary-treasurer, Spokane Regional Labor Council; American Federation of Musicians, Spokane



- Mark Riker, president, Washington State Building and Construction Trades Council, Olympia
- Lamont Styles, owner, Life's Styles Barber Academy, Federal Way

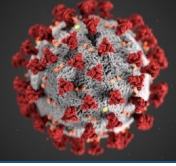
### 3. Social Supports Community Leaders Group

The Social Supports group offers perspectives on the increasing need for social services because of the COVID-19 pandemic, including food security and safe shelter and housing.

This group includes representatives from community who are disproportionately affected by COVID-19 and likely will be a higher priority for COVID-19 vaccine.

Members include:

- Sonya Campion, president, Campion Advocacy Fund, Seattle (Group lead)
- Michael Byun, executive director, Asian Counseling and Referral Service, Seattle
- Jodi Daly, president and CEO, Comprehensive Health care, Yakima
- Stacy Dym, executive director, Arc of Washington, Olympia
- Toni Lodge, CEO, The Native Project, Spokane
- Steve Maher, director, Our Valley, Our Future/Nuestro Valle, Nuestro Futuro, Wenatchee
- Estela Ortega, executive director, El Centro de la Raza, Seattle
- Thomas Reynolds, CEO, Northwest Harvest, Seattle
- Loria Yeadon, president and CEO, YMCA of Greater Seattle, Seattle



## Section 3: Phased Approach to COVID-19 Vaccination

### Instructions:

- A. Describe how your jurisdiction will structure the COVID-19 Vaccination Program around the three phases of vaccine administration:

### Administration of COVID-19 vaccine will require a phased approach

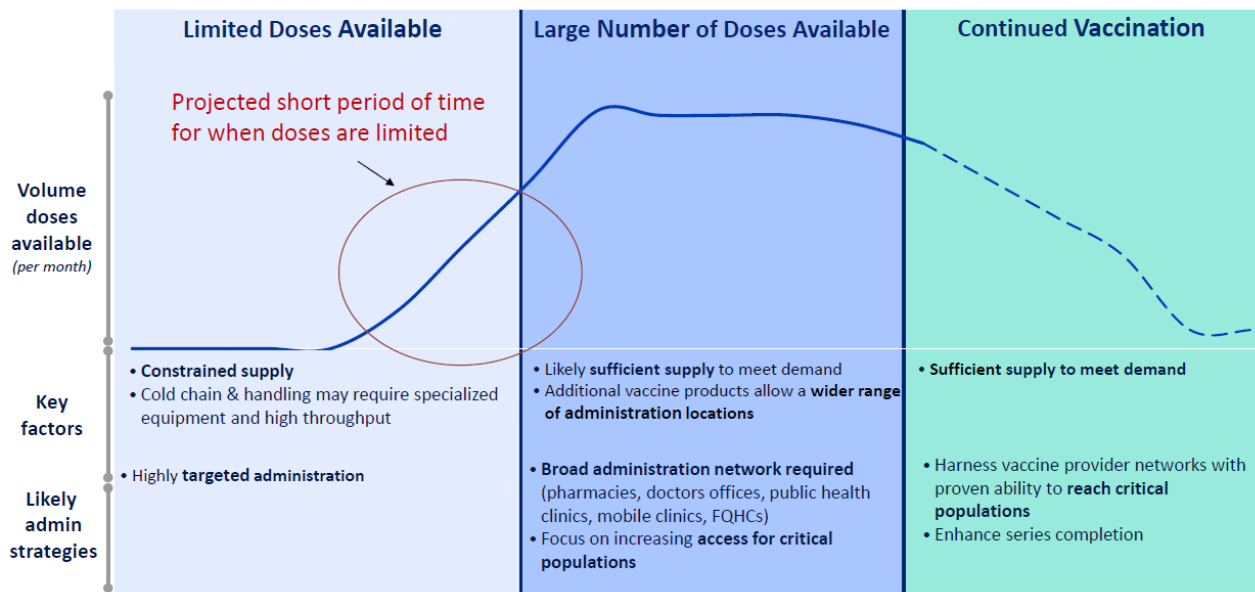
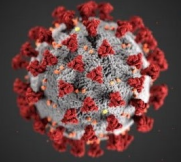


Figure 1: August 26 ACIP Meeting, Dr. Kathleen Dooling "COVID-19 vaccine prioritization: Work Group considerations" <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-08/COVID-08-Dooling.pdf>

One priority for vaccination across phases will be to ensure individuals vaccinated complete their series. This may mean two doses for certain vaccines or populations (based on the recommendations of the Advisory Committee on Immunization Practices). While we make an effort to vaccinate as many people that vaccine supply allows for those recommended, it will be important to take equal effort to ensure those who require a second dose are reminded or recalled to receive vaccine.

Note: For phase 1A (initial release of vaccine), providers are not expected to hold back vaccine for a second dose. The second dose will be held at the federal level, and all vaccine that is received in phase 1A should be used on as many people as possible.



## Phase 1: Potentially Limited Doses Available

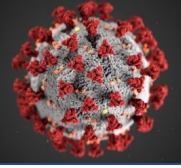
Phase 1 vaccination will be at specific sites highly targeted at those recommended first to receive FDA approved vaccine that is safe and effective. Recommendations for who receives vaccine in phase 1 will be based on ACIP recommendations, the National Academies’ Framework for Equitable Allocation, and state allocation framework developed with input from partners and communities collected through mixed methods during fall 2020. Our goal is to use a staged approach and create points of access to reach those recommended to receive vaccine first.

Table 1 below lists groups that are identified for phase 1 vaccination (from national discussions and frameworks for the equitable allocation of vaccine), estimated state-level population sizes, and example locations for vaccination for each group. Further refinement, sub-prioritization, and sequencing work is needed to develop and operationalize allocation strategies during time-period of limited supply.

Possible Phase 1 Groups	State-level data – population size	Example locations for phase 1 vaccination
High-risk workers in health care settings <sup>1</sup>	~500,000 workers in health care settings (further prioritization required)	Hospitals, health care systems
High-risk first responders	EMS: 16,900 Police/law: 16,500 Firefighters: 7,800 Ambulance: 12,000 Total: 53,200	Mass vaccination points of dispensing (PODs), health care systems
People of all ages with comorbidities	Over 3 million (further prioritization required)	Pharmacies, health care systems, outpatient clinics
Older adults in congregate/crowded settings	Long-term care facility residents: 33,000	Long-term care facilities (with or without pharmacy partnerships)
Essential workers	TBD	Employer or occupational site PODs, pharmacies, mobile clinics, labor union partnerships

Table 1. Possible groups for phase 1 vaccination based on NASEM framework and ACIP discussions. See [Annex A](#) and [Annex B](#) for additional group categories and population size estimates across phases.

Planning work to identify and recruit vaccination sites for phase 1 will include collaboration with local health jurisdictions, health care systems, health care coalitions, pharmacies, professional associations, and long-term care. We will seek input from internal and external groups about Phase 1 vaccination



implementation; this input will inform us on prioritized allocation of at-risk health care providers and other essential workers for potentially limited doses of vaccine. The state's allocation framework also will be informed by cross-cutting equity considerations based on community and partner input. This could include considerations for areas of high COVID-19 disease or high social vulnerability indexes. Identifying and recruiting provider sites for phase 1 will also include assessing the capacity of health care systems, hospitals, and pharmacies to manage procedures as outlined in the CDC COVID-19 Vaccine Provider Agreement Form, CDC COVID-19 Vaccine Provider Profile, and the CDC COVID-19 Vaccine Storage and Handling Requirements.

The process for placing vaccine orders in phase 1 may differ from later phases when vaccine supply is more readily available. Early in the vaccination response with limited vaccine, the department may develop a process to push vaccine doses to specific locations instead of using a traditional vaccine ordering process through the state immunization information system (IIS). This would involve developing an allocation process for targeted provider sites identified to receive vaccine first and require close communication and collaboration with provider sites to coordinate the distribution of vaccine. This provider site identification and pre-booking process concept would be similar to what was used during early phases of the 2009 H1N1 vaccine distribution. In later phases, as vaccine supply increases to meet demand, vaccine ordering will transition to traditional methods using the IIS.

## **Phase 2: Large Number of Doses Available, Supply Likely to Meet Demand**

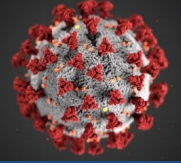
During phase 2 when there is sufficient supply to meet demand, the state will need many vaccine administration locations. We will use a broad network of provider settings, including community health centers, pharmacies, primary care providers, community or business points of dispensing (PODs), long-term care facilities, congregate living facilities, and occupational health clinics. Both traditional and non-traditional vaccination sites will deliver vaccine to ensure that all people who are recommended to receive it have many access points. This is especially helpful to increase uptake among critical groups at highest risk for severe outcomes from COVID-19 disease.

While the partners previously mentioned will handle most vaccine distribution, mass vaccination clinics may supplement these efforts to provide access for specific communities or populations.

The department will partner with health care coalitions, business, labor and industry representatives, long-term care, education, and community organizations throughout the state to inform programmatic work, ensure vaccine uptake, and provide consistent messaging to build vaccine confidence and trust within communities.

## **Phase 3: Likely Sufficient Supply, Slowing Demand**

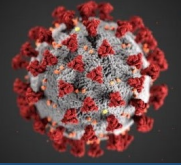
Phase 3 moves to a steady state where there is sufficient supply to meet demand and vaccination continues to grow using routine provider networks proven to reach critical populations. While the



department and our partners will promote completion of vaccination series, phase 3 will be an opportunity to enhance efforts to remind or recall individuals to complete any missing doses.

The Center for Public Affairs in the department will continue their work to increase vaccine confidence and build trust with communities across the state. Using vaccine uptake data, the department will identify populations with inequitable access to the COVID-19 vaccine and address those gaps.

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## Section 4: Critical Populations

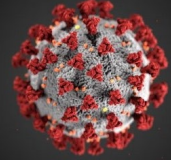
### **Instructions:**

**A.** Describe how your jurisdiction plans to: 1) identify, 2) estimate numbers of, and 3) locate (e.g., via mapping) critical populations. Critical population groups may include:

- Health care personnel
- Other essential workers
- Long-term care facility residents (e.g., nursing home and assisted living facility residents)
- People with [underlying medical conditions](#) that are risk factors for severe COVID-19 illness
- People 65 years of age and older
- People from racial and ethnic minority groups
- People from tribal communities
- People who are incarcerated/detained in correctional facilities
- People experiencing homelessness/living in shelters
- People attending colleges/universities
- People living and working in other congregate settings
- People living in rural communities
- People with disabilities
- People who are under- or uninsured

The department is using principles, criteria, and frameworks from the CDC, the National Academy of Medicine, and the Advisory Committee on Immunization Practices (ACIP) to develop a vaccine allocation framework for Washington. This framework will outline prioritization and allocation guidance and identify critical populations recommended for vaccination in each phase of the COVID-19 vaccination response.

# WASHINGTON STATE COVID-19 VACCINATION PLAN



The National Academy of Medicine Framework for Equitable Allocation of COVID-19 Vaccine (Figure 2) approaches vaccination in four phases, with equity as a critical crosscutting consideration.

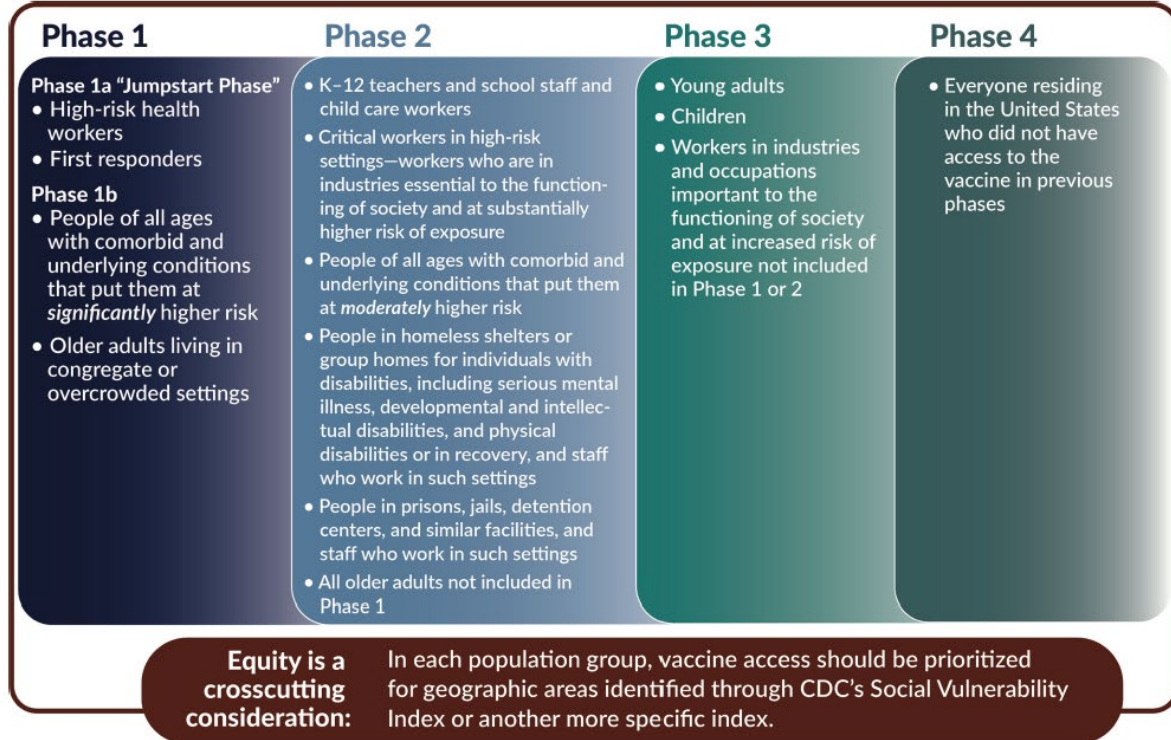


Figure 2: National Academies of Sciences, Engineering, and Medicine 2020. Framework for Equitable Allocation of COVID-19 Vaccine. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25917>

## Possible groups for Phase 1 vaccination

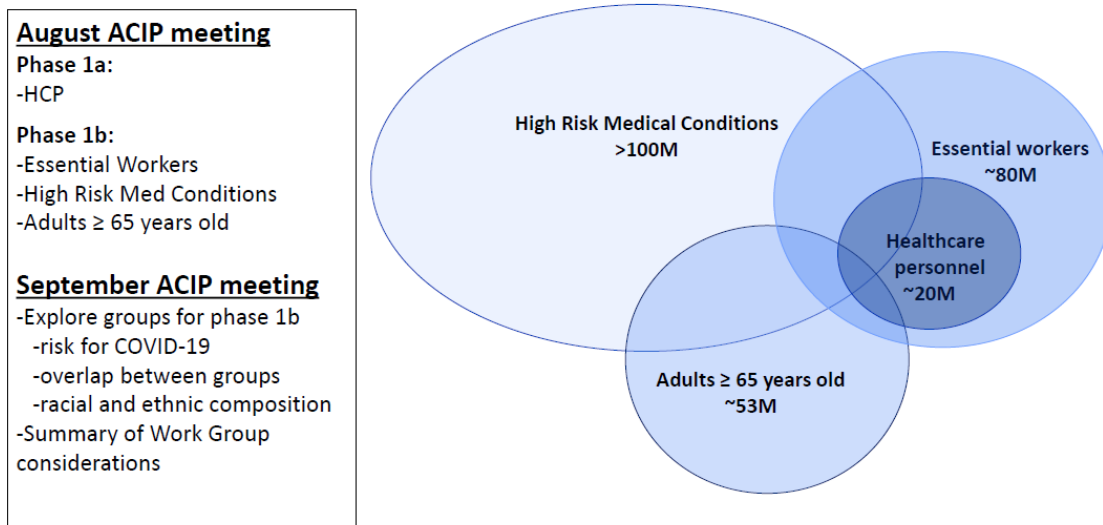
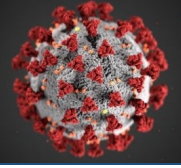


Figure 3: Sept 22 ACIP Meeting, Dr. Kathleen Dooling "Phase 1 allocation COVID-19 vaccine: Work Group considerations" <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-09/COVID-07-Dooling.pdf>





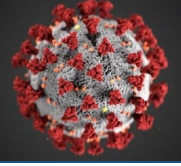
The department awaits final guidance from the ACIP to identify specific groups who will be recommended for vaccination. Possible groups identified by the ACIP for Phase 1 vaccination include health care personnel, essential workers, individuals with high-risk medical conditions, and adults age 65 and older (Figure 3).

The department is developing a prioritization and allocation framework in consultation with public health and health care partners; first responders; critical and essential workforce sectors; business groups; black, indigenous, and people of color communities; education systems; and other governments, including tribal nations, local governments, and local health jurisdictions. By November, we will update this allocation framework based on partners' feedback, recognizing the potential for change given many unknowns (e.g., ACIP recommendations, vaccine efficacy, and vaccine safety). As part of the allocation framework, we will develop guidance outlining considerations for clinical decision making, such as risk of exposure or disproportionate morbidity or mortality.

The department has gathered population estimates for specific groups, including health care personnel, other essential professionals, age, race, and ethnicity (see [Appendix A](#)). We know there is need for further sub-prioritization within categories in response to vaccine supply projections. To estimate the size of sub-populations, we are reviewing Census data, industry classification data (e.g., North American Industry Classification System), state administrative data (e.g., licensed facilities for long-term care), and other data shared by partners (e.g., critical and essential workforce sectors). Some of these sub-population sizes are more difficult to estimate. For example, although we can estimate the number of people with one underlying medical condition associated with high risk of severe COVID-19 illness, it is challenging to estimate the number of persons with more than one underlying condition without contacting Medicare or commercial insurance companies to provide summary statistics.

The department is working to aggregate information to locate different populations. To identify effective strategies for reaching priority populations in the first phases, we are gathering input from various partners, including health care systems, state-wide health care professional associations and labor unions, and community groups. Partners will help us gather geocoded mapping data to show what areas need access to vaccinations for recommended groups. The use of social vulnerability indexes and maps will also inform how critical populations and sub-populations can be reached equitably and will inform allocation decisions under supply constraints. We will use tools such as [Washington Tracking Network Information](#) and [CDC Social Vulnerability Index](#) to identify Census tracts in Washington that have higher health inequities overall and to map other relevant social determinants of health, such as overcrowded housing, poverty, disability, or health insurance coverage. We also will rely on partners to help us reach additional populations as vaccine supply becomes more readily available, and to locate additional sites that can serve specific groups identified for vaccination.

Mapping resources already exist for locating health facilities, businesses, adult homes, correctional facilities, and educational sites. However, these mapping resources may leave out places where critical populations can be located. To fill these gaps, we will reach out to local or federal partners and use the federal mapping toolkit referenced in the CDC playbook as a guide. Additionally, equity mapping analyses will allow us to locate socially vulnerable populations in all phases of vaccine introduction. The department will map critical populations where there is available geocoded data to support vaccine outreach and site planning that reaches the target populations.



- B. Describe how your jurisdiction will define and estimate numbers of persons in the critical infrastructure workforce, which will vary by jurisdiction.*

[Appendix A](#) provides estimates for a subset of critical infrastructure workforce, which includes frontline workers in law enforcement and public safety, and first responders. We will continue to work to identify estimates for other critical workforces, such as COVID-19 testing site staff, utility workers, and childcare providers.

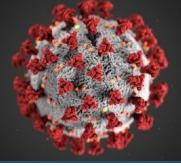
Some critical infrastructure sub-populations are more difficult to estimate, especially those that are not in an organized association. For example, it is challenging to estimate the number of people who handle bodies of people who had confirmed or suspected COVID-19 infection, such as medical examiners, coroners, morticians, and mortuary staff.

- C. Describe how your jurisdiction will determine additional subset groups of critical populations if there is insufficient vaccine supply.*

The department is exploring how to prioritize within critical populations for when there is insufficient vaccine. For instance, among health care workers, the department differentiates between workers who are exposed to confirmed or suspected COVID-19 patients, workers performing activities involving aerosolization, and workers who serve patients at high risk of severe COVID-19 illness. To make these distinctions, the department will consider risk of acquiring infection, risk of severe COVID-19 illness, risk of negative societal impact, and risk of transmitting the virus to others. The information outlined above will allow the department to identify priority populations for COVID-19 vaccination based on likely supply scenarios.

- D. Describe how your jurisdiction will establish points of contact (POCs) and communication methods for organizations, employers, or communities (as appropriate) within the critical population groups.*

The department plans to meaningfully and significantly engage critical populations while planning and implementing vaccine distribution. As noted above, the department is initiating consultations with partners and governments to gather feedback on the proposed allocation framework. Additionally, the COVID-19 Vaccination Implementation Committee can help develop points of contact to engage with a broad set of community players, including critical populations. The charter for this committee is still under design, but the intention of the committee is to facilitate linkages and identify communication and problem-solving strategies. The Center for Public Affairs is developing additional strategies to reach critical populations with tailored messaging in all phases of COVID-19 vaccination.



## Section 5: COVID-19 Provider Recruitment and Enrollment

### **Instructions:**

- A. *Describe how your jurisdiction is currently recruiting or will recruit and enroll COVID-19 vaccination providers and the types of settings to be utilized in the COVID-19 Vaccination Program for each of the previously described phases of vaccine availability, including the process to verify that providers are credentialed with active, valid licenses to possess and administer vaccine.*

The department continuously seeks to enroll adult and pediatric vaccine providers and will increase those enrollment outreach efforts to have existing and new providers participate and enroll in COVID-19 vaccine distribution. We have established an internal workgroup focused on expanding provider outreach and enrollment. Outreach to providers not traditionally part of the existing immunization program will be approached from several fronts, including provider identification by local governmental partners, equity partners, professional health care associations, labor unions, and community organizations.

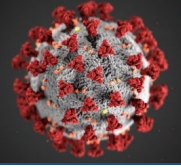
For the earliest phase, we will identify health care systems and health care partners who can support high-throughput vaccination services, as we will prioritize them for enrollment. All provider sites able to meet conditions of the COVID-19 vaccination program and interested in enrolling (for any phase of the vaccination effort) can begin enrolling in November.

The department has developed and disseminated materials to assist providers in enrolling in the program. These materials include a preparation checklist and enrollment overview, walkthrough guide, and frequently asked questions.

We will continue to add more materials and trainings to assist providers in following program requirements for administration, storage, handling, and other needs identified in the planning process. We will post materials and trainings on our website and send those and other updates to providers through a GovDelivery newsletter and listserv.

The department and the Washington State Pharmacy Association (WSPA) will engage pharmacies on several different fronts, including informational webinars, newsletters, and direct member outreach. These efforts will educate about the process of enrollment and the expectation of how reporting and distribution will work. Together, the department and WSPA are conducting informational sessions to educate pharmacies about the enrollment process, reporting requirements, and storage and handling expectations. These sessions have been very popular and engaging and will continue prior to and after enrollment begins. We have gauged that nearly 90 percent of pharmacies across the state are interested in enrolling to provide COVID-19 vaccine. There are about 1,000 pharmacies in Washington (not including hospitals) and about 9,000 licensed and practicing pharmacists.

We have initiated relationships with statewide health care coalitions and hospital systems to discuss enrollment requirements and plans for vaccine distribution.



Licenses will be reviewed and verified using Washington State Department of Health Provider Credential Search (<https://fortress.wa.gov/doh/providercredentialsearch/>) at time of initial provider enrollment request, if/when new authorized providers are added to established agreement, and if/when re-enrollment occurs. In limited situations where providers are licensed in another state and providing vaccination services for COVID-19 vaccination response, department staff will verify the validity of licenses using similar credential search tools from the states issuing the licenses.

*B. Describe how your jurisdiction will determine the provider types and settings that will administer the first available COVID-19 vaccine doses to the critical population groups listed in Section 4.*

The provider types and settings that will administer first available COVID-19 vaccine will be high-throughput locations where those groups recommended for vaccination can receive the vaccine. This is anticipated to be large health care facilities and/or mass vaccination points of dispensing (PODs) and reach health care workers, first responders, essential workers, and adult residential care facilities for the first available vaccine doses. This will allow us to establish what settings have the capacity for vaccine administration and meet the needs for critical populations. The engagement work will continue as additional guidance on vaccine allocation, distribution, and administration evolves.

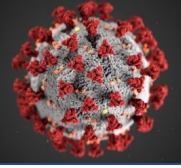
Using the allocation framework in Section 4, the department is engaging providers through surveys, workgroups, and meetings, including consultation or collaboration with the Washington State Hospital Association (WSHA), health care coalitions, health care worker and employee labor unions, the Washington State Pharmacy Association, the Washington State Medical Association (WSMA), long-term care facilities, Washington State Vaccine Science Advisory Workgroup, the Vaccine Advisory Committee, tribal nations and organizations, and local governments.

*C. Describe how provider enrollment data will be collected and compiled to be reported electronically to CDC twice weekly, using a CDC-provided Comma Separated Values (CSV) or JavaScript (JSON) template via a SAMS-authenticated mechanism.*

The department plans to collect the provider enrollment data in an electronic system, REDCap, beginning in November. We will extract provider enrollment data following CDC guidance and templates for reporting twice weekly. If the system were to crash, we will temporarily implement a manual review process of collecting new provider enrollment applications by fax or email and transposing it into the CDC required template.

*D. Describe the process your jurisdiction will use to verify that providers are credentialed with active, valid licenses to possess and administer vaccine.*

Licenses will be reviewed and verified using Washington State Department of Health Provider Credential Search (<https://fortress.wa.gov/doh/providercredentialsearch/>) at time of initial provider



enrollment request, if/when new authorized providers are added to established agreement, and if/when re-enrollment occurs.

*E. Describe how your jurisdiction will provide and track training for enrolled providers and list training topics.*

The department plans to implement trainings developed and required by the CDC for receiving COVID-19 vaccine (e.g. You Call the Shots Vaccine Storage and Handling and CDC Storage and Handling Toolkit). Additionally, trainings on the enrollment process, use of IIS and other data software, and distribution guidelines will be created and conducted to enrolling providers through live and recorded webinars.

Based on feedback from enrolled providers and ongoing analysis of ordering, community feedback and operations related to vaccinations, the department will determine whether additional trainings are required dependent on essential trainings provided by the CDC. Record of training completion will be electronically recorded at time of provider enrollment.

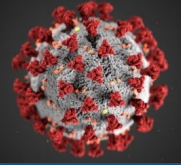
*F. Describe how your jurisdiction will approve planned redistribution of COVID-19 vaccine (e.g., health systems or commercial partners with depots, smaller vaccination providers needing less than the minimum order requirement).*

Later in October, the department will issue a survey in partnership with WSHA and WSPA to assess capacity for redistribution and provide all CDC redistribution agreement requirements. Provider trainings will include all storage, handling, and redistribution requirements and vaccine manufacture instructions. The department will develop a quick view guide for vaccine presentation and equipment able to be used for transfers, similar to this:

<https://content.govdelivery.com/accounts/WADOH/bulletins/2700395>.

We will verify and approve all redistribution requests prior to orders being fulfilled. We will provide a review of the CDC Storage and Handling Toolkit sections that outline specific COVID-19 vaccine redistribution requirements at pre-enrollment, training, enrollment, and ordering. We will assure CDC COVID-19 Vaccination Program Provider Agreements are in place for any sites who request redistribution. This will include verifying that enrollees have validated cold-chain procedures in place (initially reviewed with survey) and that they provide a completed CDC COVID-19 Vaccine Redistribution Agreement and have a completed CDC COVID-19 Vaccination Provider Profile. We will ensure that secondary locations receiving redistributed COVID-19 vaccine, constituent products, or ancillary supplies also sign and comply with all conditions in the CDC COVID-19 Vaccination Program Provider Agreement prior to ordering vaccine.

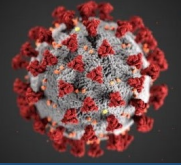
*G. Describe how your jurisdiction will ensure there is equitable access to COVID-19 vaccination services throughout all areas within your jurisdiction.*



The department will aggregate information on how to locate different populations and cross reference this with existing provider location and patient information. These providers are already familiar with the fundamentals of the immunization enrollment and reporting structure. In addition to working through existing providers, we are working directly with the WSPA, WSHA, community partner organizations, and many other provider group resources to identify new providers in geographic and socio-economic relation to the intended target populations. We are also working directly with local health jurisdictions in coordinating recruitment of providers to maximize coverage for high risk populations.

*H. Describe how your jurisdiction plans to recruit and enroll pharmacies not served directly by CDC and their role in your COVID-19 Vaccination Program plans.*

The department and the WSPA will engage pharmacies on several different fronts, including informational webinars, newsletters, and direct member outreach. These efforts are designed to educate about the process of enrollment and how reporting and distribution are expected to proceed. The department and WSPA gauge that currently, nearly 90 percent of pharmacies across the state are interested in enrolling to provide COVID-19 vaccine. There are about 1,000 pharmacies in Washington (not including hospitals) and about 9,000 licensed and practicing pharmacists. Working directly with WSPA provides a centralized information portal with access to all pharmacies and pharmacists. The support and partnership of WSPA leadership has informed our recruitment process and strategy.



## Section 6: COVID-19 Vaccine Administration Capacity

### **Instructions:**

- A.** Describe how your jurisdiction has or will estimate vaccine administration capacity based on hypothetical planning scenarios provided previously.

The department will estimate vaccine administration capacity using a combination of tools and the information gathered during the enhanced influenza campaign. We have used information from the U.S. Census and other federal surveys to construct a tool that identifies populations of interest by county and across the state.

We can estimate health care provider participation in COVID-19 vaccination based on the amount of childhood and adult vaccine providers in Washington that participated in the enhanced influenza campaign. This information will help us determine provider capacity given the need for additional infection control and social distancing practices. We can estimate vaccine administration capacity using the CDC's PanVax Tool, population breakdown, and information from the enhanced influenza campaign.

We are still determining what health care organizations in the state can administer COVID-19 vaccinations, including local health jurisdictions, hospital systems, and occupational health programs. In addition, we are exploring mass vaccinator contracts with organizations to supplement vaccination staffing levels. We also will use survey data to identify vaccine storage and administration capacity.

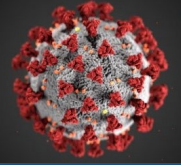
We have drafted three different scenarios for distribution and administration of vaccine based on information from the CDC's Planning Scenarios.

#### Scenario A – Ultra-Cold (-80°C) Only

The department has not been asked to supply ultra-cold storage for COVID-19 vaccinations. Based on information from the CDC, vaccine A must be stored at ultra-cold temperatures and will be shipped in minimum order sets of 1,000 doses. These vaccines will come in special containers fitted with dry ice to maintain ultra-cold temperature for a maximum of 10 days. This vaccine can be stored at 2-8°C but NOT reconstituted for five days; if thawed and reconstituted at room temperature, it must be used within six hours or discarded.

Given the storage and handling requirements of this vaccine, this planning scenario may require very limited redistribution. The department will work with LHJs and health care partners to develop guidance and procedures to assure cold-chain management and minimize wastage.

While the department is not procuring storage currently, we are actively seeking to document the current ultra-cold storage options at various facilities and determine the capacity to store



vaccine. As part of the prioritization process, the department will look at geographic location across the state for wide dissemination. The department itself does not have refrigerated, frozen, or ultra-cold storage capacity. In addition, we have run scenarios to estimate a range of dry ice that might be required depending upon the portion of orders for this vaccine that may require recharge. For the first two months, our best estimate is between 7,000-20,000 pounds of dry ice which local suppliers have verified is feasible over weekly orders.

### Scenario B – Frozen (-20°C) Only

Based on information from the CDC, vaccine B must be stored at -20°C or below and will be shipped in order sets of 100. This would require freezer capacity at sites ordering vaccine and may still require redistribution if providers order in quantities less than 100. Providers can manage the cold chain requirements and order sizes of vaccine B easier than vaccine A, but vaccine capacity will be directly impacted by freezer capacity in the state. We are working with local health jurisdictions and health care partners to document and map storage solutions, redistribution costs, and cold-chain management. The department itself does not have refrigerated, frozen, or ultra-cold storage capacity.

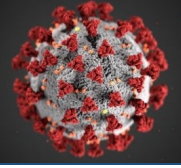
### Scenario C – Ultra-Cold and Frozen

In a situation where both vaccines are available, we will prioritize vaccine A and vaccine B for different health care providers. In this scenario, large provider sites should receive the ultra-cold vaccine A to increase capacity and minimize the risks with handling a large order set. Smaller vaccination sites will be prioritized to receive vaccine B, as these sites will benefit from a vaccine with easier cold chain requirements and a smaller order quantity.

## **B. Describe how your jurisdiction will use this information to inform provider recruitment plans.**

The department will identify locations with gaps in coverage based on the information gathered using the CDC's PanVax Tool, population breakdown tools, survey data, and the enhanced influenza vaccination campaign data. We will work with local health jurisdictions, health care partners, and internal teams to document gaps. Enrollment data will be mapped out geographically to help identify coverage gaps. Where gaps exist, we will work government to government with tribes and support local health jurisdictions to identify health care providers in the region and recruit them as COVID-19 vaccination providers. We are also exploring contracting with health care staffing organizations to fill in gaps in areas with less health care. Moreover, we will work closely with Health Care Authority. This agency is responsible for gathering COVID-19 data from hospitals and medical facilities and reporting that data to state agencies and the U.S. Department of Health and Human Services (HHS). HHS can provide the state with detailed information on health care facilities and identify local disease hotspots.





## Section 7: COVID-19 Vaccine Allocation, Ordering, Distribution, and Inventory Management

### **Instructions:**

- A.** *Describe your jurisdiction's plans for allocating/assigning allotments of vaccine throughout the jurisdiction using information from Sections 4, 5, and 6. Include allocation methods for populations of focus in early and limited supply scenarios as well as the variables used to determine allocation.*

Overall allocation will be guided by maximizing health and societal benefit while taking an equity lens into consideration. As noted above, the department has identified different populations and sub-populations and is estimating size and location for these groups. In parallel, we are enrolling providers and facilities. We aim to overlap this information and ensure there are adequate facilities to cover key population groups. We will recruit additional providers to ensure optimal and equitable coverage in areas needing additional support. We will test our plans by identifying different scenarios (e.g., ultra-cold vaccine only available, 100,000 new people covered each month) and determining how to handle them. In situations given by the CDC where early vaccine supply is limited, we estimate Washington state will receive approximately 2% of total supply. This suggests vaccination coverage of between 150,000 and 450,000 people in the first two months of vaccine distribution. In these scenarios, we are estimating how many of the phase 1 priority populations could be covered and how they might be prioritized into smaller groups.

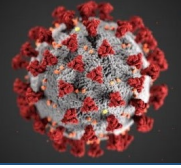
Variables to be considered will include:

- Vaccine availability
- Vaccine safety/efficacy with different populations
- Ultra-cold vaccine capacity management
- Provider enrollment and capacity to administer
- Geographic burden/epidemic context
- Social vulnerability indices
- Efficacy related to transmission blocking
- Emerging evidence regarding differential transmissibility of populations, etc.

For the phase 1 populations, we expect that most of the immunization provision will occur through hospital systems and health care facilities.

- B.** *Describe your jurisdiction's plan for assessing the cold chain capability of individual providers and how you will incorporate the results of these assessments into your plans for allocating/assigning allotments of COVID-19 vaccine and approving orders.*

### **Assessing provider cold chain capability**



During the provider enrollment process, the department will use the information collected from the provider profile to assess the site's cold chain storage capacity (e.g., types and size capacity of refrigerators, freezers, and/or ultra-low temperature freezers) and size of various age groups served. We will define additional provider profile elements to collect to assure the site's ability to maintain cold chain temperatures and vaccine viability, and aid in vaccine planning. We are also collaborating with hospitals, health care coalitions, and local health through surveys to identify cold chain capability.

### **Use of assessment allotments and approving orders**

Data collected during the enrollment and survey processes will inform estimated local-level or facility-level capacity and potential surge capacity for storing and administering vaccine. We will be able to use these data in estimation and exercise tools to validate that allocation strategies are reaching the appropriate populations. Cold chain capacity will be a factor to assess when approving or pushing orders, to assure adequate cold storage capacity for the size of the order.

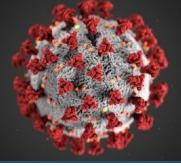
- C.** *Describe your jurisdiction's procedures for ordering COVID-19 vaccine, including entering and updating provider information in VTckS and any other jurisdictional systems (e.g., IIS) used for provider ordering. Describe how you will incorporate the allocation process described in step A in provider order approval.*

The department plans to use existing IIS vaccine ordering functionality to process COVID-19 vaccine orders. Enrolled providers will submit orders through the IIS. Those orders are then uploaded into CDC's Vaccine Tracking System (VTckS) for processing. All orders will be reviewed to assure that ordering aligns with previously described allocation strategies.

The process for placing vaccine orders during phase 1 may differ from later phases when vaccine supply is more readily available. Early in the vaccination response with limited vaccine, the department may develop a process to identify doses needs for specific locations to push allocations of vaccine doses in lieu of using the IIS. As vaccine supply increases to meet demand, vaccine ordering will transition to traditional methods using the IIS.

- D.** *Describe how your jurisdiction will coordinate any unplanned repositioning (i.e., transfer) of vaccine.*

The department has existing processes and approval procedures for transferring vaccine between providers or locations. Based on the vaccine presentation needing to be repositioned, the provider will complete transfer request documentation, which assures cold chain integrity in the transfer process, dose accountability, and dose reassignment in IIS. These procedures will be communicated to providers during the enrollment process.

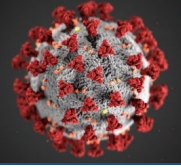


The real-time monitoring of doses shipped, doses administered, and doses on hand will be assessed to inform any needs to reposition vaccine among providers to meet varying needs within various jurisdictions. We also will have doses administered data to validate the monitoring data and vaccine movement decisions.

**E.** *Describe jurisdictional plans for monitoring COVID-19 vaccine wastage and inventory levels.*

The department has an existing process in place for providers to report wastage within the IIS. This process includes documenting reasons for wastage and providing instructions for completing the process. We will use the inventory monitoring system previously describe to identify doses that may need to be repositioned to a higher volume provider to avoid wasting doses.

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## Section 8: COVID-19 Vaccine Storage and Handling

### **Instructions:**

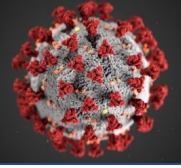
- A. *Describe how your jurisdiction plans to ensure adherence to COVID-19 vaccine storage and handling requirements, including cold and ultracold chain requirements, at all levels:*
- *Individual provider locations*
  - *Satellite, temporary, or off-site settings*
  - *Planned redistribution from depots to individual locations and from larger to smaller locations*
  - *Unplanned repositioning among provider locations*

The department will implement CDC's developed recommendations and requirements to ensure adherence to COVID-19 vaccine storage and handling expectations. We will also review current documents used for the department's publicly supplied vaccine programs and modify as needed for COVID-19 vaccine distribution and tracking, including but not limited to the following:

- **Vaccine Transfer Guidelines and Request Form:** Ensures the program can verify the provider is requesting to transfer viable vaccines to another provider who is actively enrolled in the program, has the correct material to conduct a vaccine transfer, and can ensure accountability of the doses.
- **Offsite Vaccination Guidelines and Request Form:** Ensures the program has adequate equipment to maintain the vaccine cold chain.
- **Vaccine Loss Policy:** Outlines program expectations and requirements about vaccine loss.
- **Vaccine Loss Log:** Allows providers to record vaccine loss. Providers can reference this log when completing their inventory reconciliation report or to analyze and prevent future vaccine loss.
- **Vaccine Temperature Excursion Guide:** Outlines what providers should do when they experience a vaccine temperature excursion.
- **Adult Vaccine Program Manual and User Guide:** Provides an overview of all adult vaccine program requirements for health care providers to receive 317-program funded vaccines.
- **Provider Map:** Identifies providers who can accept transfers of short-dated vaccines, finds geographical gaps in access to COVID-19 vaccines, and helps patients find a health care provider.

The department will develop a COVID-19 vaccination email distribution list to share information to providers actively enrolled in the program.

- B. *Describe how your jurisdiction will assess provider/redistribution depot COVID-19 vaccine storage and temperature monitoring capabilities.*



To ensure adherence to COVID-19 vaccine storage and handling requirements for facilities and redistribution depots, providers must meet certain criteria to enroll in the program. Providers will need:

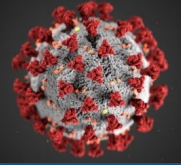
- A proper storage unit.
- A calibrated digital data logger (DDL).
- To submit digital data logger data showing their storage units can maintain stable temperatures.

The department will develop an enrollment survey tool for providers to make sure they meet the above requirements. If providers do not meet the requirements, they will be given information on proper storage units and temperature monitoring equipment. Providers can re-apply when they meet the requirements.

After enrollment, providers will need to follow certain guidelines to remain in the program.

Providers must:

- Submit their digital data logger data or paper temperature log to verify they are following cold chain requirements.
- Update their data logger certificates when they expire or purchase new DDL.



## Section 9: COVID-19 Vaccine Administration Documentation and Reporting

### **Instructions:**

- A.** *Describe the system your jurisdiction will use to collect COVID-19 vaccine doses administered data from providers.*

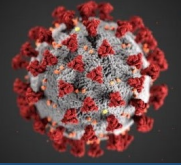
The department will use PrepMod and the IIS to collect doses administered data from providers within 24 hours of vaccine administration.

- B.** *Describe how your jurisdiction will submit COVID-19 vaccine administration data via the Immunization (IZ) Gateway.*

The department is currently working in QA/Testing environment to ensure the connection is working accurately for both Connect and Share components. Once we confirm the system works the way it's intended to, we will replicate that connection in production environment. The IZ Gateway is directly connected to the IIS in the cloud. In early 2021 we plan to connect the IZ Gateway via the state Health Information Exchange (HIE). The HIE helps providers meet Meaningful Use (MU) and Promoting Interoperability (PI) public health reporting requirements by providing connectivity to department data systems. This allows providers to connect once through a shared interface and make an unlimited number of transactions with an unlimited number of clinical and public health partners. The HIE provides secure transport with end-to-end encryption and includes message tracking and audit capabilities. Consolidating transport methods for submitting and receiving health care data promotes efficiency and improves interoperability. Another benefit of the HIE is that it may allow access/data exchange to other resources and registries, where direct connection to the IIS does not.

- C.** *Describe how your jurisdiction will ensure each COVID-19 vaccination provider is ready and able (e.g., staff is trained, internet connection and equipment are adequate) to report the required COVID-19 vaccine administration data elements to the IIS or other external system every 24 hours.*

The department has several staff that will be dedicated to outreach and training for COVID-19 vaccine administration and reporting. We will train COVID-19 vaccination providers through IIS training videos, accessible 24/7 on our website. These videos teach organizations and facilities how to use the IIS, administer vaccines, create and print patient records, add and search for patients, and create reports. We will provide support and training as needed through Zoom and GoToWebinar, supplemental documents, materials, and resources. We are also partnering with PrepMod to provide training and a call center for any provider questions. We will continue provider outreach, communication, and training as more detailed information becomes available around COVID-19 vaccine administration.



**D.** *Describe the steps your jurisdiction will take to ensure real-time documentation and reporting of COVID-19 vaccine administration data from satellite, temporary, or off-site clinic settings.*

The department will require providers to use the IIS or PrepMod per the CDC provider enrollment agreement. Both programs offer real-time data exchange to the IIS. The department will educate vaccinators on the importance of submitting timely data and provide assistance as necessary.

**E.** *Describe how your jurisdiction will monitor provider-level data to ensure each dose of COVID-19 vaccine administered is fully documented and reported every 24 hours as well as steps to be taken when providers do not comply with documentation and reporting requirements.*

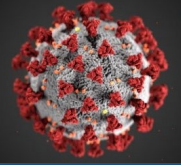
The department uses tools within the IIS to support data monitoring needs. Provider orders in the IIS go through the system validation rules to ensure orders contain all required elements. The vendor will create a report to determine that doses are being reported within 24 hours. When a provider is out of compliance with the requirements, we will follow up to determine if there is an educational opportunity or if they are unwilling/unable to comply. If providers are unwilling or unable to follow guidelines, they will not be allowed to order additional COVID-19 vaccine.

Enrolled providers will be required to submit daily inventory to CDC's Vaccine Finder. If daily inventory reports to CDC will be shared with states, the department can compare reported inventory data in Vaccine Finder to doses administered reported to the state IIS to reconcile differences and follow up with providers.

**F.** *Describe how your jurisdiction will generate and use COVID-19 vaccination coverage reports.*

The department's immunization program will use existing data systems and processes to generate COVID-19 vaccination coverage reports. The department has extensive experience in generating coverage rates from the IIS and supplying these reports to many partners, including local health, academic institutions, and the CDC.

Seven employees in the immunization program have direct access to all IIS data, meaning IIS tables with real-time data can be accessed at any time. All of these employees have experience pulling data, and existing scripts can be revised for COVID-19 specific estimates. Staff can generate coverage reports using different geographic levels and population groups to identify potential gaps in coverage and provide areas to focus efforts. Coverage reports can be reviewed with disease surveillance and inventory data to help identify potential areas needing vaccine inventory and/or outreach. We will make coverage reports available by county level and by specific population groups available to the public for situational awareness.



## Section 10: COVID-19 Vaccination Second-Dose Reminders

### **Instructions:**

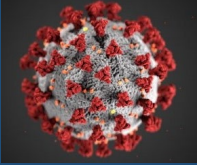
- A. *Describe all methods your jurisdiction will use to remind COVID-19 vaccine recipients of the need for a second dose, including planned redundancy of reminder methods.*

Providers will collect as much information before a vaccination is administered to be able to contact the recipients in multiple ways afterward: address, email, phone, and cell phone. The department intends to use the quickest and most cost-effective electronic methods first but will mail reminders as a last resort.

Some of the intended methods of outreach include:

- Using PrepMod to send out emails and text message reminders.
- Working with mass vaccination clinics to ensure they too are sending out appropriate second-dose reminders.
- Communicating that best practice for mass vaccination clinics is to set up an additional clinic at the appropriately spaced interval and offer a second dose to those who were vaccinated at the first clinic. That way a second appointment can be scheduled immediately following administration of the first dose. The department would also encourage use of cards/stickers with second-dose reminders that contains date due, vaccine type, and location.
- Promoting the use of MyIR, or My Immunization Registry, so recipients can see the date of the vaccination and the type of vaccine administered.
- Providers using reminder/recall in the Immunization Information System (IIS). The clinic facility is able to use the IIS to generate a reminder list, postcards, mailing labels, or auto dialer files specifically for the second dose of COVID-19 vaccine. Instructions on how to use this function will be provided through training videos and quick reference guides.
- Running an IIS report on individuals who have not completed their second dose. That report would then be used to send out paper mailings to those who are past due for their second dose of vaccine and calling them to action to complete. The recall mailing would contain the vaccine type and the date the second dose should have been completed.





## Section 11: COVID-19 Requirements for IISs or Other External Systems

**Instructions:**

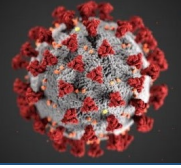
- A. Describe your jurisdiction’s solution for documenting vaccine administration in temporary or high-volume vaccination settings (e.g., CDC mobile app, IIS or module that interfaces with the IIS, or other jurisdiction-based solution). Include planned contingencies for network outages or other access issues.

The department plans to use PrepMod, which will interface with the IIS as well as the module in IIS for high-volume vaccination clinics. PrepMod is an application that includes Clinic Wizard and ReadConsent, which are HIPAA-compliant companion technologies that automate registration, planning, implementation, evaluation, recording, and reporting for mass vaccination and preparedness efforts.

If there were to be a network outage or other inability to access either PrepMod or the IIS, the user would be able to use an Excel spreadsheet or paper form. If the clinic can get the information into their EHR, but not into the IIS, the possibility to send batch messages once the outage has been resolved is also an option.

- B. List the variables your jurisdiction’s IIS or other system will be able to capture for persons who will receive COVID-19 vaccine, including but not limited to age, race/ethnicity, chronic medical conditions, occupation, membership in other critical population groups.

Data Elements
Administered at location: facility name/ID
Administered at location: type
Administration address (including county)
Administration date
CVX (Product)
Dose number
IIS Recipient ID
IIS vaccination event ID
Lot number Unit of Use
MVX (Manufacturer)
Recipient address
Recipient date of birth
Recipient name
Recipient race
Recipient sex
Sending organization
Vaccine administering provider suffix



Vaccine administering site on the body
Vaccine expiration date
Vaccine route of administration
Vaccination series complete

**C.** *Describe your jurisdiction’s current capacity for data exchange, storage, and reporting as well as any planned improvements (including timelines) to accommodate the COVID-19 Vaccination Program.*

There are no issues with the current volume of data exchange, storage, or reporting. The department’s systems are in the cloud so there is flexibility for additional storage as needed. Conversations with the IIS vendor are under way to discuss the possibility of load testing, to ensure adequate storage is available before the system becomes overtaxed.

During the testing and onboarding of the PrepMod connection, we will work to simulate the anticipated volume of data once it is in production. This will help ensure when the system is live that there are no issues with data exchange, storage, or reporting.

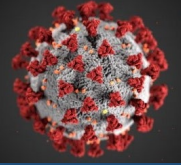
**D.** *Describe plans to rapidly enroll and onboard to the IIS those vaccination provider facilities and settings expected to serve health care personnel (e.g., paid and unpaid personnel working in health care settings, including vaccinators, pharmacy staff, and ancillary staff) and other essential workers.*

The department has an existing streamlined process for adding additional facilities to currently participating organizations in Washington, including those who are targeting health care personnel. If the organization is new to the IIS, we are developing a streamlined way for new providers to sign an information sharing agreement for COVID-19 response.

We also plan to implement the vendor’s first responder module (iCAT) in November, which will allow organizations to maintain their cohort of facilities to track who has and has not been vaccinated. It also allows organizations to see the professions of people in their cohort to administer the vaccine during the appropriate phase.

**E.** *Describe your jurisdiction’s current status and plans to onboard to the IZ Gateway **Connect** and **Share** components.*

The department is currently working to connect (Share and Connect components) with the IZ Gateway established with our vendor, STC. We intend to have this completed by October 16, 2020.



The memorandum of understanding and data use agreement are in final legal review, and the department should have those signed and in place by the beginning of November.

**F.** *Describe the status of establishing:*

1. *Data use agreement with the Association of Public Health Laboratories to participate in the IZ Gateway:*

The data use agreement is in the final stage of review by the Washington State Attorney General's Office and is expected to be executed by November 1, 2020.

2. *Data use agreement with CDC for national coverage analyses:*

The department has not received the data use agreement from the CDC but is working to establish soon.

3. *Memorandum of Understanding to share data with other jurisdictions via the IZ Gateway Share component:*

The Memorandum of Understanding is in the final stage of review with the Washington State Attorney General's Office and is expected to be executed by November 1, 2020.

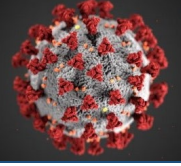
**G.** *Describe planned backup solutions for offline use if internet connectivity is lost or not possible.*

COVID-19 vaccine providers will be required to enter vaccine administration data into the IIS within 24 hours of administration. If internet access is not available, providers are required to complete the vaccine administration form during the vaccination event and record it in the IIS within 24 hours.

**H.** *Describe how your jurisdiction will monitor data quality and the steps to be taken to ensure data are available, complete, timely, valid, accurate, consistent, and unique.*

The department will use the currently established processes for data monitoring. We use the PHC Hub, a module within the IIS for message validation and data quality review for all interfaces with the IIS. This application provides improved interface monitoring tools, including automated error and warning report delivery. This in turn supports more efficient issue resolution and improved data quality for all IIS users. Each interface is associated with an Import Profile within PHC Hub. The profile defines how key data elements will be reviewed and analyzed to ensure strict data quality standards are met before being sent to the IIS for processing. For selected data elements, the Import Profile is set to perform one of the following actions:

- Ignore the data element if missing, incomplete, or invalid and accept the message.

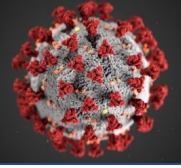


- Warn the submitter of missing, incomplete, or invalid data elements and accept the message. Providers are encouraged to correct issues in the EHR and resubmit the message, or manually correct the issue in both the EHR and the IIS. Whenever possible, they should adjust workflow and/or data submission practices to avoid similar warnings in the future.
- Error the message if required data elements are missing, incomplete or invalid. Submitter must correct issues and resubmit the message. Providers must adjust workflow and/or data submission practices to avoid similar errors in the future.

Import Profiles for providers participating in the COVID-19 response will include settings to support program-specific requirements.

During the testing and validation stage of an interface project, providers will receive the Provider Detail Error/Warning Report via email. Errors and warnings are determined by the Import Profile settings in PHC Hub. This report helps identify and resolve issues before the interface is approved for production. After an interface is moved to production, providers will continue to receive the Provider Detail Error/Warning Report. Providers are expected to use this report to quickly identify issues and address problems to ensure quality data continues to be submitted in the IIS.

We will also work with the IIS vendor to develop scripts as necessary to clean up records. Staff help determine specific matching criteria for the vendor to write scripts to automate matching and the deduplication process. The department has hired one data quality specialist for COVID-19 and has two additional recruitments in process. Other IIS staff are being trained for specific COVID-19 data requirements and will help with the workload.



## Section 12: COVID-19 Vaccination Program Communication

- A. *Describe your jurisdiction's COVID-19 vaccination communication plan, including key audiences, communication channels, and partner activation for each of the three phases of the COVID-19 Vaccination Program.*

### Communication Objectives

The COVID-19 vaccine communications staff at the department will work to coordinate and disseminate information through systems and partners to ensure the right messages reach the right people in the right ways. The messaging will be accurate and credible while being culturally and linguistically appropriate for the intended audiences. The team will facilitate both internal and external communication with key partners.

The communications objectives are:

- Provide timely, accurate, and credible information to the people of Washington on COVID-19 vaccine. This information will include the benefits and risks of vaccination and vaccine safety data.
- Lay the groundwork for eventual COVID-19 vaccine distribution by educating the public about key vaccine topics.
- Encourage willingness and intent to get the vaccine when available.
- Encourage continuing safe behavior practices, such as masking, distance, small groups, and hand washing.

Phase one will include building value and confidence in vaccines overall and in the COVID-19 vaccine, assuring the public it's safe to go in to get vaccinated, and laying the groundwork for who will be prioritized when the vaccine is available and explaining why.

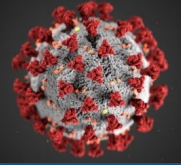
Phase two will include messaging on who gets the vaccine, what people need to know about it, where to get it, and how it works.

### Key Audiences

A key audience in each phase will be those recommended to receive the vaccine in that phase. The final list of these audiences is still to be determined as we wait on the allocation prioritization decisions. Some of these audiences will include:

- Age 65 and older
- Essential workers
- People with underlying health conditions
- Long-term care facility residents and staff

In addition, we will have the following as key audiences in all phases:



- Those at increased risk of acquiring or transmitting COVID-19 disease due to race, ethnicity, living situation, or other factors
- Health care workers
- Approved coronavirus vaccine providers
- Health insurance issuers and plans
- Employers
- Government and community partners, including:
  - Community organizations that work with high-risk and high-priority groups
  - Organizations and agencies with direct ties to the key audiences in each phase
- Stakeholders
- Immigrants and refugees
- Disability community

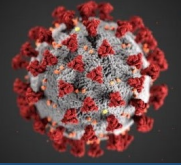
We will produce materials in 6 or more languages, ensure the department is reaching a broad age range, and include a special focus on those who are at high risk for COVID-19 disease. In addition, we plan to reach audiences who are usually comfortable receiving vaccinations but may be concerned about a COVID-19 vaccine for specific reasons.

## *Broad Communication Planning Phases and Activities*

Within the department, four teams are working together to reach all key audiences in Washington. The department has begun media relations and some other work, but most of these areas are currently in a planning and partner connection phase to get ready for later broad communication. The department is also working to gather audience feedback. The next step will be broad outreach, matching each planning phase, followed by evaluation. This is an iterative process and audience feedback, outreach, and evaluation may take place several times during the process to make sure the communications stay effective and relevant.

The four planning areas and their status and broad activities are:

- **Campaign:** Educate the public about a specific topic, promote a service or behavior, and influence behavior change using advertising and marketing principles through a paid media buy. This strategy is informed by literature reviews and audience research. It will include engagement with trusted digital influencers to disseminate messaging. Campaign funding was approved in early October and we will be moving into planning, design, and launch as quickly as possible.
- **Direct communication:** Coordinate and disseminate information through systems (health care, schools, long-term care facilities). Facilitate internal and external communication with key partners. This is currently in planning phase. We have been meeting with potential key partners to establish interest and confirming existing relationships. The partners, especially local health jurisdictions, are also in planning phase and will be ready to move to outreach phase with us.



- **Community engagement:** Leverage partnerships to understand need, build capacity in community, and implement a feedback loop between the department and community-based organizations. This strategy is informed by audience research and partner input. Planning for the audience and partner input is well under way.
- **Media relations:** Develop and coordinate information to the news media and the department's organic social media channels. Maintain partnerships with local health public information desks to create a feedback loop between local and state jurisdictions. We already have begun media relations: As of September 2, we publish a statement or news release every Wednesday. The Wednesday COVID-19 media telebriefing includes a vaccine update section, and we update a Frequently Asked Questions webpage at least once per week. We also have created an internal process for routing both media and public inquiries and keeping them separate.

In addition to the broad activities above, the department has these specific activities planned. More activities will be planned over the next few weeks, and these may pivot as the situation changes and as the department passes through phases.

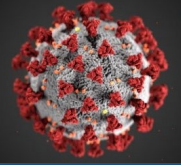
## **Campaign**

This campaign will feature 10 weeks of paid media, including:

- Facebook and Instagram (English, Spanish, Russian, traditional Chinese, Vietnamese)
- Twitter and Snapchat (English)
- TV and cable (English and Spanish)
- OTT (English and Spanish)
- Digital video ads (English and Spanish)
- Digital audio and podcasts (English and Spanish)
- Radio (English and Spanish)
- Newspaper
- Billboards
- Community media (print, online, radio)

## **Direct communication**

- Create partner toolkits (health care workers, approved coronavirus vaccine providers, health insurance issuers and plans, employers, government and community partners, and stakeholders)
- Create sample newsletter content and blog posts, on-hold recorded messages, social media content, and social media graphics.
- Stand up a local health jurisdiction rapid review team to vet communication materials
- Contribute content for and/or facilitate webinars and trainings for providers
- Develop a system to communicate with approved COVID-19 vaccine providers and LHJs



- Develop and maintain talking points for providers
- Develop and maintain talking points for public information officers (PIOs)
- Inform the public about the status of COVID-19 vaccine release and other key updates via the department's website and social media

## ***Community engagement***

Conduct audience research and key informant interviews.

## ***Media relations***

- Draft weekly media statement.
- Produce weekly televised brief with agency leaders and key external partners.
- Draft news releases as needed.
- Supply agency leadership with talking points and coach as requested.
- Facilitate regular COVID-19 update calls with local health jurisdiction communicators and PIOs.
- Maintain a Frequently Asked Questions page in English and Spanish ([www.doh.wa.gov/Emergencies/COVID19/vaccine](http://www.doh.wa.gov/Emergencies/COVID19/vaccine)).

## **Messaging Considerations**

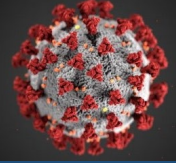
Some general considerations while developing messaging are:

- Competing information in the news, such as the presidential election that feel high stakes for many
- Some workers have lost health insurance from layoffs and may assume they cannot access no-cost vaccine.
- Many people have not paid much attention to vaccine information before and may not know what's normal or not in vaccine development and distribution. Some audiences may need basic vaccination knowledge before they can start learning about COVID-19 vaccine specifically.
- People who are recommended to get the vaccine in each phase need messaging, but those who are not getting it also will be curious why certain groups were chosen.
- We may encounter changes to the expected plan along the way and must have alternate plans in place for these issues.
- Audience will need help knowing what's changed and not be confused by different phases of the vaccine response.
- Some individuals and groups have grown (more) distrustful of government and/or vaccines during the pandemic.

Some barriers to communication that the department expects:

- Stakeholders opposing vaccination may spread misinformation on our social media, at events, through earned media, or in other ways such as billboards.





- It's difficult to reach populations who don't use social media.
- The large amount of information and misinformation available could be confusing or overwhelming.
- The department is hearing many concerns over safety of the vaccine and not trusting or believing that all safety measures will be taken.

Ways the department plans to address these barriers:

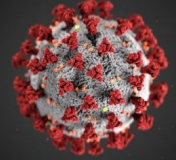
- Paid social media to increase reach of messaging.
- Help traditional media outlets understand how to share vaccine information most effectively and how to avoid misinformation.
- Have multiple groups review messaging for clarity and readability.
- Follow the social media plan for communicating changes to audiences over time.
- Creating an appendix to the communications plan that has pivot points and alternate plans for changes or unexpected events (for example, if there is a vaccine shortage or recall or if the epidemiology suggests a change in recommendations).

## Communication Channels

External to Department of Health:

- [Coronavirus.wa.gov](https://coronavirus.wa.gov)
- [www.doh.wa.gov/Emergencies/COVID19](https://www.doh.wa.gov/Emergencies/COVID19)
- The department's social media, including Facebook, Twitter, Instagram, and Medium (English and Spanish)
- LinkedIn
- Direct email to contact lists via GovDelivery
- Website slider
- Media advisories (weekly)
- News releases (weekly)
- Care Coordination call center
- 211 call center
- The department's information line for individuals to call or email
- Stakeholder e-mail distribution lists
- Equity and engagement e-mail distribution lists
- Local health jurisdiction communicator calls
- Set up inquiry line at [covid.vaccine@doh.wa.gov](mailto:covid.vaccine@doh.wa.gov), or media inquiries to [doh-pio@doh.wa.gov](mailto:doh-pio@doh.wa.gov).
- Websites and communication channels of partner state agencies, such as Health Care Authority and the Governor's Office

Internal to Department of Health:



- Daily all-staff email
- Cascading messages
- Agency town halls
- Basecamp
- SharePoint pages and the department Intranet

Partners and trusted sources:

- Tribal governments
- Tribal health centers and organizations
- Local health jurisdictions
- Community-based organizations
- Local and community leaders
- Other state agencies, including Health Care Authority, Department of Social and Health Services, and the Governor's Office
- Insurance companies and managed care organizations
- Influencers, including past CDC Childhood Immunization Champions from Washington, and social media influencers from target age groups.

The department will also use internal partners, such as:

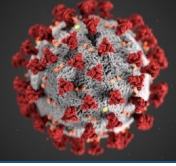
- The Community Education Task Force and the translation coordinator to ensure the COVID-19 vaccine materials are culturally and linguistically appropriate.
- The health promotion and education team to ensure the effectiveness of messaging.
- The Office of Immunization and Child Profile

*B. Describe your jurisdiction's expedited procedures for risk/crisis/emergency communication, including timely message development as well as delivery methods as new information becomes available.*

During this pandemic response as during any emergency, the department follows the CDC's Crisis and Emergency Risk Communication strategies. The department stands up a public information desk or a Joint Information Center depending on the emergency's needs; in the COVID-19 response, the department stood up both and incorporated many state agencies and partners into the JIC so everyone could share information quickly and speed up processes. In addition, we have adapted pandemic influenza planning and communication strategies to fit the needs of the COVID-19 pandemic.

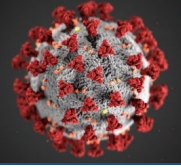
In addition to the principles from CERC and pandemic flu, the department has used other techniques to expedite procedures during the COVID-19 response:

- Designating leads for each topic area, with decision-making power.
- Removing some state procedures that could slow down the response, such as requiring publication numbers.



- Streamlining the translation process, with designated funding for expedited processing by the contractor.
- Routing all media messaging through one central intake email and phone line.
- Combining messaging into coordinated twice-weekly briefings and reducing to once weekly when the situation called for it.
- Relying on partners to share work and messaging.
- Staggered shifts and designated on-call staff ensured 24-hour response ability, with the ability to adjust or reduce the hours as the pandemic continued.
- Incorporating audience testing into the launch of some products rather than being a separate, slower phase before launch.
- Weekly calls with local health jurisdictions to ensure everyone got the messaging and deliverables they needed quickly, and the department could hear immediate needs.

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## Section 13: Regulatory Considerations for COVID-19 Vaccination

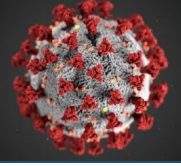
### **Instructions:**

- A.** *Describe how your jurisdiction will ensure enrolled COVID-19 vaccination providers are aware of, know where to locate, and understand the information in any Emergency Use Authorization (EUA) fact sheets for providers and vaccine recipients or vaccine information statements (VISs), as applicable.*

Health care providers, including pharmacists who currently provide vaccines, are knowledgeable about the requirement to provide a Vaccine Information Sheet as part of their patient information and education process. The department already requires Childhood Vaccine Program providers to complete training that includes this material. As part of enrollment information and orientation, providers will be educated of the requirement to provide the VIS or EUA fact sheet as appropriate for the vaccine. Ongoing plans for provider education and toolkit information are in development that would include this material in addition to materials provided by CDC on this subject. Ongoing updates for providers will occur with updates through education campaigns, monitoring of VAERS reports, and feedback from communities. In addition, we will add links to the CDC COVID-19 webpages that contain the fact sheets and forms.

- B.** *Describe how your jurisdiction will instruct enrolled COVID-19 vaccination providers to provide Emergency Use Authorization (EUA) fact sheets or vaccine information statements (VISs), as applicable, to each vaccine recipient prior to vaccine administration.*

Provider education plans are currently in development, but the CDC provider agreement includes a provider acknowledgment about use of the VIS/EUA to be provided for the patient. We are working with multiple health care partners to ensure all health care providers who administer the vaccine are aware of the requirement. Some specific partners in this work include the Vaccine Advisory Committee (VAC), a clinically diverse advisory group with representation from health care community practice disciplines, including retail pharmacies across Washington. Input from VAC members will be used to ensure the developed materials provide a comprehensive message for all vaccination providers. The department will also use CDC-developed training materials and assure these materials are also available for distribution through local health jurisdictions.



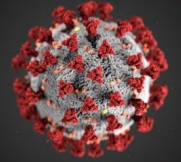
## Section 14: COVID-19 Vaccine Safety Monitoring

### **Instructions:**

- A.** *Describe how your jurisdiction will ensure enrolled COVID-19 vaccination providers understand the requirement and process for reporting adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).*

Education for health care providers is in development with training scheduled for health partners in November and in December to including vaccine administration, safety, and VAERS reporting. Additional and ongoing updates will be distributed through newsletters, educational outreach materials, and webinars for provider audiences. These webinars are being scheduled through the first half of calendar year 2021 to ensure awareness.

We will be actively monitoring VAERS as increased vaccinations occur with additional outreach if gaps are identified. We established a Scientific Advisory Workgroup in September 2020 to support vaccine allocation and administration planning in Washington through the active participation of vaccine experts (biomedical and social sciences), providing information on COVID-19 vaccines. The clinically diverse group will use scientific expertise and professional experience to synthesize information on vaccine candidates and licensed vaccines to guide allocation, administration, planning, and overall success of COVID-19 vaccination strategies in Washington.



## Section 15: COVID-19 Vaccination Program Monitoring

### Instructions:

- A. Describe your jurisdiction’s methods and procedures for monitoring progress in COVID-19 Vaccination Program implementation, including:

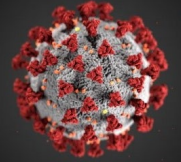
#### Provider enrollment

The department will use REDCap to collect provider enrollment information. The information can be summarized and visualized to create snapshots and monitor enrollment statistics. These graphics can be filtered and exported to allow the program to review the raw data. This will give the program the opportunity to find and assess gaps within the jurisdiction to tailor outreach.

If the system were to crash, we will temporarily implement a manual review process of collecting new provider enrollment applications by fax or email and transposing them into the CDC required template. This data will then be imported into the electronic system when the program is able.

We will monitor and report on the progress of implementing the COVID-19 vaccination program by creating and reporting out key milestones and metrics on all areas of the response (see areas below in table). These metrics will be used internally to guide programmatic decisions and identify gaps in provider enrollment, access to vaccine services, system performance, data reporting, and vaccine coverage. Some measures will also be available externally to inform the public on access and overall coverage. Metrics will be revisited and revised throughout the response as movement is made through each phase of the implementation. The table below describes initial methods that will inform specific metrics, data systems identified, intended audiences, and frequency of monitoring.

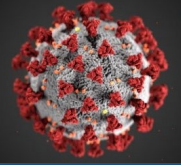
Method	Data System(s)	Intended audience(s)	Frequency
<b>Provider Enrollment</b>			
Track number of providers enrolled by location, provider type, populations served	IIS, provider enrollment system solution	Internal programmatic tracking, situational awareness	Weekly
<b>Access to COVID-19 vaccination services by population in all phases of implementation</b>			
Overlaying vaccination coverage with inventory and high-risk population data to ensure areas with high-risk populations have adequate supply and high coverage	IIS, provider enrollment system solution, disease surveillance	Internal programmatic tracking	Weekly
Ensure Vaccine Finder is current and promoted as a resource	Vaccine Finder	External audience	Monthly



<u>IIS or other designated system performance</u>			
Participate in IIS consortium calls to prioritize system enhancements	NA	Internal programmatic tracking	Monthly
Monitor IIS system speed to ensure providers can access it and data are entered	IIS	Internal programmatic tracking	Daily
<u>Data reporting to CDC</u>			
Review internal report that data were successfully submitted daily	IIS	Internal programmatic tracking	Daily
<u>Provider-level data reporting</u>			
Track date from dose administered at provider to date entered into IIS	IIS	Internal programmatic tracking	Daily
<u>Vaccine Ordering and Distribution</u>			
Track vaccine ordered by providers based on populations served to ensure vaccine is going to high-priority groups	Provider enrollment system solution	Internal programmatic tracking	Weekly
Compare state-, county-, and provider-level doses ordered with doses administered to ensure vaccine is being used	IIS	Internal programmatic tracking	Weekly
<u>1- and 2-dose COVID-19 vaccination coverage</u>			
Calculate percent with vaccine initiation (1-dose) and series completion (2-dose) by broken out by various geographic and population groups (by county, age group, race/ethnicity, sex)	IIS	Internal programmatic tracking, situational awareness, external audience	Weekly

**B. Describe your jurisdiction’s methods and procedures for monitoring resources, including:**

- Budget
- Staffing



- *Supplies*

The Office of Immunization and Child Profile (OICP) has established fund coding specific to COVID-19 activities that enables the department to monitor, track, and reconcile COVID-19 expenditures related to all required object areas, including staffing, supplies, and contracts. OICP's budget staff work closely with office leadership to determine staffing needs and other required services and develop cost projections that are added to the department's financial software. This enables teams to run the necessary reports to assure funds are spent appropriately and that balances are accurate. The department also maintains parallel spreadsheet systems, which provides quick snapshots of funding and expenses on a routine basis.

**C.** *Describe your jurisdiction's methods and procedures for monitoring communication, including:*

- *Message delivery*
- *Reception of communication messages and materials among target audiences throughout jurisdiction*

The department will distribute messages through Outlook, Basecamp, GovDelivery, website downloads, local television, and social media (both paid and organic). Some messages will be sent directly and others through partners, other governmental entities, and influencers. GovDelivery, website metrics, and social media metrics will allow us to monitor number of message opens, number of interactions, forwards/shares, and some demographics of social media interactions. We also will track the number of partners and other governmental entities messaging is shared with and will monitor media coverage and track the number of media articles covering this topic. We also can monitor the number of meetings or connection points through Outlook calendars.

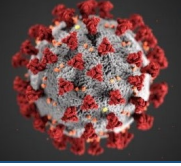
To monitor reception, we will hold regular calls with local health jurisdictions to gather their feedback, stay engaged with tribal entities for feedback, and engage with social media users. Weekly recorded telebriefings give the media space to ask questions and share what their readers are asking. The department's equity and social justice staff will be conducting surveys, interviews, and focus groups with various groups in the state to determine attitudes about vaccination and gauge the effectiveness of the department's messaging and their receptiveness to it.

**D.** *Describe your jurisdiction's methods and procedures for monitoring local-level situational awareness (i.e., strategies, activities, progress, etc.).*

The department will continue active engagement with local health jurisdictions, currently meeting bi-weekly with program staff and weekly with communication staff. In addition to these situational update meetings, the department will:

- Review provider enrollment progress.
- Continuously monitor vaccine availability.
- Continue active engagement with professional associations to assess program effectiveness.
- Analyze vaccine administration in target populations.





- Conduct and continue situational update meetings with engagement workgroups.
- Provide vaccine dose administration and vaccine coverage data to LHJs, state planners, engagement workgroups, and other partners.
- Closely monitor media and grassroots communications for vaccine attitudes and concerns.

**E.** *Describe the COVID-19 Vaccination Program metrics (e.g., vaccination provider enrollment, doses distributed, doses administered, vaccination coverage), if any, that will be posted on your jurisdiction’s public-facing website, including the exact web location of placement.*

The department plans to publish COVID-19 Vaccination Program metrics to be available for the public. Final metrics and location of publication are still being developed. The following are proposed metrics that will be finalized over the next month:

- Doses administered
  - By week, month, county of administration
- Vaccination coverage – 1 dose and series completion
  - By county of residence, age group, race/ethnicity, sex

Final decisions on where metrics will be published will be determined over the next month. Data could be integrated into existing COVID-19 dashboards, including the following:

- Department of Health COVID-19 Data Dashboard: <https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard>
- WA State COVID-19 Risk Assessment Dashboard: <https://coronavirus.wa.gov/what-you-need-know/covid-19-risk-assessment-dashboard>

## Appendix

### Appendix A: Sample Population Estimates for Washington State

This is a work in progress and the Department of Health continues to identify different population groups through engagement efforts with partners and the review of data sources. This appendix includes preliminary size estimates for a number of categories and population groups. Sub-population groups are included, but not limited to, those listed below.

Category	Population group (includes, but not limited to)	Sizing
Health care and community support services	Health care providers—physicians	~55,000
	Health care providers—other	~55,000
	Hospitals	~134,000
	Long-term care facilities for the elderly	~18,000
	Other elderly and disabled care professions	~66,000
	Other nursing and residential care facilities	~46,000
	Other health care facilities	~3,000
	Testing laboratories	~3,000
	Pharmacies	~1,000
	Ambulance services <sup>1</sup>	~2,500
	Social assistance	~47,000
	Public health personnel <sup>2</sup>	~7,500
	Health care—other	~42,000
Critical infrastructures	Elementary and secondary schools <sup>3</sup> (incl. teachers)	~173,000
	College/university staff (incl. junior colleges)	~68,000
	Other education facilities	~7,500
	Childcare services	~4,000
	Grocery stores	~12,000
	Mortuary services	~2,000
	Telecommunications	~22,000
	Waste management and hygiene	~18,000
	Power and water generation and distribution	~18,000
	Postal service	~12,000
	Transportation program administration	~7,000
Volunteer workforce	TBD	
Vaccine manufacturing/distribution	TBD	

1. To split between contracted vs. public sector services. 2. To split between exposed and non-exposed. 3. Elementary vs. secondary split to be identified.

Source: North American Industry Classification System (NAICS)

Category	Population group	Sizing
Security, justice, and non-education institutions	Deployed National Guard	~700
	Correctional facilities residents	~16,000
	Correctional facilities staff <sup>1</sup>	~9,500

	Fire protection	~8,000
	Police protection	~7,500
	Security and justice—other	~12,000
	Election personnel	TBD
	Executive offices (state government)	~372
	Legislative bodies (state government)	~606
	Executive offices (local government)	~1,213
	Legislative bodies (local government)	~300
Disproportionately affected professional groups	Food production	~104,000
	Agriculture support activities	~34,000
	Beauty salons, barber shops and similar services	~17,000
	Meat slaughtering, processing and packing	~5,500

1. To be eventually split between federal, state, and local workforce

Sources: NAICS, Washington Department of Corrections

Category	Population group	Sizing
Age and condition factors <sup>1</sup>	Pregnant people	~95,000
	Infants/toddlers (0–2 years old)	~264,000
	Children 3-9 years old	~606,000
	Children 10-18 years old	~808,000
	Adults 19-29	~1,034,000
	Adults 30-49 with risk condition	~415,000
	Adults 30-49 w/o risk condition	~1,440,000
	Adults 50-63 with risk condition	~472,000
	Adults 50-63 years old w/o risk condition	~783,000
	Adults ≥ 64 years old <sup>2</sup>	~904,000
Other vulnerable groups <sup>1</sup>	Hispanic or Latinx population	~990,000
	Asian alone	~731,000
	Black or African American alone	~335,000
	American Indian and Alaska Native alone	~145,000
	Native Hawaiian and Other Pacific Islander alone	~61,000
	Population below poverty line	~784,000
	Pop. < 65 y.o. w/o health insurance	~571,000
	Homeless population	~22,000

1. Overlap with other professional and population categories and between population groups 2. To be split by age further

Source: U.S. Census, Centers for Disease Control and Prevention

Target population	Sub-group	Size (WA State)
Residential care facilities	Adult family homes	~2,150/~1,900 <sup>1</sup>
	Assisted Living facilities	~18,400/~15,300 <sup>1</sup>

	Certified community residential services and support	~4,400/~5,900 <sup>1</sup>
	Enhanced service facilities	~35/~75 <sup>1</sup>
	Nursing home/skilled nursing facilities	~10,600/~20,000 <sup>1</sup>
	Residential habilitation centers	~400/1,150 <sup>1</sup>
Population at increased risk of illness	Homeless population	~22,000
	Population with disabilities, chronic conditions, and other risk factors	~960,000
Health care workers	Health care providers	~110,000
	Hospitals	~135,000
	Pharmacies	~112,000
	Testing laboratories	~3,000
People 65+ years old		~1,200,000
Communities of color	American Indian and Alaska Native alone	~145,000
	Black or African American	~335,000
	Latinx	~990,000
	Native Hawaiian and other Pacific Islanders	~61,000

1. Residents/staff  
Source: DSHS, CDC, NAICS, U.S. Census

Target population	Sub-group	Size (WA State)
Frontline essential workers	Ambulance services	~2,500
	Agriculture support activities	~34,000
	Childcare services	~4,000
	College/university staff (incl. junior colleges)	~68,000
	Election personnel	TBD
	Elementary and secondary school staff (incl. teachers)	~173,000
	Food production	~104,000
	Grocery stores	~12,000
	Meat processing, slaughtering and packing	~5,500
	Mortuary services	~2,000
	Other education facilities	~7,500

	Postal service	~12,000
	Power and water generation and distribution	~18,000
	Public health workers	~7,500
	Telecommunications	~22,000
	Vaccine manufacturing/distribution	TBD
	Volunteer workforce	TBD
	Waste management and hygiene	~18,000
Other congregate settings	Colleges/universities	~420,000/~68,000 <sup>1</sup>
	Correctional facilities	~16,000/~9,500 <sup>1</sup>

1. Residents or students/Staff  
Source: CDC, NAICS, U.S. Census

Appendix B: Assessing the Size of Priority Populations considering the National Academy of Medicine Framework for Equitable Allocation of COVID-19 Vaccine

In addition to gathering size estimates for populations above, we have begun to estimate sizes for different phases using the National Academy of Medicine’s Framework for Equitable Allocation of COVID-19 Vaccine (source: <https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus#sectionPublications>). Below is an example of our work in progress focusing on phase 1 populations; we are still gathering data from the health care community on different populations. This first phase represents over 4 million people, so further prioritization will be necessary. Work is under way for estimating the populations in other phases as well.

EXAMPLE - NATIONAL ACADEMY OF MEDICINES PHASE 1 ONLY – **WORK IN PROGRESS**

COVID-19 population group	WA Population Estimate	Data Source(s)	County data (Y/N)
High-risk workers in health care settings with high exposure to confirmed or suspected COVID-19 patients			
ICU settings			
Emergency Department settings			
Ambulatory			
Performing autopsies			
High risk of aerosolization (intubation, bronchoscopy, invasive dental procedures, CPR, etc.)			
TBD			
High-risk workers exposed to specimens of known/suspected COVID-19 people			
Laboratory personnel	3,000 (to be refined)	Job data - industry tab; NAICS	Y
TBD			
High-risk workers in health care settings with an elevated risk of acquisition/transmission with populations at higher risk of mortality (ex: chemotherapy, chronic renal disease, etc.)			
Staff at long-term care facilities (AFH, ALF, ESF, NH, SL)	44,500	DSHS - May 2020 survey; LTCF tab	Y
Home health aides	21,500	HSQA Roles tab	Y
TBD (cancer treatment centers, dialysis centers, etc.)			
TBD (pharmacists administering vaccines in high-risk settings)			
High-risk frontline first responders (with frequent public contact performing high-risk procedures)			

COVID-19 population group	WA Population Estimate	Data Source(s)	County data (Y/N)
EMS (fire, ambulance, health clinic, etc.)	16,900	EMS Summary tab	Y
Ambulance/ambulatory care (fire, health clinic, etc.)	12,000	Job data - industry tab; NAICS	Y
Field staff in high-risk and outbreak settings			
TBD			
<b>People of all ages with comorbid and underlying conditions that put them at <i>significantly higher risk</i></b>			
Cancer	1,083,100	<a href="https://statecancerprofiles.cancer.gov/">https://statecancerprofiles.cancer.gov/</a>	Y
Chronic kidney disease (over 18)	159,000	WA DOH; >18 chronic tab	N
Chronic kidney disease (under 18)	140	United States Renal Data System	N
Chronic obstructive pulmonary disease (over 18)	300,000	WA DOH; >18 chronic tab	N
Chronic obstructive pulmonary disease (under 18)			
Immunocompromised state from solid organ transplant	200	<a href="https://unos.org/data/transplant-trends/">https://unos.org/data/transplant-trends/</a>	N
Obesity (over 18)	1,700,000	WA DOH; >18 chronic tab	N
Obesity (under 18)	25,900	National Health Examination Surveys	N
Serious heart condition (e.g., heart failure, coronary artery disease, cardiomyopathies) (over 18)	316,000	DOH - epi team; >18 chronic tab	N
Serious heart condition (e.g., heart failure, coronary artery disease, cardiomyopathies) (under 18)			
Sickle cell disease	2,000	<a href="https://www.cdc.gov/ncbddd/sicklecell/data.html">https://www.cdc.gov/ncbddd/sicklecell/data.html</a>	N
Type 2 diabetes mellitus (over 18)	550,000	WA DOH; >18 chronic tab	N
Type 2 diabetes mellitus (under 18)	15,000	SEARCH for Diabetes in Youth Survey	N

<b>COVID-19 population group</b>	<b>WA Population Estimate</b>	<b>Data Source(s)</b>	<b>County data (Y/N)</b>
Older adults living in congregate or overcrowded settings			
Residents at long-term care facilities (AFH, ALF, ESF, NH, SL)	33,000	DSHS - May 2020 survey; LTCF tab	Y
TBD			

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