Community Questions and Answers:
Collaborative Meeting March 3, 2021

Below are questions we have received during the Collaborative space held on March 3, 2021. We have compiled those questions and answers in this document. We will do this for every meeting held.

If you have any questions and/or would like to follow-up, please feel free to contact us at vax.collaborative@doh.wa.gov.

Vaccine Safety

Q: Can you speak on any updated information about transmission after you get vaccinated?

I.e. If I am vaccinated how likely is it that I would be able to transmit to others who are not vaccinated if I am exposed? (many people are still confused about this piece, from what I am hearing)

Washington State Department of Health

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A: Although COVID-19 vaccines are effective at keeping you from getting sick, scientists are still learning how well vaccines prevent you from spreading the virus that causes COVID-19 to others, even if you do not have symptoms.

Early data show the vaccines do help keep people with no symptoms from spreading COVID-19, but we are learning more **as more people get vaccinated. We're also still learning** how long COVID-19 vaccines protect people.

For these reasons, people who have been fully vaccinated against COVID-19 should keep taking precautions in public places, until we know more, like wearing a mask, staying 6 feet apart from others, avoiding crowds and poorly ventilated spaces, and washing your hands often.

Vaccine Supply & Allocation

Q: Are you going to talk about the recent directive from Inslee regarding childcare providers being able to get vaccinated?

His statement says only "licensed childcare providers"...which does not take into account all the informal & unlicensed providers offering care... is proof required for providers to get vaccinated?

A: Eligible caregivers are eligible in Phase 1a - which include: licensed, unlicensed, paid, unpaid, formal, or informal caregivers who support the daily, functional and health needs of someone who is at high risk for COVID-19 due to advanced age, long-term physical condition, co-morbidities, or developmental or

intellectual disability.

The person for whom they are providing care can be an adult or child. This has been communicated to vaccine providers and partners. Eligible caregivers will need to provide phase finder eligibility.

Q: Why are they asking for SSN (social security number) at the time to check in for the vaccine? A social security number is not required to get the vaccine.

A: Correct! A SSN is not required to obtain the vaccine. You may be asked by a provider.

However if you do not have one or do not feel comfortable providing it, you can respond you do not have one or do not feel comfortable providing one.

Race & Ethnicity Data

Q: We have started hearing about vaccine hesitancy between the two doses here in the Latinx community, has this been brought up at all?

When the DOH sees these (and other) documented health inequities, what steps are being taken to correct and ensure that these populations have easier access to vaccines?

A: Yes! Vaccine hesitancy is coming up in many community

partner spaces including among Latinx community partners.

The Community Relations & Equity team is leading focused community engagement efforts with specific populations (i.e. Latinx, immigrant and refugees, agricultural workers, Black/African American (AA), Native Hawaiian and Other Pacific Islanders (NHOPI), people who are incarcerated and detained in prisons, jails, and detention centers, individuals experiencing homelessness and several other communities most harmed by COVID-19) to inform vaccine access and outreach.

If you would like to learn about a specific community engagement effort, please reach out to us at vax.collaborative@doh.wa.gov.

Community engagement efforts informed our current vaccine engagement strategies to ensure equitable vaccine distribution and allocation:

- Engaging communities to inform vaccine prioritization and planning;
- Integrating a pro-equity approach into vaccine allocation and distribution;
- Prioritizing allocation and support to providers who effectively serve disproportionately impacted communities;
- Investing in trusted community leaders, messengers and organizations;
- Ensuring all communications, education and outreach efforts are culturally and linguistically appropriate and accessible;
- Strengthening **the public health system's ability to center** communities in vaccine outreach and access;
- Fostering opportunities for collaboration;

- And supporting a trauma-informed approach to vaccine conversations.

More information can be found on our vaccine equity and engagement page.

We have also developed the following pro-equity strategies that vaccination providers and sites will be required and encouraged to implement.

Providers will need to comply with DOH's minimum requirements for language access, accessibility, and reporting of demographic data.

All providers are asked to assess their accessibility for people with limited English proficiency and people with disabilities by April 2, 2021 and work on areas that need improvement.

Pro-equity strategies include:

1. Investing in trusted community leaders, community members and organizations.

    - We know community rooted organizations are better positioned to respond to their community needs in the most culturally responsive and linguistically relevant way, we also know they are better equipped to incorporate a trauma informed approach and lens to their outreach strategies.
    - DOH is investing in trusted community leaders, messengers and organizations through community-based messaging contracts and prioritizing organizations serving disproportionally impacted communities.
    - More details can be found under our 4th strategy here.

- We are encouraging vaccine providers to do the same by:
    - Partnering, investing and collaborating closely with their local community trusted leaders/messengers;
    - Ensuring there is opportunity for community partners to provide feedback on vaccine prioritization and planning;
    - Co-sponsoring vaccine events and outreach with community;
    - And consider partnering with and activating community health workers to assist with culturally responsive and linguistically appropriate vaccine outreach and access needs (i.e. education, interpretation, scheduling appointments).

2. Creating alternative pathways for scheduling appointments and building out community-based scheduling appointments.

- We recognize the digital inequities and the many technology barriers in scheduling appointments. Alternative pathways include offering advance scheduling to community organizations, co-sponsoring vaccine events and outreach with community partners.
- We are currently exploring better ways to utilize and make 211 (phone-based scheduling) accessible. We currently reserve about 20% vaccine appointments for phone-based scheduling.
- Providers are recommended to:
    - Offer community specific days or hours for appointments.

- Hold a set of appointments for phone-based scheduling. Recommendation: Consider holding 20-30% for phone-based scheduling.
- Hold a percent of appointments for scheduling by community partners. Recommendation: Consider holding 20-30% for community-based scheduling.
- Develop a separate online scheduling link to improve community access (e.g. offer a Spanish-only link to address language barriers).
  - We have seen success with our recent efforts at the Wenatchee site where we partnered with local community-based organizations in Wenatchee area that serve Latinx and/or Spanish speaking populations to set up an alternative pathway for scheduling appointments and registering community members.
  - We are working on expanding these efforts and sharing successful best practices with partners.

3. Meeting people where they are: **"vaccines going to people, not people going to vaccines"**

- Considering community centered vaccination sites where people feel safer.
- Employer-based vaccine sites to save eligible employees time.
- Providing alternative and extended hours.
- Implementing **"past tier" catch**-up days or times to ensure access for harder to reach groups who were eligible in previous tiers.

- Planning proactive efforts to reach communities who are likely to be missed by traditional channels.

4. Ensuring language access

- All vaccination providers are required to ensure language access – identify and pro-actively provide information and materials in the top languages in their area; ensure all communications, education, and outreach efforts are culturally and linguistically appropriate and accessible; translation and culturally relevant materials are available on-site; provide translation/interpretation services in-person and/or via phone service; and know accommodation needs of community.
    - DOH Resources and Recommendations and COVID-19 Partner toolkit is where we house COVID-19 material. Materials can be searched by language. DOH translates all COVID-19 material into the top 36 languages spoken in Washington, and through community requests, will translate other specific languages.
    - Other resources include: Language access planning tool

5. Equitable site placement

- DOH is prioritizing allocation and support to providers who are effectively serving disproportionally impacted communities. This includes utilizing the Equitable site planning tool and the Social Vulnerability Index to ensure vaccine sites are in communities with highest

need (using the SVI map, highest need is defined by a rank of 7+).

- Other resources include: Checklist to ensure vaccine sites are accessible to people with disabilities.

Prioritization & Access

Q: How does an employer navigate those who are symptomatic? Can they return to work without a COVID test and immediately after recovery?

A: Great question! Employees should not return to work until they have met the criteria to discontinue home isolation and have consulted with a health care provider.

Q: How would you be sure the individuals with developmental disabilities can be vaccinated? Are there any risks for them?

A: Individuals with disabilities may be at a higher risk for COVID-19 because of their underlying medical condition. For example Down Syndrome is an underlying condition that may place someone at higher risk of getting very sick from COVID-19. Conditions are added when there is enough scientific evidence to support putting them on the list.

The list is updated as new information becomes available. You should discuss your risk of illness with your healthcare provider.

Q: Is HIV considered a comorbidity that expedites priority for COVID-19 vaccination? If no, why not?

A: Yes! Phase 1b Tier 3 includes people who have certain medical conditions (such as HIV) that put them at increased risk for severe illness if infected with COVID-19 leading to increased hospitalization, morbidity and mortality.

The list of conditions is based upon research by CDC that is posted here. It is a living document that may be updated as science evolves. People 16 years and older with 2 or more co-morbidities or underlying conditions will be eligible on March 31st (*estimated*).

Q: Do you anticipate offering any of the vaccines to homeless shelters, persons of any age, taking the vaccines to places where homeless congregate. These folks have so many barriers before the in seeking any medical care.

A: Yes! Currently eligible in Phase 1B Tier 2 include high-risk critical workers who work in certain settings. This includes critical staff and volunteers who work at homeless and domestic violence shelters. People living in congregate settings including people experiencing homelessness are eligible in Phase 1b Tier 3.

Q: I've heard rumors around "extra vaccines" that are being handed out to people who aren't currently eligible in the phase. Is this true? How is equitable access being tracked?

A: Vaccine providers are encouraged to develop an equity-informed extra dose plan – provide vaccines in a way that still

aligns with current vaccine guidance and prioritizes those at higher risk without wasting doses.

Q: How do we assure that migrant workers do not have to be concerned with ICE intervention at any site and specifically for those needing to come for a second shot?

A: No personal identifying information is collected or reported that could be utilized for civil or criminal prosecution including immigration enforcement. We continue to communicate and push through all channels and reinforcing clearly that information about immigration status is not collected or asked.

Johnson and Johnson Vaccine

Q: What were the vaccine reactions related to the J&J vaccine during the trials?

A: J&J vaccine reactions were similar to the ones experienced by Moderna and Pfizer.

Most common effects include pain, redness and/or swelling on the arm of vaccinated site.

Other symptoms throughout the body may include tiredness, headache, muscle pain, chills, fever, and/or nausea.

Q: With the J&J vaccine being a single dose it would be a great option for homeless individuals who will likely struggle with getting to multiple appointments for a two dose vaccine.

How could we prioritize distributing the J&J vaccine to homeless populations, ideally through pop-up clinics?

A: Thank you for your feedback! Related to J&J we consider factors that may be more applicable for certain providers and geographic regions such as such as rural sites, ease of transport, storage, administration, and technology that would make it easier for specific sites/providers to administer one dose vs two dose vaccines.

However, regardless of what vaccines is provided, we would like to proactively ensure any vaccine is accessible for people experiencing homelessness.

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