2020

COVID-19 Vaccine: Community Engagement Findings

December 2020

Washington State Department of Health

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Center for Public Affairs

Community Relations and Equity

101 Israel Road SE

Tumwater, WA 98501

Covid.Vaccine@doh.wa.gov

We want to thank all of the community members, partners, and leaders who provided their time, feedback, and perspective during this process. Your input has been immensely beneficial to our COVID-19 vaccine planning efforts.

Thank you,

The COVID-19 Vaccine Planning Team

Contents

Introduction

Over the course of October 2020, the Washington State Department of Health led a comprehensive community engagement effort to get feedback on how people are feeling about the COVID-19 vaccine and perspectives for how COVID-19 vaccine should be prioritized and allocated in Washington state. This approach included both focused and broad engagement efforts. Focused efforts were more qualitative in nature and included a mixed methods approach. We did 90 total key informant interviews, group interviews, community conversations, and focus groups with 568 total individuals representing a variety of communities and perspectives. We were intentional in centering the experiencing of communities most disproportionately impacted by COVID-19 and bringing groups together over shared experience rather than geography. The broad engagement approach provided an option for greater public feedback using a web-based survey. We collected and analyzed results based off occupational and other risk factors. The survey was available in multiple languages and we received 18,023 participants.

Focused Engagement Approach

To hear from communities most impacted by COVID-19 about the allocation and prioritization framework, we used a mixed methods approach and conducted 90 separate interviews, group interviews, focus groups, and community conversations. These were conducted primarily by phone and video chat with 568 individuals across the state over a three-week period in October 2020.

The Department of Health's internal COVID-19 Community Engagement Task Force led these efforts. We also partnered with several of the existing Emergency Language and Community Outreach Services contractors and other partners to carry out additional culturally appropriate community engagement efforts within their own communities. The information gathered through these activities was also supplemented by advocacy letters from disproportionately impacted businesses and other sectors, as well as by qualitative open-ended responses to survey questions.

We engaged community members, partners, and representatives and asked participants to self-identify the communities they belong to and/or represent. Most often, people self-identified with more than one community. Over the course of all focused engagement efforts, we identified representation from the following communities, groups, and sectors (**Table 1**).

Participants identified as being connected with 28 counties or said they were connected statewide (**Table 2**). Being connected to a county includes the county that a participant lives in as well as the county or counties a participant works in. We did not focus our engagement

efforts on geographic communities, however, we do have the ability identify any geographic-specific feedback.

Table 1: Community engagement group representation

Disproportionately Impacted Communities[1]	Essential Sectors, Services Sectors, and Industries	Health Care and Public Health Partners	Other High Priority Communities, Groups, and Sectors

Black/African American community
Asian/Asian American community
Native American
Native Hawaiian and other Pacific Islanders community
  Marshallese, Micronesian, and COFA (Compact of Free Association) communities
Latinx community
Immigrant and refugee communities
Asian diaspora
African diaspora
Latin American diaspora
Former Soviet Union (FSU) diaspora
Undocumented communities
People with underlying health conditions
Older adults
Pregnant people
Individuals with disabilities
People experiencing homelessness
People who are incarcerated
Low-income communities
Uninsured communities
	Essential and front-line workers
	Agricultural sector
	  Migrant workers
	  Farmworkers
	  Seafood industry
	Food bank services
	Business community
	Public transportation
	Hospitality industry
	Public utilities
	Parks and recreation
	Technology sector
		Local Health Jurisdictions
		Community health clinics
		Community Health Workers and promotoras
		Behavioral health and substance use disorder services
		Community blood centers
		Rural medical services
		Pharmacy
		Post-acute and Long-Term Care
		Veterinary care
			Children with special health care needs
			Youth
			Youth in foster care
			College and university students
			Parents
			Early learning and early childhood
			LGBTQ+ community
			Rural communities
			Border communities
			Sub-urban communities
			Faith-based communities
			Veterans
			Women

[1] Communities that have experienced the greatest COVID-19 inequities related to cases, hospitalizations, deaths, and risk of severe illness. Participants self-identified as being in these groups and were often in more than one group.

Table 2: Counties of participants

All (statewide)	Ferry	Kitsap	Pend Oreille*	Thurston*	*Focused engagement efforts
Adams	Franklin*	Kittitas*	Pierce*	Wahkiakum	
Asotin*	Garfield	Klickitat*	San Juan*	Walla Walla*	
Benton*	Grant*	Lewis*	Skagit*	Whatcom*	
Clallam*	Grays Harbor*	Lincoln	Skamania*	Whitman	
Clark*	Island*	Mason*	Snohomish*	Yakima*	
Cowlitz*	Jefferson*	Okanagan*	Spokane*		
Douglas	King*	Pacific*	Stevens		

Focused Engagement Analysis

For all activities, either a designated note taker or the facilitator took notes. As needed, all engagement activities were facilitated in-language or with the assistance of an interpreter or Communication Action Real-time Transcription (CART) services. We redacted all participant names, saved all transcripts as text documents, and then uploaded into Dedoose (version 8.3.35). A contractor analyzed qualitative data using thematic analysis. The codebook was developed iteratively and derived from assessment goals, data, and the prioritization framework. Each transcript was coded individually, and the codebook was adapted as necessary. Each code report was summarized into a table of theme domains and subdomains with associated quotes.

Broad Engagement Approach

We also collected feedback from the broader public through a web-based survey. This survey was provided in the following languages (see **Table 3**) and disseminated through existing partner channels, Department of Health (DOH) listservs, the DOH website, and social media accounts. We selected these languages because they are common in Washington state and we have had success reaching people who speak them through other web-based communications during the pandemic.

Table 3: Survey respondents by language

Language	Number of Respondents
English	17,678
Spanish	70
Vietnamese	36
Chinese (simplified)	36
Chinese (traditional)	160
Russian	29
Ukrainian	12
Tagalog	2

The survey was split into three parts: 1. How are you feeling about COVID-19?; 2. How should we decide who gets the vaccine first?; and 3. Tell us about yourself (optional). In addition to analyzing the overall survey results, we also filtered and analyzed the results by the respondent's area of work and whether they identified as someone at increased risk for COVID-19 because of their race/ethnicity, disability status, or overall health and age.

Our analysis included all in-language surveys that had at least 10 respondents. These survey results supplement what we learned through the qualitative, focused engagement efforts with these respective communities. We also collected information about the specific county respondents reside in.

COVID-19 and Health Equity Considerations

The COVID-19 pandemic has shed light on existing health inequities, amplified them, and revealed their root causes. The inequities in cases, hospitalizations, and deaths, among other telling metrics, are the result of broader societal and structural factors like racism and other forms of oppression. These structural factors result in differential access to resources, services, and opportunities, including access to health care.

Inequities can be exacerbated or alleviated by intersecting identities. For example, recent research has shown that nurses of color are more likely to die from COVID-19 than their white counterparts. While occupation data is not available for all COVID-19 deaths, available data showed that registered nurses accounted for 30 percent of COVID-related deaths among health care workers nationally. Approximately 24 percent of registered nurses in the United States are individuals of color, but people of color accounted for 58 percent of deaths from COVID-19 among registered nurses. By comparison, 75 percent of registered nurses are white and accounted for 40 percent of deaths. Another study showed more broadly that health care providers with COVID-19 who died tended to be older, male, Asian, Black, and have an underlying medical condition when compared with health care providers who did not die.

Disparities in Cases, Hospitalizations, and Deaths

There are stark differences in COVID-19 cases, hospitalizations, and deaths for certain communities. The disparities we see in exposure and illness are also impacting many of the same historically marginalized groups that experience other health inequities. This is true at the state level and the national level. There are other communities that experience inequities related to COVID-19 that are not well captured in our data systems, for example people with disabilities. Additionally, a lack of disaggregation for large groups, for example by race/ethnicity, can mask differences in outcomes at a sub-population level.

The Department of Health's COVID-19 morbidity and mortality by race, ethnicity and spoken language in Washington state report, COVID-19 Confirmed Cases by Industry Sector and current data dashboard further details the disparities that do appear within currently available data. The Department of Health acknowledges these limitations and is actively working to promote data equity and address the systemic and technical challenges to more representative data collection systems. The following data are provided by the Washington State Department of Health.

Confirmed Case Rates

In terms of age-adjusted confirmed case rates:

- Native Hawaiian and Other Pacific Islander (NHOPI) and Hispanic populations have the highest rates, while white and Asian people have the lowest.
- NHOPI and Hispanic populations have approximately six times higher rates than Asian and white populations.
- Black populations have approximately three times higher rates Asian and white populations.
- American Indian/Alaska Native people account for 2 percent of COVID-19 cases but only 1 percent of the total population.

Table 4. Percentages of confirmed COVID-19 cases hospitalized by primary language spoken

Language	Cases	Hospitalizations	Percent language specific hospitalizations
English	39,145	3,068	7.8%
Spanish	11,845	848	7.2%
Marshallese	305	49	16.1%
Vietnamese	254	42	16.5%
Russian	533	110	20.6%
Chinese (all)	84	17	20.2%
Ukrainian	165	46	27.9%
Tagalog	73	19	26.0%
Other	900	116	12.9%

Employment data also shows disparities in COVID-19 cases among certain industries. In a report published on November 10, 2020, lab-confirmed cases of COVID-19 among residents reported through 11:59 PM on September 13, 2020 showed:

- People in the **health care and social assistance** industry sector account for 25 percent of COVID-19 cases even though only 13 percent of Washington's employed population is employed in this sector.
- People in the **agriculture, forestry, fishing and hunting** industry sector account for 11 percent of COVID-19 cases even though only 3 percent of Washington's employed population is employed in this sector.

Hospitalization Rates among Confirmed Cases

Among confirmed COVID-19 cases:

- Native Hawaiian and Other Pacific Islander (NHOPI) populations have the highest hospitalization rates and white populations have the lowest. NHOPI hospitalization rates are 13 times higher than white populations.
- Hispanic populations hospitalization rates are seven times higher than white populations.
- Black and American Indian and Alaska Native populations have hospitalization rates that are three times higher than whites.
- Certain language groups have hospitalization rates that suggest increased exposures and/or barriers to care may contribute to more severe disease. (See **Table 4**.)
- American Indian and Alaska Native people account for 2 percent of COVID-19 hospitalizations but only 1 percent of the total population.

Death Rates among Confirmed Cases

Among confirmed COVID-19 cases:

- White populations have the lowest death rates of all race/ethnicity groups.
- Native Hawaiian and Other Pacific Islander populations have death rates are 6.5 times higher than whites.
- American Indian and Alaska Native (AI/AN) and Hispanic populations have death rates that are nearly four times higher than whites.
- Black populations have death rates that are nearly twice as high as white populations.
- AI/AN people account for 3 percent of total COVID-19 deaths but only 1 percent of the population.

Causes of Health Inequities in COVID-19 Health Outcomes

Adverse health outcomes from COVID-19 come not only from the virus itself, but also from the unintended consequences of the Washington state government's mandates and initiatives to contain it. Again, these impacts are felt most by those who are historically and currently marginalized.

Access Barriers

Many communities experience barriers to accessing critical health information and services due to race/ethnicity, language, culture, nationality, immigration status, or disability status. Structural, institutional, financial, social, cultural, and sociodemographic factors impact their access both now and historically.

Types of access barriers include:

- **Economic barriers** such as insurance status and cost of care.
- **Structural barriers** such as limited or no transportation; work, school, or childcare limiting someone's time and availability; lack of culturally and linguistically appropriate services; inaccessible clinic environment and conditions; lack of access to broadband.
- **Social barriers** include differential treatment by providers; experience of discrimination; health literacy; and historical trauma.

Employment Conditions

Many employment-related factors can impact worker health. Depending on their jobs, workers face increased risk of exposure to COVID-19, lost jobs or income due to unintended consequences of COVID-19 restrictions, or workplaces where they are unable to socially distance or are not provided personal protective equipment.

EXAMPLE Low-income workers are less likely to be able to socially distance while at work or to work remotely. People of color are more likely to work in service industries, such as restaurants, retail, and hospitality, which puts them at higher risk for loss of income during the pandemic. Also, people of color are more often working jobs that are not amenable to teleworking and they more often use public transportation that puts them at risk for exposure to COVID-19 (SAMHSA, 2020; Benfer, E. & Wiley, L., 2020; and Artiga, S., Garfield, R., & Orgera, K., 2020).

Housing

Individuals experiencing homelessness and individuals living in shared or transitional housing are at increased risk for exposure. In addition, stay-at-home orders or other COVID-19 response initiatives have unintended consequences on the health and well-being of survivors of domestic violence.

EXAMPLE People of color are more likely to live in multigenerational family co-housing and low-income and public housing. These situations make it difficult to social distance, quarantine, or self-isolate (SAMHSA, 2020; Benfer, E. & Wiley, L., 2020; and Artiga, S., Garfield, R., & Orgera, K., 2020). Also, individuals experiencing homelessness may be at particular risk of COVID-19 due to their mobility (it is difficult to track and prevent transmission); lack of access to hygiene

supplies; limited access to health care; lack of a medical home; and limited access to public spaces as a result of shutdowns.

Other Unintended Consequences

The Washington state government has worked to prevent the spread of COVID-19 through travel bans, social distancing measures, and isolation and quarantine protocols. In addition, COVID-19 cases have brought increased strain on the health care system. People who are likely to experience the unintended health consequences of these factors include, but are not limited to, pregnant people; people with unrelated acute, severe, or chronic health conditions; people of color; and individuals with disabilities.

EXAMPLE Sixty-one percent of Black adults and 60 percent of Hispanic adults reported that the COVID-19 pandemic has impacted their mental health, in comparison with 55 percent of white adults.

Equity as a Cross-Cutting Factor

As illustrated in the previous sections, the root causes of differences in COVID-19 cases, hospitalizations, and deaths are due to long-standing systemic inequities; as are the differences in access to COVID-19 information, services, and treatment in culturally and linguistically responsive ways. As a result, Washington state is intentionally taking a pro-equity approach to COVID-19 vaccine prioritization and allocation.

We have focused on the following groups as cross-cutting all phases of our prioritization and allocation framework. The focus on these cross-cutting groups were well supported by the impacted communities, partners, groups, and sectors who participated in our engagement and public feedback opportunities.

- **People with access barriers to health care:** People with limited transportation, people with limited English proficiency, individuals with disabilities, people without health insurance, undocumented people
- **People at higher risk for exposure:** Farm and factory workers, essential workers, people who live in congregate housing, people experiencing homelessness, people who are incarcerated or detained, people in workplaces with outbreaks
- **People essential to health and wellbeing of populations at higher risk:** Doulas, caregivers (both formal and informal), home care aides, health care interpreters, community and mutual aid volunteers, community health workers
- **People who have been disproportionately impacted by COVID-19 because of systemic inequities:** Communities of color, people with limited English proficiency, individuals with disabilities, low-income people

- **People at risk for severe illness:** Older adults and elders, pregnant people, people with underlying medical conditions that put them at a higher risk for severe morbidity or mortality if infected with COVID-19
- **People who are at higher risk for spreading COVID-19 to high risk populations:** Caregivers, people living in multi-generational households, children and youth, essential workers, people who must travel for work
- **People who live in areas with greater spread:** Geographic hotspots and outbreaks, congregate housing with outbreaks

Understanding COVID-19 Risks

1. *Older Adults are at risk due to their work, where they live, family gatherings, or cultural shared spaces*

- Older adults who live in intergenerational homes, multi-family housing, nursing homes or other congregate care settings, jails, and homeless shelters are at higher risk for exposure, as are older adults who receive assistance from their family or neighbors.
- Some older adults have occupations that may put them at increased risk, including fishing boat managers (also likely to be black, indigenous, or people of color), teachers, utility and water operators, and other occupations where they can't make choices about the safety of their jobs. Those in working class jobs are unable to reduce their workplace risk and are too reliant on income from those positions to leave or stay home even when isolation is warranted.
- Communities of color, including immigrants and refugee communities, expressed concern for their elders. They reported that if religion is important to them, they will attend religious gatherings; and if they cannot, they may be at increased risk for depression or anxiety. Others reported that elders value family contact and may be at additional risk because they continue to meet with family. In addition, some older adults with cognitive difficulties need to stay isolated but may not understand what is going on.

"Being part of the Asian community, we put a lot of resources and respect toward our elders. My concern is really toward my grandparents and other members that I really think of as staples of our community."

2. *Those who face barriers to health care or quality health care are at risk*

- The Latinx community, including farmworkers and those working at food processing plants, may be uninsured or underinsured. In addition, fear of losing their job, the cost

of tests and treatment, and worries about their status (if they are undocumented), are likely to prevent them from seeking care.

- Rural communities often face delays in getting care and those without transportation cannot access care.
- Low-wage workers without health insurance often do not access health care. In addition, low-wage workers may not seek care because they would become food insecure if they miss work.
- Communities of color have limited access to testing, may be homebound with limited access, and have comorbidities that are a direct result of health care they have received. Native Americans struggle to get health care.
- Transgender and homeless queer youth may not have access to health care.
- Note that these communities overlap.

"[Farmworkers] are going to go to work or die."

3. People with underlying health conditions are at risk

- Latinx, Indigenous, Black people, other communities of color, and immigrants and refugees often have underlying conditions, such as diabetes, cancer, asthma, or other pulmonary conditions as well as higher health disparities overall due largely to systemic oppression.
- Medically fragile children are at greater risk as are children with disabilities.
- People with disabilities may have multiple health conditions, rely on home health workers, and have marginalized immune systems.
- Older people are more likely to have heart disease, diabetes, COPD, and compromised immune systems that put them at greater risk.
- Those with mental illnesses, especially those who are homeless, may be more likely to congregate together or spread COVID-19 without knowing it.
- Note that these communities overlap.

4. People who live in congregate living situations or in multi-generational homes are at greater risk

- Workers who live where they work, such as farmworkers, fish processors, and rural utility district work site employees are at greater risk. They live in shared quarters with shared bathrooms with other workers. Many sleep in bunk beds that are not socially distanced.

- Black people, Indigenous communities, and other communities of color, including immigrants and refugees, reported that they often live close to one another, with multiple generations in one household.
- The high cost of living also forces low-wage workers across the spectrum to live in overcrowded or dense housing situations. Families living in low quality housing have underlying respiratory diseases, which are exacerbated by stay-at-home orders. Low-wage workers are also likely to rely on public transportation, further exposing them to the virus.
- People experiencing homelessness, especially homeless queer youth, are at particular risk. Those who are transient, may not able to test/treat/isolate; for those who do want to access shelter beds, the number of beds is reduced due to an effort to separate people for social distancing.
- People with disabilities, older adults, and staff in congregate care living settings, are at higher risk especially if the setting employs shift staff who are at high risk themselves. In addition, isolating people in long-term care facilities is detrimental to their mental health.
- People who are incarcerated cannot be isolated and do not have options to isolate themselves.
- University students living in congregate housing are at risk. Students have higher social and mental health needs for personal contact and may take more risks.
- Note that these communities overlap.

"Agricultural workers living in cabins: They have 40 people to 2 bathrooms."

"Bunk beds are not social distancing."

5. People who are exposed to others and/or the general public at work and/or in work settings where proper protocols are not taken are at greater risk

- People working in jails and prisons, health workers, front line workers, pharmacists, restaurant and grocery workers, utility workers, critical infrastructure workers, contact tracing professionals, public transport workers, volunteer firefighters, people who work in hospitals, parks and recreation staff, hatchery staff, long-term care workers, farmworkers, sex workers, veterinarians and veterinary staff are at increased risk. Child care workers, school staff and nurses, teachers, and workers who leave their children in congregate child care, and other workers that are exposed to people or work in settings where proper safety precautions aren't taken are at high risk.

- People who work in food processing may work in spaces that are closed, spaces that do not adapt well to social distancing, or where installing separation barriers would create barriers to safety. In these settings where spread occurred, 75 percent or more of the crew were infected. Farmworkers are at risk on buses that bring them to the field and in their sleeping accommodations.
- Black and brown communities, including immigrants and refugees, are highly represented in jobs that are at higher risk because of exposure to others. Or the workplaces don't have enough safety protocols in place or are the last to receive PPE. Examples include: farmworkers and food processors (as stated above), dairy workers, meat packing plant workers, public transportation workers, housekeepers, nail salon workers, fishery staff, community-based organization staff who meet with clients, home health care workers, grocery store staff, community workers who go with clients to their appointments, Uber or Lyft drivers, retail industry workers, and health workers. In addition, older adults in these communities often work in high exposure jobs.
- Sex workers are at risk when seeing clients, which disproportionately impacts queer and trans Black, Indigenous, and other people of color.
- Low-wage workers often need to work to support their families and work multiple high-risk jobs where their attendance is critical to support others impacted by COVID. This may include working in service jobs in community based organizations such as homeless shelters. People with disabilities often work in lower-paying jobs as home health workers, in grocery stores, and in restaurants where they have higher risk of encountering people with COVID-19. Students who work in retail or at restaurants may need their salaries but their workplaces may not protect them. In addition, low-wage workers often take public transportation and don't have funds to purchase their own PPE.
- Note that many of these communities overlap.

"I got infected at work in the cafeteria. People would take off their mask to eat and leave the mask on the table. If you arrived at that table after that person and did the same, right there you caught the virus."

"I was infected at work. In our work place there was not enough disinfection. They didn't give us gloves or masks and it is very easy to get infected."

"Our crews [fishery crews] are a pretty diverse group the higher up the managerial people tend to be older and are approaching high-risk for their health. We also have minority populations our company in particular employs Asian and Pacific Islanders. Some other are Somali Americans. That should be considered when you think about the category of risk."

Disproportionate Impacts: Many interconnected layers

1. *COVID-19 affects many individuals within families and between families*

- Children: Children in much of Washington have been unable to return to in-person schooling. The safety nets provided at school (teacher attention, school nurse, special education aides) are either absent or seriously overwhelmed in the online environment. For low income, rural, LEP, disabled and low tech students, online schooling is very challenging if not impossible. Children are experiencing loss of housing, hunger, postponement of well-child medical care and, in the most extreme cases, death of relatives and friends. Older children may be responsible for younger children's care. Children with special needs are especially impacted when they lose support services or have to care for themselves. Young adults: College and university students experience mental health impacts resulting from isolation, loss of job/pay covering the cost of education, assumption of family care for younger siblings, and many of the same impacts as their younger counterparts.
- Working age adults/parents: Adults are impacted by employment, housing, physical and mental health factors to varying degrees. Adults of color and low-income adults are particularly impacted as individuals, parents and caregivers of older adults. Essential workers discover it is difficult to access child care when the adult becomes ill from COVID.
- Older adults: Seniors living in extended family homes are exposed to risk via their housing situation and in the case of low-income seniors via their workplace. This is particularly true for People of Color (POC), immigrants and disabled seniors. Older adults are particularly affected by the intersectionality of age, ethnicity, profession and poverty.

2. *Impacts reach people in their homes*

- For families with multiple generations under one roof, the strength of sharing costs, social support and cultural values are now undermined by the risk of contagion via family members who are engaging in risky behaviors. These behaviors are oftentimes necessary to feed and house the family, such as shift work in essential work environments.
- Congregate housing, like multi-generational housing, results in infection, illness and death.

- Families living in substandard housing have COVID-like symptoms due to mold and allergens, which prevent them from accessing medical and other services because they cannot pass COVID screening even if the symptoms are long-term pre-COVD chronic environmental health symptoms.
- Isolation during the pandemic means that individuals already experiencing family violence are at increased risk. Families in small homes experience work and school impacts and have to juggle those activities in the home space. And people living alone are experiencing anxiety and depression during isolation.
- For families who have lost their jobs or experienced pay cuts, failure to make rent/house payments means evictions. They then have to live in cars or shelters in which occupancy is already high and capacity is reduced due to social distancing. For those who have family or friends with whom they can stay, the situation of multi-family housing becomes a new risk.

3. Impacts happen in the workplace

- Job-related impacts are felt most intensely by low-income workers. They often work in high-risk environments without the ability or autonomy to reduce their personal risk.
- The same elements of the workplace that increase risk for contracting COVID exacerbate the impact when one becomes sick with the disease and prevent individuals from quarantining at home:
    - Lack of health insurance or sick pay, low pay, necessity to purchase one's own PPE all keep sick people going to their job while sick or plunges them into poverty when medical crises hit.
    - Shift work, multiple low paying jobs, crowded workplaces and the inability to work from home increase COVID-related stress, financial insecurity and ongoing risk of exposure.

4. The social safety net is necessary to catch people but it, too, is damaged by COVID-19

- For many communities, community-based and government-based social services are familiar options on which families may have relied on in the past, or rely on in an ongoing fashion. Reliance is due to systemic racism, barriers to financial security and an incomplete public insurance system. They are services most people expect to be available when pandemic-level crises occur. These include:
    - Schools, public transportation, hospitals, health clinics, psychiatric hospitals, prisons/jails, DSHS, behavioral health services, public utilities

    - First responders: police, fire/emergency medical
    - Unemployment benefits, CARES act funds (specific to 2020 pandemic),
    - Homeless shelters, churches/temples/mosques/religious organizations, CBOs, child care facilities, food banks
- However, the pandemic has demonstrated to communities that the social safety net is vulnerable as well -often because the same impacts felt by individuals and families are experienced by organizations. For some service agencies and organizations, the same people disproportionately impacted by COVID work or volunteer at those agencies/organization and are unable to report for work or support the safety net but instead need to draw upon it.
- Community members trying to access assistance have discovered the agencies and organizations have: reduced hours, staff out sick or on quarantine, reduced funding, reduced capacity (due to lower resources or social distancing protocols), inability to pivot to reliance on internet-based activities, an unsafe (contagion for COVID) environment.

5. The "wellness" of low-income people and POC is already fragile and the fragility is further exacerbated by COVID-19

- Disproportionately affected communities experienced the start of the pandemic already at higher risk due to: stress, discrimination, hunger, chronic disease, exhaustion, poor nutrition, family violence, structural racism, substance abuse/addiction, communication challenges due to language or disability. All of these factors have been exacerbated by COVID infection, illness and death.
- Even those who were managing relatively well prior to COVID have experienced reduced immunizations, chronic disease management/care, and routine screening due to COVID's impact on health care availability and access.
- People across all disproportionately impacted communities are experiencing major economic impacts as well as food and housing insecurity due to loss of income, lack of access to unemployment benefits, and other public assistance resources. Low wage workers are especially impacted when they must find additional jobs to earn a livable wage - thus increasing potential virus exposure.
- Many families' financial well-being has been impacted when they have had to pay for their own PPE, COVID tests in order to attend school or work, quarantine costs (especially for those forced to quarantine away from home), medical appointments, medications, hospitalization, basic needs, internet and technology devices for schooling

or work. For those who expect to survive the pandemic, many expect to be in debt or further in debt or completely bankrupt.

6. *COVID-19 requires health resources that are not easily accessible to many communities especially when the demand increases exponentially*

- Essential workers, first responders and many others have had to purchase their own PPE when employers could not or would not supply it.
- Workers who were required to show a negative COVID test often paid for it out of pocket, especially in areas where no free tests were available. Many reported having been told the test was free or inexpensive and billed for hundreds of dollars after the fact.
- People without health insurance put off getting COVID treatment or found themselves saddled later with unreasonably high bills they would never be able to pay.
- For individuals and families needing behavioral health services, an overburdened system nearly shut down in the face of unprecedented demand.

COVID-19 Impacts

1. *Difficult to follow COVID-19 preventative behaviors without adequate support and enforcement*

- There was concern across all groups that there is inadequate access to PPE for essential workers in high-risk settings especially among settings staffed by Black, Indigenous, and people of color (BIPOC) communities (i.e. farmworkers, public transportation, health services, long-term care facilities, restaurants, food banks).
- COVID-19 preventive behaviors outlined in formal guidelines, such as wearing masks and social distancing, are difficult to follow without enforcement and support in workplace, school and community group settings.. Specifically, in the farmworker and food processing community, congregate settings and workplace transportation make it extremely challenging to follow any preventive measures.
- Groups need support to continue preventive behaviors such as free and accessible testing, masks, transportation, distribution of PPE, funding and financial relief to maintain safe business structure and quarantine/isolation measures.

"Ensuring safety supplies is the most critical"

Misinformation and Distrust

1. *Vaccine hesitancy due to historical trauma and mistrust of government agencies and health care entities*

- There is an overwhelming distrust of federal and government agencies, health care systems and entities due to historical events and trauma (i.e. Tuskegee experiment). There is a long history of medical experimentation, harm and testing on Black communities, Indigenous communities, disability communities and communities of color as well as experiences of racism and discrimination within health care that contribute to mistrust.
- There is concern about safety and efficacy of a vaccine due to rapid development and lack of transparency about vaccine development.
- All groups expressed fear that BIPOC communities will be the first individuals vetted to take the vaccine and utilized as test subjects.
- There is collective agreement and support to partner with community representatives and community members for transparent vaccine information, communication, and distribution efforts.

"Generational trauma is huge in the Black and Brown community especially around vaccinations, around government testing, and around the government. There is no trust there."

"I am not willing to be the guinea pig for this government."

2. *Community trust is impacted by misinformation related to how the COVID-19 vaccine is being managed/manipulated by the government*

- U.S. medical and public health history of medical experimentation results in overall distrust of the government, pharmaceutical industry, and medical industry. It also results in distrust of vaccine trials and the current vaccine(s) under development. Some communities are hearing that the vaccine is being tested on people with disabilities and the BIPOC community without their knowledge.
- Some farm workers and food processors from the Latinx community, who have been one of the hardest hit in Washington State, are receiving misinformation that they will be last to receive the vaccination and there is concern that it will not be affordable.
- Asian American Pacific Islander community participants are getting misinformation that the Administration is trying to prevent certain groups from getting vaccinated. The

Latinx community is getting misinformation that the vaccine is going to just be "tested" with Latino and African American communities only.

"There are conversations about that there is a vaccine that is used as a tool for the government. The government will use this for population control, and this is a great way to get rid of these populations and they want to get rid of the Hispanics, undocumented, and those in poverty are the ones get rid of through this vaccine."

"Is it a vaccine that's going to help us or is it just population control?"

3. Many people rely on digital media for information whether or not the digital information sources are accurate or factual

- People interviewed from the Latinx population believe misinformation also exists on social media. Many don't have other sources for reliable information, so they rely upon social media.
- A circulation of misinformation and opinion rather than fact and research in digital media sources are affecting community trust. Many groups do not see or hear their voice reflected through tailored messaging efforts.
- People from immigrant and refugee communities fear there is too much uncertainty and "bad news" misinformation and not enough trusted tailored community messages getting to their communities. Many are getting their information from Facebook and are influenced by antivaccine forces.

"It is kind of confusing to stay on top of it and find which one is actually reliable and which one is just saying something to make the community feel more at ease."

"A lot of disinformation out there. A lot of work with homeland and community and huge piece has been misinformation and disinformation campaign."

"There is so much uncertainty and there's so much like bad news and not direct message to -- like catered messages to these people, when they go to Facebook and they get their information from there, and a lot of times these people are exposed to these very -- they are very like mellow and moldable, and they just get influenced by other antivaccine forces, because they feel that, okay, this is something that they need to protect themselves and their family, because there's so much unknown about the vaccine."

4. There are a lot of conspiracy theories and misinformation regarding the COVID 19 vaccine and any developments of a vaccine.

- There is general misinformation across all communities, groups, and sectors surveyed and fear that a vaccine may be required or mandated by the federal government, state

government, or even one's place of employment as a contingency for services/employment. This fear is exacerbated for Latinx communities, Asian American and Pacific Islanders (AAPI) communities, and communities of color. (NOTE: No vaccine produced under an Emergency Use Authorization [EUA] can be mandated by federal or state government, but it can be mandated by one's employer.)

- There is a conspiracy theory particularly in the low income and Latinx populations interviewed that the vaccines will contain tracking devices or "microchips" without their knowledge.
- Some groups are hearing misinformation within their religious affiliations that the vaccine is made from aborted baby cells or contains pork products.
- Some pharmacy administrators report that local groups are protesting that pharmacists were adding COVID to the flu vaccine before administering it to people.

"Conspiracy that the vaccines will contain tracking devices."

5. Those who are unable to access timely, accurate information or only see misinformation and disinformation are at risk.

- Lacking enough information about the disease leads to increased risk. For example, the belief that tests were costly caused many people of color to avoid getting tested. Health departments need to share more accurate basic information in languages other than English, including ASL, and provide oral information for non-literate people and those who do not speak a written language. Formats could include the radio, flyers, or providing information at food banks in conjunction with the dispersal of PPE.
- Those without access to computers or technology, such as immigrants and refugees and disabled people living in rural areas, may have an especially difficult time getting accurate, timely information.
- Rural community members reported that local health departments do not post enough information due to real or perceived opposition to the Governor. In addition, politicization has caused the spread of misinformation in rural areas, meaning that some people are in denial about COVID-19 and question its severity.

"Many of the Latino population were listening to the word of their buddies or friends, and that information was not verified by the Department of Health."

Fears about the vaccine: safety, development, efficacy, logistics

1. There are many different concerns and fears about the COVID-19 vaccine.

- People across all communities, groups, and sectors fear that a vaccine may be mandated by the federal government, state government, or even one's place of employment. This fear is made worse for Black communities, Indigenous communities, and communities of color due to a history of medical experimentation.
- There are fears the vaccine will be inaccessible due to the high cost and inadequate supply of the vaccine. Many people are also concerned their community will not be prioritized.
- Distrust of the government and the medical community due to the historical legacy of medical research on Black, Indigenous, and people of color, and people with disabilities is contributing to distrust in the vaccine.
- For many, possible ingredients spark fears of physical or spiritual safety: live virus, fetal cells, pork products.
- Families that are living at the edge of financial ruin and parenting stress talked about their concerns with meeting immediate daily needs such as securing child care and social distancing in risky work situations; their daily concerns overshadow fears about getting the vaccine. For undocumented individuals, there is a fear that ICE might utilize vaccination clinics as a means for capturing non-citizens.

"What type of assurances are there going to be if the vaccine causes harm, illness or death? … not having privilege mean that we aren't going to bounce back the same. Most folks don't have insurance or the resources to cover themselves if they have health issues because of the vaccine. What's the plan for folks if something goes wrong with the vaccine? Who is accountable for it and will help out our community?"

"African American elders should be prioritized. But, it depends on the risk of the vaccines: What are the risks of being prioritized for the vaccine?"

2. Most cited fears clustered around safety and efficacy

- People across all communities and groups have questions and concerns about the safety and efficacy of the vaccine.
- Fears about possible short- and long-term side effects from getting the vaccine were the predominant worry. For healthy people, side-effects were seen as creating an additional risk while for individuals with disabilities and underlying health conditions; vaccines were perceived as potentially making current problems worse.
- Efficacy, durability and reliability all caused respondents to express hesitation and concern.

"I think our community needs more education in regard to COVID vaccine from people from our community, especially about what harms it can have."

3. Concerns about the process of development, the quality/rigor of the science, and the challenges of conquering a mutating virus formed the foundation of many fears.

- There are fears around the speed of development of the vaccine, specifically shortening of clinical trials, including how the vaccine will affect older adults, people with disabilities, pregnant people, children and people of color.
- Long-term questions drive fears about future virus mutations and long-term effects of both the disease and the vaccine that cannot be fully known or understood in this short lifetime of the virus.
- There are questions and concerns around the efficacy of the vaccine due to lack of diversity in vaccine trial participants.
- There are concerns about the reliability of the vaccine trials due to lack of diversity in the clinical trials as well as concerns about the adequacy of the trial period and adverse events during trials.
- Fears about mutation also include fears that the vaccine will not protect those who have already contracted COVID from being re-infected.

"Right now COVID is mostly affecting people of color, do we have enough people of color participating in the trials? The data need to be truthful, I can tweak the data to my favor when I submit the report which is very dangerous."

4. Fears are exacerbated by a perceived lack of transparency, lingering questions and silencing of scientists.

- Communities called for clear safety information to be shared with the public to ease fears. They want to know "the science behind it," from development to distribution. People asked for access to data and explanations of the steps of clinical trials including explanations about adverse events.
- They see DOH as the appropriate messenger to share this scientific information and confirm the integrity of the process.

"I really want to see the science behind it in a way that a non-scientist could understand."

We need "visibility with the results of trials and with a consensus of official scientists that would be recommending it."

Vaccine Prioritization

1. *There is support for prioritizing high-risk workers in health care settings, but we also need to intentionally define a high-risk role or environment.*

- Not all health care environments and settings have the same access to personal protective equipment (PPE), and not all workers within a setting have equitable access to PPE.
- There are other people who work in high-risk health care settings and environments or with high-risk patients, beyond nurses and doctors. Community Health Workers (CHWs) and *promotoras*, doulas, janitorial staff, caregivers, and aides move through these settings too.
- More than 90 percent of all communities and groups who participated in the general feedback survey, interviews, or focus groups - across all language and cultural groups - agreed that high-risk health care workers should receive priority for the COVID-19 vaccine.

"Essential medical personnel need to save the rest of us, and if they get the shot, we will follow their example."

"I think medical people should be given the vaccine first, not just because of their risk, but because seeing doctors and scientists, maybe especially from communities of color, and even those in government getting the vaccine early will hopefully give the general public confidence that it is safe."

2. *Prioritization for key groups including farmworkers, elders, people with disabilities, and communities of color should be stronger.*

- Some groups received strong support for being a higher priority, including farm/agriculture (and H2-A- "guest") workers, people with disabilities, people experiencing homelessness, and elders.
- There is a need to think about the other individuals who surround high risk groups. Many farm/food processing workers are living in multi-generational households. People with disabilities may have caregivers that put them at risk.
- People who are incarcerated may have identities and risk factors that put them in a different phase of priority, such also having a disability or comorbidities. Also, we need to consider the potential of corrections staff getting sick.

- There is a need to think more broadly about "congregate settings." Agricultural workers living in cabins would fall under congregate settings. Individuals with disabilities may also be in congregate living situations.

"There is no real mention of race in this plan. It needs to be called out."

"Farmworkers and essential workers need to be at the top countered with the equity issues of how bodies of color have been used as test subjects in the past."

"Pacific Islanders are top highest infected more than any other group."

3. Many essential services sectors feel left out and under-prioritized.

- Certain groups are very concerned their frontline workers (or highly impacted people) won't be considered in the first round of vaccinations. Many groups expressed feelings of being left out, forgotten, not supported, or not considered.
- Non-profits, service, and volunteer organizations do not feel supported or considered as essential.
- There are critical infrastructure workers in almost every sector that have no alternatives if they get sick, and many could have long-term effects if their work goes undone. Everything from hatchery staff protecting and maintaining our food supply to data and cyber security teams to utility operators to foster care; so many of these workers feel like they haven't been considered essential.
- The hospitality industry has by far the highest number of individuals on unemployment in the state and nationally, and the long-term economic impact on these workers reaches all aspects of their wellness.

"Childcare, custodial, and maintenance workers should be moved up. They keep the community going, clean, safe."

4. There is overall support for the National Academies of Medicine Equitable COVID-19 Allocation Frameworks' principles, criteria, and equity considerations.

- The overwhelming majority of people who participated in all engagement activities including the public feedback survey, interviews, and focus groups—across all language and cultural groups—supported the inclusion of the working principles and criteria. The framework includes recommendations for equitable vaccine allocation.

Motivation to get the vaccine

1. *Vaccination is an essential part to assist in returning to a resemblance of normal.*

- Across many disproportionately affected communities, individuals expressed desperation to return to "normal" as quickly as possible and try to rebuild their lives.
- Many groups are motivated by having the ability to protect themselves and their families.
- People who identify as older adults know people who had polio. But due to vaccination development polio is a disease they do not worry about anymore.

"The sooner the better—the quicker we can get vaccines the quicker we can return to semblances of normal."

"It would help us to go back to normal."

2. *The social emotional and mental health aspects of a vaccine are high motivations for vaccine acceptance.*

- There is a general feeling of hope that having a vaccine to move forward in our daily lives would be appealing to some individuals in all groups.
- Some groups expressed strong support for vaccine acceptance as a way of being able to resume activities and engagement---from children's schooling to older adults' recreating.
- Some groups feel there is a need to resume in person learning, sports, and activities for youth.

"People just don't want to be alone anymore."

"Unemployment, closing of businesses, allowing no social ceremonies, etc. are unbearable."

"I think having a vaccine, will make me hopeful. I don't think it will fix it all but will make things better."

"My kids want to get it so they can go play with their friends."

Communications, Engagement and Outreach Activities

1. *Community engagement needs to start early and be done with trusted members in the community.*

- Community engagement and communication about the vaccine information need to start in the beginning before vaccination begins to ensure people are prepared to receive the vaccine.
- Working with people in the community who are trusted by community members is necessary. Community and religious leaders, social service and health providers, community health workers, and community organizations can effectively communicate and disseminate vaccine information. Communities see labor associations and industry leaders as viable spokespeople within farm worker, food/seafood processing and hospitality industries.
- Hiring people from the community is necessary for building trust and ensuring communication is linguistically and culturally responsive. Hiring Department of Health staff members that represent the community as well as increasing funding and pay for community health workers are important.

"The biggest part is to lay the groundwork, the infrastructure, information campaign about it that has enough lead time so people can plan for it."
"Locally things always get around by word of mouth, having trusted people in the community who can deliver this message that this vaccine is safe is going to be critical."

2. *People want culturally and linguistically appropriate information.*

- People across all communities, groups and sectors want comprehensive, easy to understand, culturally and linguistically appropriate information about the effectiveness, safety and side effects of the vaccine. This includes how the vaccine works, the ingredients it contains, how long it will work in the body and long-term effects.

"I really want to see the science behind it in a way that a non-scientist could understand. What is the way it was developed, transparent honesty around known risk factors. It might be helpful for the community to have a side-by-side conversation about risk factors: getting COVID versus the vaccine."

3. Communities trust people and organizations that look like them and have a reputation of community care.

- People across most communities, groups and sectors expressed distrust in government and the current administration. Incarcerated communities and communities with disabilities have a deep distrust of government and the current administration.
- Historical trauma, racism and discrimination impact who Immigrant/refugee communities, Indigenous communities and communities of color trust. Representation and community reputation were huge factors in who these communities trust.
- People across most communities, groups and sectors expressed a level of trust with known doctors, nurses, medical providers, pharmacists, and veterinarians.

"People looking like us, speaking our language in YouTube videos: …show faces that look like our faces, … to give the message to the community."

4. Communities also rely on public leaders, scientists and institutions when they speak directly, clearly, and apolitically.

- Known local health jurisdiction leaders and public health officers were cited as being credible, as were representatives of the state DOH, Governor Inslee, CDC, established scientific community, and specifically Dr. Anthony Fauci. Trust in these public leaders was not universal, but there are certainly individuals across the sample who saw these public leaders and institutions as respectable and trustworthy.
- Celebrities and former well-loved leaders such as Russell Wilson, Kamala Harris, the Obamas and professional athletes were cited as being potentially compelling spokespeople

5. Consider access needs and formats for all COVID-19 communications.

- People identified a need for thoughtful planning to ensure all COVID-19 communications are accessible to all people including those with sensory/cognitive impairments.
- Information and education should also be shared orally for communities with lower written literacy.
- Rural communities may not have reliable internet; web-based communications and vaccine appointment reservations will not be accessible for all.
- The best ways to convey accurate cost information to communities is through community leaders and town halls.

- People need information that is over the phone or online to be accessible across various languages or technology capacity.
- Communication on how to reserve vaccine appointments must be translated and disseminated through creative networks. Reserving appointments should not be reliant on technology.

6. Ensure all public health, healthcare, and vaccine providers have the same communications resources.

- Local Health Jurisdictions, hospitals, community health centers, medical and dental associations, pharmacists, health care providers, and vaccine administrators need key messages about the vaccine before distribution so they can answer all questions from community members.
- Increased communication and coordination between local and state entities could reduce administration burdens for clinics.
- Border communities have unique needs and will require strategic coordination between states.

"Anticipate people trying to cross borders to get vaccine. Coordinate deployment with border states."

7. Communication efforts should focus on transparency and building trust as a central goal.

- People received unexpected bills for COVID-19 tests. All COVID-19 cost information needs to be clearly and accurately shared. There needs to be clear messaging and communications about cost and how to pay.
- Partnering with organizations and leaders who hold trusted relationships with communities is the most effective way to ensure communities have access to information about where and when to get the vaccine.

"Partner with CBOs (Community Based Organizations) to educate and distribute."

"Pay community leaders for their time and role in assisting with vaccine clinics."

Equitable Distribution

1. *Need to proactively address common health care access barriers experienced regularly by vulnerable communities; same barriers will impact vaccine access.*

- People identified cost as a barrier to receiving the vaccine, especially for low-income people, service workers, community-based volunteers, and people on fixed incomes.
- Anticipated barriers to the vaccine include citizenship status, and no primary care provider or health care home.
- There are concerns about health insurance status impacting access to vaccines, especially for people without health insurance, people on Medicaid, and retired people on Medicare.
- If multiple vaccines are approved, there is confusion about whether they would also have differing costs.
- People with restrictive work schedules may face time barriers to accessing the vaccine, and people recommended alternative and accessible options including walk up, drive up, on demand, with and without appointment, outside business hours vaccine clinics, and workplace vaccine clinics.
- People with limited transportation and mobility issues will have barriers to accessing drive-through vaccine clinics. Look for options to provide transportation or alternative options.

  "I think the folks who have insurance and who have insurance that allows them to visit doctors regularly are the ones that are more likely to get vaccinated and have their families vaccinated, but disproportionately, that's not us."

  "Our concern is that there will be a push to distribute to the urban areas of Western WA initially. However, the east side of the State has a high proportion of essential workers as well as socioeconomically disadvantaged citizens."

  "Everyone should be able to get it and everyone should be able to afford it."

  "Our tax dollars are going to development so the vax should be free."

2. *Two dose series and refrigeration requirements may create challenges for serving some communities.*

- Among agricultural and food processing workers, a two-dose series works for packing house workers and domestic farmworkers. A two-dose series may be challenging for migrant farmworkers, field farmworkers, and aquaculture crews. This is particularly true for families that move across state borders following the crops.

- Some potential vaccine sites already struggle with follow-up compliance and a two-step vaccine will be challenging. Small hospitals don't have as good of tracking and database capacity that large hospitals have.
- Large jails and correctional facilities are well set up to follow current protocols around the flu and HEP vaccine. Smaller jails will need support from Local Health Departments.
- Rural hospitals have storage constraints, which may pose barriers.
- Some rural health departments will need much more support from the Department of Health to do adequate distribution.

3. *Set up vaccine clinics in places that are safe, familiar, and accessible.*

- Place-based vaccine clinic site recommendations include schools, colleges, senior centers, shelters, long term care facilities, health care facilities and offices, public health clinics, and local health department locations. Community pharmacies are considered to have good reach within communities but face their own challenges with tracking.
- Recommended point in time vaccine events included mobile "pop up" clinics, medical vans, and drive-up sites. Communities named school parking lots as a convenient, familiar, and easy to access location. There were recommendations to provide as many community sites as possible for people with transportation problems, and to distribute in places that feel safe and familiar.
- Flu shot clinics have been effective in urban and rural sites, which provides a good model to replicate.
- Other recommended locations include: libraries, community/neighborhood centers, religious sites, and stores. Mobile van options were also recommended. Specific private sector recommendations included Walgreens, Costco, local banks, shopping malls, and airports.
- Participants recommended focusing on a community hub and ensuring community outreach and the presence of culturally congruent community members on site for education.
- Participants expressed the need to ensure that all those distributing stick to the prioritization plan until a vaccine is universally available.
- Among potential vaccine sites, different sites may be more or less effective at serving certain communities. Medical offices have been perceived as dangerous by some during the pandemic and pharmacies may not reach many in the Black community.

Survey Findings: Public Feedback Opportunity. How Should Washington State Prioritize The COVID-19 Vaccine?

The Department of Health provided a public feedback opportunity using a web-based survey. This survey was conducted in October 2020 to understand how people are feeling about the COVID-19 vaccine and perspectives on who should get priority for the vaccine. This survey was provided in multiple languages and disseminated through existing partner channels, DOH listservs, the DOH website, and social media accounts.

Our in-language surveys vary a bit in terms of response. We included all in-language surveys that had at least 10 respondents in our analysis. We are using these survey results to supplement what we learn through the qualitative, focused engagement efforts with these respective communities.

The English survey results are further disaggregated based on whether the respondent answered "yes" to specific questions related to occupation or personal risk factors. All survey questions were optional and some respondents skipped occasional questions. The results show the percent of respondents who answered each question a certain way, and may not always add up to 100%. Results were rounded up or down to the nearest whole percent, except for the question 2 about geographical locations.

Survey Analysis Overview		
	# of respondents	percent
English (all)	17,678	100%
Health care (high risk)	4521	33%
Health care (low risk)	2955	21%
Essential business (high risk)	545	4%
Essential business (low risk)	913	7%
First responder (high risk)	209	2%
First responder (low risk)	95	1%
Teacher or school staff	845	6%
Early learning or day care provider	526	4%
Higher risk because of race/ethnicity	871	6%
Higher risk because of disability status	716	5%
Higher risk because overall health or age	4802	35%
Spanish (all)	70	100%
Russian (all)	29	100%
Ukrainian (all)	12	100%
Simplified Chinese (all)	36	100%
Traditional Chinese (all)	160	100%
Vietnamese (all)	36	100%

Q1. Do you live in Washington state? Yes/No to continue to take survey.

Q2. What county do you live in?		
County	**Percent**	**Number**
Adams	0.2%	35
Asotin	0.2%	36
Benton	3.32%	587
Chelan	2.11%	373
Clallam	1.02%	180
Clark	6.53%	1154
Columbia	0.1%	18
Cowlitz	2.05%	362
Douglas	0.97%	172
Ferry	0.07%	12
Franklin	1.09%	193
Garfield	0.05%	8
Grant	1.01%	178
Grays Harbor	1.17%	207
Island	1.36%	241
Jefferson	0.49%	86
King	30.98%	5477
Kitsap	3.16%	558
Kittitas	0.74%	131
Klickitat	0.41%	72
Lewis	0.74%	131
Lincoln	0.1%	18
Mason	1.04%	184
Okanogan	0.75%	133
Pacific	0.23%	41
Pend Oreille	0.14%	25
Pierce	10.2%	1804
San Juan	0.26%	46
Skagit	1.43%	252
Skamania	0.1%	18
Snohomish	8.99%	1589
Spokane	5.93%	1048
Stevens	0.46%	82
Thurston	5.36%	947
Wahkiakum	0.05%	9
Walla Walla	0.71%	126
Whatcom	3.88%	686
Whitman	0.41%	73
Yakima	2.18%	386

Q3. How worried are you about getting COVID-19?					
	Very worried	Worried	Neutral	Not worried	Not at all worried
English (all)	16%	43%	21%	12%	9%
Health care (high risk)	19%	47%	21%	9%	4%
Health care (low risk)	9%	38%	24%	16%	13%
Essential business (high risk)	25%	48%	18%	6%	4%
Essential business (low risk)	13%	40%	21%	15%	11%
First responder (high risk)	15%	39%	27%	10%	9%
First responder (low risk)	8%	24%	25%	25%	17%
Teacher or school staff	18%	50%	18%	9%	5%
Early learning or day care provider	19%	39%	22%	11%	8%
Higher risk because of race/ethnicity	34%	42%	13%	6%	5%
Higher risk because of disability status	38%	41%	12%	6%	4%
Higher risk because overall health or age	27%	52%	14%	5%	2%
Spanish (all)	58%	33%	8%	0%	2%
Russian (all)	37%	44%	7%	7%	4%
Ukrainian (all)	27%	27%	9%	27%	9%
Simplified Chinese (all)	64%	27%	6%	3%	0%
Traditional Chinese (all)	57%	29%	10%	3%	1%
Vietnamese (all)	73%	24%	3%	0%	0%

Q4. How bad is being sick with COVID-19?					
	Very Bad	Bad	Neutral	Not bad	Not bad at all
English (all)	35%	39%	18%	5%	2%
Health care (high risk)	38%	43%	15%	3%	1%
Health care (low risk)	26%	42%	22%	7%	3%
Essential business (high risk)	47%	37%	14%	1%	1%
Essential business (low risk)	35%	35%	22%	5%	2%
First responder (high risk)	28%	39%	25%	7%	1%
First responder (low risk)	15%	38%	29%	12%	6%
Teacher or school staff	38%	42%	15%	3%	2%
Early learning or day care provider	37%	35%	23%	3%	2%
Higher risk because of race/ethnicity	57%	31%	9%	2%	2%
Higher risk because of disability status	58%	31%	8%	2%	1%
Higher risk because overall health or age	54%	35%	9%	1%	0%
Spanish (all)	68%	32%	0%	0%	0%
Russian (all)	67%	19%	7%	4%	4%
Ukrainian (all)	42%	42%	0%	8%	8%
Simplified Chinese (all)	64%	36%	21%	6%	3%
Traditional Chinese (all)	73%	33%	3%	0%	0%
Vietnamese (all)	76%	24%	0%	0%	0%

Q5. How much would the COVID-19 vaccine protect you and your family from COVID-19 disease?					
	Extremely	Very	Moderately	Slightly	Not at all
English (all)	20%	32%	26%	10%	12%
Health care (high risk)	26%	35%	26%	8%	5%
Health care (low risk)	13%	28%	29%	14%	17%
Essential business (high risk)	29%	36%	23%	6%	6%
Essential business (low risk)	17%	33%	25%	12%	13%
First responder (high risk)	23%	40%	23%	5%	8%
First responder (low risk)	9%	20%	26%	22%	22%
Teacher or school staff	20%	38%	25%	9%	8%
Early learning or day care provider	23%	28%	25%	11%	13%
Higher risk because of race/ethnicity	35%	35%	17%	6%	7%
Higher risk because of disability status	34%	32%	19%	7%	8%
Higher risk because overall health or age	27%	40%	25%	5%	4%
Spanish (all)	49%	34%	11%	3%	3%
Russian (all)	0%	56%	24%	8%	12%
Ukrainian (all)	8%	25%	8%	33%	25%
Simplified Chinese (all)	33%	36%	21%	6%	3%
Traditional Chinese (all)	30%	46%	23%	1%	0%
Vietnamese (all)	41%	50%	9%	0%	0%

Q6. Do most people in your life get vaccinated?					
	Almost always	Often	Sometimes	Seldom	Never
English (all)	64%	18%	11%	5%	2%
Health care (high risk)	72%	18%	8%	2%	1%
Health care (low risk)	59%	17%	12%	7%	4%
Essential business (high risk)	61%	22%	13%	3%	2%
Essential business (low risk)	57%	19%	14%	7%	2%
First responder (high risk)	70%	21%	5%	2%	2%
First responder (low risk)	49%	21%	15%	12%	3%
Teacher or school staff	70%	18%	9%	2%	1%
Early learning or day care provider	66%	17%	9%	6%	2%
Higher risk because of race/ethnicity	70%	17%	10%	2%	2%
Higher risk because of disability status	71%	14%	10%	3%	2%
Higher risk because overall health or age	75%	16%	7%	2%	1%
Spanish (all)	57%	20%	17%	5%	2%
Russian (all)	30%	26%	30%	15%	0%
Ukrainian (all)	17%	33%	25%	8%	17%
Simplified Chinese (all)	39%	36%	6%	12%	6%
Traditional Chinese (all)	54%	29%	14%	2%	1%
Vietnamese (all)	34%	34%	25%	3%	3%

Q7. Do you think you will get the COVID-19 vaccine?					
	Definitely will	Probably will	Not sure	Probably won't	Definitely won't
English (all)	40%	21%	16%	8%	15%
Health care (high risk)	48%	23%	15%	6%	8%
Health care (low risk)	34%	20%	16%	10%	20%
Essential business (high risk)	44%	24%	19%	7%	7%
Essential business (low risk)	36%	24%	13%	8%	18%
First responder (high risk)	48%	23%	14%	7%	8%
First responder (low risk)	28%	13%	12%	21%	26%
Teacher or school staff	44%	22%	17%	7%	10%
Early learning or day care provider	36%	19%	20%	9%	16%
Higher risk because of race/ethnicity	45%	21%	21%	6%	8%
Higher risk because of disability status	48%	21%	17%	5%	9%
Higher risk because overall health or age	53%	22%	16%	4%	5%
Spanish (all)	38%	45%	17%	0%	0%
Russian (all)	30%	33%	11%	15%	11%
Ukrainian (all)	8%	17%	50%	0%	25%
Simplified Chinese (all)	70%	12%	15%	3%	0%
Traditional Chinese (all)	62%	20%	16%	1%	0%
Vietnamese (all)	67%	18%	15%	0%	0%

Q8. Do you have any fears about the COVID-19 vaccine?					
	A large amount	Many	Some	A few	None
English (all)	19%	17%	32%	21%	10%
Health care (high risk)	15%	17%	34%	23%	12%
Health care (low risk)	22%	19%	30%	20%	10%
Essential business (high risk)	18%	18%	35%	19%	11%
Essential business (low risk)	18%	15%	34%	21%	12%
First responder (high risk)	14%	15%	33%	25%	12%
First responder (low risk)	24%	14%	35%	16%	12%
Teacher or school staff	16%	18%	34%	26%	7%
Early learning or day care provider	22%	18%	33%	18%	10%
Higher risk because of race/ethnicity	23%	20%	32%	17%	9%
Higher risk because of disability status	23%	17%	31%	21%	9%
Higher risk because overall health or age	13%	16%	36%	24%	11%
Spanish (all)	22%	18%	37%	12%	11%
Russian (all)	26%	15%	30%	30%	0%
Ukrainian (all)	25%	42%	17%	8%	8%
Simplified Chinese (all)	18%	21%	42%	15%	3%
Traditional Chinese (all)	5%	23%	52%	16%	5%
Vietnamese (all)	21%	9%	27%	30%	12%

Q9. If you get the COVID-19 vaccine, where would you prefer to get it?									
	Primary care provided	Hospital	Pharmacy	Workplace	Mobile clinic	At home	I don't have a preference	I don't want the COVID-19 vaccine	Other
English (all)	27%	2%	12%	9%	2%	1%	29%	17%	2%
Health care (high risk)	24%	3%	12%	16%	2%	1%	32%	9%	2%
Health care (low risk)	21%	1%	9%	11%	3%	1%	29%	23%	2%
Essential business (high risk)	34%	2%	12%	6%	3%	2%	30%	8%	2%
Essential business (low risk)	28%	1%	12%	4%	3%	1%	29%	20%	3%
First responder (high risk)	20%	0%	7%	20%	2%	0%	36%	11%	3%
First responder (low risk)	11%	0%	11%	8%	1%	0%	32%	38%	0%
Teacher or school staff	33%	1%	12%	5%	3%	0%	31%	13%	3%
Early learning or day care provider	38%	1%	9%	2%	1%	1%	26%	19%	3%
Higher risk because of race/ethnicity	36%	4%	9%	9%	4%	1%	26%	8%	3%
Higher risk because of disability status	39%	2%	12%	6%	2%	2%	24%	9%	4%
Higher risk because overall health or age	33%	2%	16%	7%	3%	1%	30%	5%	3%
Spanish (all)	47%	8%	5%	0%	5%	2%	23%	9%	2%
Russian (all)	22%	22%	15%	0%	0%	0%	19%	22%	0%
Ukrainian (all)	25%	8%	8%	0%	8%	0%	8%	42%	0%
Simplified Chinese (all)	3%	18%	42%	9%	0%	0%	27%	0%	0%
Traditional Chinese (all)	8%	27%	27%	3%	5%	5%	20%	3%	1%
Vietnamese (all)	27%	27%	27%	9%	0%	3%	6%	0%	0%

Q10. How much do you agree with the principle: Maximization of social benefits?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	57%	26%	11%	3%	3%
Health care (high risk)	63%	27%	8%	1%	1%
Health care (low risk)	53%	26%	13%	4%	5%
Essential business (high risk)	59%	29%	9%	2%	1%
Essential business (low risk)	55%	25%	11%	4%	5%
First responder (high risk)	49%	35%	13%	2%	1%
First responder (low risk)	36%	26%	21%	11%	6%
Teacher or school staff	58%	29%	9%	2%	3%
Early learning or day care provider	50%	29%	14%	3%	3%
Higher risk because of race/ethnicity	61%	27%	9%	2%	2%
Higher risk because of disability status	56%	26%	12%	3%	4%
Higher risk because overall health or age	63%	27%	7%	1%	1%
Spanish (all)	61%	33%	4%	2%	0%
Russian (all)	18%	50%	14%	9%	9%
Ukrainian (all)	22%	22%	33%	11%	11%
Simplified Chinese (all)	52%	38%	7%	3%	0%
Traditional Chinese (all)	50%	45%	5%	0%	0%
Vietnamese (all)	60%	35%	5%	0%	0%

Q11. How much do you agree with the principle: Equal concern?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	53%	27%	14%	4%	3%
Health care (high risk)	54%	27%	12%	4%	2%
Health care (low risk)	51%	26%	16%	5%	3%
Essential business (high risk)	59%	25%	11%	3%	2%
Essential business (low risk)	50%	25%	14%	6%	4%
First responder (high risk)	43%	31%	17%	4%	4%
First responder (low risk)	33%	27%	26%	8%	5%
Teacher or school staff	53%	30%	11%	4%	2%
Early learning or day care provider	50%	30%	14%	4%	2%
Higher risk because of race/ethnicity	55%	29%	10%	3%	4%
Higher risk because of disability status	53%	27%	12%	4%	3%
Higher risk because overall health or age	57%	27%	10%	4%	2%
Spanish (all)	59%	29%	6%	2%	4%
Russian (all)	27%	36%	14%	18%	5%
Ukrainian (all)	78%	11%	11%	0%	0%
Simplified Chinese (all)	38%	41%	21%	0%	0%
Traditional Chinese (all)	46%	43%	9%	1%	1%
Vietnamese (all)	71%	24%	5%	0%	0%

Q12. How much do you agree with the principle: Mitigation of health inequities?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	56%	26%	14%	3%	2%
Health care (high risk)	56%	28%	12%	2%	2%
Health care (low risk)	55%	24%	15%	3%	4%
Essential business (high risk)	60%	26%	10%	3%	1%
Essential business (low risk)	58%	23%	13%	4%	3%
First responder (high risk)	39%	36%	20%	3%	2%
First responder (low risk)	41%	24%	22%	7%	5%
Teacher or school staff	58%	30%	10%	2%	1%
Early learning or day care provider	55%	27%	16%	2%	1%
Higher risk because of race/ethnicity	61%	25%	10%	2%	3%
Higher risk because of disability status	59%	24%	12%	2%	3%
Higher risk because overall health or age	60%	26%	10%	2%	1%
Spanish (all)	57%	35%	6%	2%	0%
Russian (all)	32%	45%	9%	9%	5%
Ukrainian (all)	44%	33%	11%	0%	11%
Simplified Chinese (all)	41%	34%	17%	7%	0%
Traditional Chinese (all)	54%	34%	11%	1%	1%
Vietnamese (all)	60%	35%	5%	0%	0%

Q13. How much do you agree with the principle: Fairness?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	56%	27%	13%	2%	2%
Health care (high risk)	57%	28%	12%	2%	1%
Health care (low risk)	54%	27%	15%	2%	2%
Essential business (high risk)	60%	28%	10%	2%	1%
Essential business (low risk)	53%	27%	13%	3%	3%
First responder (high risk)	46%	33%	17%	2%	1%
First responder (low risk)	39%	23%	28%	4%	5%
Teacher or school staff	55%	31%	10%	2%	1%
Early learning or day care provider	54%	29%	14%	2%	1%
Higher risk because of race/ethnicity	59%	27%	11%	2%	2%
Higher risk because of disability status	54%	27%	14%	2%	2%
Higher risk because overall health or age	61%	27%	9%	2%	1%
Spanish (all)	67%	27%	6%	0%	0%
Russian (all)	27%	59%	9%	0%	5%
Ukrainian (all)	56%	22%	22%	0%	0%
Simplified Chinese (all)	41%	41%	14%	3%	0%
Traditional Chinese (all)	55%	35%	11%	0%	0%
Vietnamese (all)	60%	35%	5%	0%	0%

Q14. How much do you agree with the principle: Evidence-based?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	72%	18%	7%	1%	2%
Health care (high risk)	78%	16%	5%	0%	1%
Health care (low risk)	70%	18%	8%	2%	2%
Essential business (high risk)	70%	21%	7%	1%	1%
Essential business (low risk)	70%	18%	8%	2%	2%
First responder (high risk)	64%	24%	10%	1%	0%
First responder (low risk)	51%	23%	16%	4%	6%
Teacher or school staff	73%	20%	5%	1%	1%
Early learning or day care provider	61%	24%	11%	1%	2%
Higher risk because of race/ethnicity	73%	19%	6%	1%	2%
Higher risk because of disability status	69%	19%	8%	1%	3%
Higher risk because overall health or age	78%	17%	4%	1%	1%
Spanish (all)	67%	27%	6%	0%	0%
Russian (all)	59%	32%	5%	5%	0%
Ukrainian (all)	67%	22%	11%	0%	0%
Simplified Chinese (all)	52%	34%	10%	3%	0%
Traditional Chinese (all)	54%	37%	9%	0%	0%
Vietnamese (all)	45%	40%	15%	0%	0%

Q15. How much do you agree with the principle: Transparency?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	72%	19%	7%	1%	1%
Health care (high risk)	74%	19%	6%	1%	1%
Health care (low risk)	71%	18%	8%	1%	2%
Essential business (high risk)	74%	17%	8%	1%	1%
Essential business (low risk)	72%	20%	6%	1%	2%
First responder (high risk)	66%	24%	8%	1%	0%
First responder (low risk)	50%	30%	14%	3%	3%
Teacher or school staff	72%	20%	5%	1%	1%
Early learning or day care provider	63%	24%	11%	1%	1%
Higher risk because of race/ethnicity	75%	18%	6%	0%	1%
Higher risk because of disability status	70%	19%	8%	1%	2%
Higher risk because overall health or age	76%	18%	5%	0%	1%
Spanish (all)	76%	20%	4%	0%	0%
Russian (all)	64%	36%	0%	0%	0%
Ukrainian (all)	67%	22%	11%	0%	0%
Simplified Chinese (all)	69%	24%	7%	0%	0%
Traditional Chinese (all)	66%	31%	3%	0%	0%
Vietnamese (all)	68%	32%	0%	0%	0%

Q16. How much do you agree with the consideration: Risk of acquiring infections?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	65%	23%	8%	2%	2%
Health care (high risk)	72%	21%	5%	1%	1%
Health care (low risk)	58%	25%	11%	3%	3%
Essential business (high risk)	66%	25%	7%	1%	1%
Essential business (low risk)	63%	24%	9%	2%	3%
First responder (high risk)	65%	27%	6%	1%	0%
First responder (low risk)	43%	32%	15%	4%	6%
Teacher or school staff	66%	24%	7%	1%	1%
Early learning or day care provider	61%	26%	10%	2%	2%
Higher risk because of race/ethnicity	67%	24%	6%	2%	1%
Higher risk because of disability status	66%	23%	8%	1%	2%
Higher risk because overall health or age	73%	21%	4%	1%	1%
Spanish (all)	65%	31%	4%	0%	0%
Russian (all)	41%	45%	9%	5%	0%
Ukrainian (all)	56%	44%	0%	0%	0%
Simplified Chinese (all)	59%	38%	3%	0%	0%
Traditional Chinese (all)	70%	27%	2%	0%	1%
Vietnamese (all)	71%	24%	5%	0%	0%

Q17. How much do you agree with the consideration: Risk of severe morbidity and mortality?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	67%	23%	7%	1%	2%
Health care (high risk)	71%	22%	5%	1%	1%
Health care (low risk)	65%	23%	8%	2%	2%
Essential business (high risk)	64%	26%	7%	1%	2%
Essential business (low risk)	67%	22%	7%	2%	3%
First responder (high risk)	60%	30%	7%	2%	0%
First responder (low risk)	46%	35%	13%	2%	4%
Teacher or school staff	70%	21%	7%	1%	1%
Early learning or day care provider	64%	25%	8%	2%	2%
Higher risk because of race/ethnicity	69%	22%	6%	1%	2%
Higher risk because of disability status	69%	21%	7%	1%	2%
Higher risk because overall health or age	74%	21%	4%	1%	1%
Spanish (all)	63%	31%	6%	0%	0%
Russian (all)	52%	38%	5%	5%	0%
Ukrainian (all)	44%	33%	0%	22%	0%
Simplified Chinese (all)	66%	31%	3%	0%	0%
Traditional Chinese (all)	60%	35%	3%	2%	0%
Vietnamese (all)	57%	43%	0%	0%	0%

Q18. How much do you agree with the consideration: Risk of negative societal impact?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	38%	29%	22%	7%	4%
Health care (high risk)	41%	30%	21%	6%	2%
Health care (low risk)	33%	30%	24%	9%	5%
Essential business (high risk)	41%	28%	21%	5%	5%
Essential business (low risk)	38%	25%	22%	8%	7%
First responder (high risk)	32%	38%	21%	4%	4%
First responder (low risk)	24%	26%	26%	17%	7%
Teacher or school staff	39%	33%	20%	6%	2%
Early learning or day care provider	38%	28%	24%	5%	4%
Higher risk because of race/ethnicity	43%	29%	19%	6%	3%
Higher risk because of disability status	41%	30%	21%	4%	5%
Higher risk because overall health or age	43%	32%	18%	5%	2%
Spanish (all)	65%	27%	8%	0%	0%
Russian (all)	19%	48%	10%	14%	10%
Ukrainian (all)	22%	33%	22%	22%	0%
Simplified Chinese (all)	38%	34%	28%	0%	0%
Traditional Chinese (all)	38%	40%	13%	6%	3%
Vietnamese (all)	53%	42%	5%	0%	0%

Q19. How much do you agree with the consideration: Risk of transmitting disease to others?					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
English (all)	52%	27%	14%	4%	3%
Health care (high risk)	58%	27%	11%	2%	1%
Health care (low risk)	45%	28%	17%	6%	5%
Essential business (high risk)	58%	26%	11%	2%	2%
Essential business (low risk)	50%	26%	15%	5%	5%
First responder (high risk)	45%	37%	13%	2%	3%
First responder (low risk)	34%	31%	16%	9%	11%
Teacher or school staff	52%	31%	12%	3%	2%
Early learning or day care provider	51%	27%	15%	4%	3%
Higher risk because of race/ethnicity	59%	27%	9%	3%	2%
Higher risk because of disability status	57%	26%	13%	3%	2%
Higher risk because overall health or age	60%	28%	10%	2%	1%
Spanish (all)	73%	24%	4%	0%	0%
Russian (all)	36%	50%	9%	5%	0%
Ukrainian (all)	22%	44%	22%	11%	0%
Simplified Chinese (all)	48%	48%	3%	0%	0%
Traditional Chinese (all)	62%	33%	4%	2%	0%
Vietnamese (all)	50%	50%	0%	0%	0%

Q20. How much do you agree with how this group is organized: High-risk health workers?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	20%	76%	4%
Health care (high risk)	26%	72%	2%
Health care (low risk)	12%	79%	9%
Essential business (high risk)	26%	72%	2%
Essential business (low risk)	15%	81%	4%
First responder (high risk)	22%	75%	2%
First responder (low risk)	10%	84%	6%
Teacher or school staff	16%	81%	3%
Early learning or day care provider	20%	78%	2%
Higher risk because of race/ethnicity	36%	60%	4%
Higher risk because of disability status	36%	61%	3%
Higher risk because overall health or age	26%	72%	2%
Spanish (all)	63%	35%	2%
Russian (all)	0%	91%	9%
Ukrainian (all)	63%	38%	0%
Simplified Chinese (all)	72%	28%	0%
Traditional Chinese (all)	55%	45%	0%
Vietnamese (all)	50%	50%	0%

Q21. How much do you agree with how this group is organized: High-risk first responders?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	19%	76%	4%
Health care (high risk)	25%	73%	2%
Health care (low risk)	13%	79%	8%
Essential business (high risk)	24%	73%	3%
Essential business (low risk)	14%	82%	4%
First responder (high risk)	28%	69%	3%
First responder (low risk)	11%	71%	18%
Teacher or school staff	15%	81%	4%
Early learning or day care provider	19%	79%	2%
Higher risk because of race/ethnicity	35%	61%	4%
Higher risk because of disability status	33%	64%	3%
Higher risk because overall health or age	25%	73%	2%
Spanish (all)	60%	40%	0%
Russian (all)	0%	91%	9%
Ukrainian (all)	38%	63%	0%
Simplified Chinese (all)	66%	31%	3%
Traditional Chinese (all)	54%	46%	0%
Vietnamese (all)	45%	55%	0%

Q22. How much do you agree with how this group is organized: People with underlying conditions that put them at significantly risk?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	18%	77%	5%
Health care (high risk)	20%	76%	3%
Health care (low risk)	16%	78%	6%
Essential business (high risk)	26%	70%	5%
Essential business (low risk)	14%	80%	6%
First responder (high risk)	16%	78%	6%
First responder (low risk)	18%	74%	8%
Teacher or school staff	15%	80%	5%
Early learning or day care provider	18%	78%	5%
Higher risk because of race/ethnicity	33%	63%	4%
Higher risk because of disability status	36%	60%	4%
Higher risk because overall health or age	21%	75%	4%
Spanish (all)	57%	41%	2%
Russian (all)	0 %	90%	10%
Ukrainian (all)	13%	75%	13%
Simplified Chinese (all)	52%	45%	3%
Traditional Chinese (all)	40%	58%	3%
Vietnamese (all)	45%	55%	0%

Q23. How much do you agree with how this group is organized: Older adults living in congregate and overcrowded settings?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	21%	73%	6%
Health care (high risk)	24%	72%	4%
Health care (low risk)	21%	73%	6%
Essential business (high risk)	28%	68%	4%
Essential business (low risk)	18%	75%	7%
First responder (high risk)	17%	77%	6%
First responder (low risk)	24%	67%	10%
Teacher or school staff	15%	78%	6%
Early learning or day care provider	20%	74%	6%
Higher risk because of race/ethnicity	33%	61%	5%
Higher risk because of disability status	33%	61%	5%
Higher risk because overall health or age	24%	72%	4%
Spanish (all)	61%	37%	2%
Russian (all)	9%	77%	14%
Ukrainian (all)	38%	50%	13%
Simplified Chinese (all)	41%	52%	7%
Traditional Chinese (all)	48%	48%	4%
Vietnamese (all)	48%	52%	0%

Q24. How much do you agree with how this group is organized: K-12 teachers and staff and child care workers?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	26%	63%	10%
Health care (high risk)	26%	66%	8%
Health care (low risk)	22%	63%	15%
Essential business (high risk)	32%	61%	7%
Essential business (low risk)	24%	64%	13%
First responder (high risk)	22%	71%	7%
First responder (low risk)	19%	59%	22%
Teacher or school staff	33%	59%	8%
Early learning or day care provider	41%	50%	9%
Higher risk because of race/ethnicity	36%	54%	10%
Higher risk because of disability status	33%	57%	10%
Higher risk because overall health or age	30%	63%	7%
Spanish (all)	51%	43%	6%
Russian (all)	23%	59%	18%
Ukrainian (all)	13%	75%	13%
Simplified Chinese (all)	48%	38%	14%
Traditional Chinese (all)	49%	50%	2%
Vietnamese (all)	24%	71%	5%

Q25. How much do you agree with how this group is organized: Critical workers in high risk settings (example: people at high risk for exposure)?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	29%	67%	4%
Health care (high risk)	35%	64%	1%
Health care (low risk)	24%	69%	7%
Essential business (high risk)	42%	55%	3%
Essential business (low risk)	22%	72%	5%
First responder (high risk)	20%	76%	3%
First responder (low risk)	20%	73%	6%
Teacher or school staff	26%	71%	3%
Early learning or day care provider	26%	71%	4%
Higher risk because of race/ethnicity	45%	52%	3%
Higher risk because of disability status	42%	54%	3%
Higher risk because overall health or age	35%	63%	2%
Spanish (all)	63%	35%	2%
Russian (all)	27%	64%	9%
Ukrainian (all)	13%	63%	25%
Simplified Chinese (all)	62%	31%	7%
Traditional Chinese (all)	50%	49%	1%
Vietnamese (all)	48%	52%	0%

Q26. How much do you agree with how this group is organized: People with underlying conditions that put them at moderately higher risk?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	13%	79%	7%
Health care (high risk)	14%	80%	5%
Health care (low risk)	11%	80%	9%
Essential business (high risk)	23%	71%	6%
Essential business (low risk)	10%	81%	9%
First responder (high risk)	10%	86%	5%
First responder (low risk)	11%	77%	12%
Teacher or school staff	12%	82%	6%
Early learning or day care provider	15%	79%	6%
Higher risk because of race/ethnicity	27%	68%	5%
Higher risk because of disability status	30%	66%	5%
Higher risk because overall health or age	17%	78%	5%
Spanish (all)	43%	51%	6%
Russian (all)	9%	77%	14%
Ukrainian (all)	13%	63%	25%
Simplified Chinese (all)	41%	48%	10%
Traditional Chinese (all)	36%	60%	3%
Vietnamese (all)	33%	67%	0%

Q27. How much do you agree with how this group is organized: People in homeless shelters or group homes for individuals with disabilities?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	19%	70%	11%
Health care (high risk)	18%	71%	11%
Health care (low risk)	20%	68%	12%
Essential business (high risk)	25%	65%	10%
Essential business (low risk)	18%	71%	11%
First responder (high risk)	11%	73%	16%
First responder (low risk)	16%	61%	23%
Teacher or school staff	18%	72%	10%
Early learning or day care provider	21%	71%	8%
Higher risk because of race/ethnicity	30%	60%	10%
Higher risk because of disability status	28%	61%	11%
Higher risk because overall health or age	20%	71%	9%
Spanish (all)	51%	43%	6%
Russian (all)	0%	82%	18%
Ukrainian (all)	13%	38%	50%
Simplified Chinese (all)	17%	55%	28%
Traditional Chinese (all)	25%	58%	17%
Vietnamese (all)	24%	67%	10%

Q28. How much do you agree with how this group is organized: People in prisons, jails, detention centers?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	14%	62%	24%
Health care (high risk)	13%	61%	26%
Health care (low risk)	15%	62%	23%
Essential business (high risk)	16%	60%	24%
Essential business (low risk)	15%	63%	22%
First responder (high risk)	12%	59%	29%
First responder (low risk)	14%	57%	29%
Teacher or school staff	14%	66%	21%
Early learning or day care provider	13%	64%	23%
Higher risk because of race/ethnicity	24%	54%	22%
Higher risk because of disability status	20%	55%	25%
Higher risk because overall health or age	14%	64%	22%
Spanish (all)	33%	51%	16%
Russian (all)	0%	59%	41%
Ukrainian (all)	0%	25%	75%
Simplified Chinese (all)	14%	59%	28%
Traditional Chinese (all)	18%	49%	33%
Vietnamese (all)	19%	62%	19%

Q29. How much do you agree with how this group is organized: Young adults?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	8%	71%	21%
Health care (high risk)	9%	72%	18%
Health care (low risk)	6%	67%	26%
Essential business (high risk)	14%	71%	15%
Essential business (low risk)	6%	68%	27%
First responder (high risk)	10%	78%	12%
First responder (low risk)	3%	64%	34%
Teacher or school staff	11%	75%	14%
Early learning or day care provider	10%	75%	16%
Higher risk because of race/ethnicity	15%	66%	19%
Higher risk because of disability status	12%	68%	20%
Higher risk because overall health or age	9%	75%	17%
Spanish (all)	31%	51%	18%
Russian (all)	5%	71%	24%
Ukrainian (all)	25%	50%	25%
Simplified Chinese (all)	14%	45%	41%
Traditional Chinese (all)	11%	40%	49%
Vietnamese (all)	14%	52%	33%

Q30. How much do you agree with how this group is organized: Children?			
	I think this should be a HIGHER priority	I agree with this priority	I think this should be a LOWER priority
English (all)	14%	69%	17%
Health care (high risk)	16%	71%	14%
Health care (low risk)	10%	66%	24%
Essential business (high risk)	23%	67%	11%
Essential business (low risk)	12%	67%	22%
First responder (high risk)	14%	75%	11%
First responder (low risk)	10%	61%	30%
Teacher or school staff	14%	73%	12%
Early learning or day care provider	18%	69%	13%
Higher risk because of race/ethnicity	24%	59%	16%
Higher risk because of disability status	20%	62%	18%
Higher risk because overall health or age	14%	72%	13%
Spanish (all)	41%	47%	12%
Russian (all)	14%	59%	27%
Ukrainian (all)	38%	50%	13%
Simplified Chinese (all)	34%	38%	28%
Traditional Chinese (all)	38%	42%	21%
Vietnamese (all)	48%	48%	5%

Q31. How would you like us to consider: People with access barriers to health care?			
	Consider	Strongly consider	Very strongly consider
English (all)	50%	32%	19%
Health care (high risk)	52%	31%	17%
Health care (low risk)	51%	30%	19%
Essential business (high risk)	43%	34%	23%
Essential business (low risk)	49%	28%	23%
First responder (high risk)	63%	26%	11%
First responder (low risk)	57%	30%	13%
Teacher or school staff	42%	37%	21%
Early learning or day care provider	51%	31%	17%
Higher risk because of race/ethnicity	38%	32%	30%
Higher risk because of disability status	46%	31%	23%
Higher risk because overall health or age	50%	32%	18%
Spanish (all)	47%	34%	19%
Russian (all)	50%	30%	20%
Ukrainian (all)	33%	17%	50%
Simplified Chinese (all)	61%	21%	18%
Traditional Chinese (all)	64%	24%	12%
Vietnamese (all)	56%	33%	11%

Q32. How would you like us to consider: People at risk for severe illness?			
	Consider	Strongly consider	Very strongly consider
English (all)	17%	37%	46%
Health care (high risk)	16%	38%	45%
Health care (low risk)	18%	34%	47%
Essential business (high risk)	15%	40%	45%
Essential business (low risk)	17%	34%	49%
First responder (high risk)	27%	39%	34%
First responder (low risk)	26%	39%	35%
Teacher or school staff	13%	39%	46%
Early learning or day care provider	20%	39%	41%
Higher risk because of race/ethnicity	17%	34%	49%
Higher risk because of disability status	16%	31%	53%
Higher risk because overall health or age	14%	37%	49%
Spanish (all)	22%	43%	36%
Russian (all)	33%	24%	43%
Ukrainian (all)	50%	17%	33%
Simplified Chinese (all)	36%	32%	32%
Traditional Chinese (all)	31%	38%	31%
Vietnamese (all)	33%	39%	28%

Q33. How would you like us to consider: People at higher risk for exposure?			
	Consider	Strongly consider	Very strongly consider
English (all)	20%	40%	40%
Health care (high risk)	17%	38%	45%
Health care (low risk)	25%	41%	34%
Essential business (high risk)	13%	42%	45%
Essential business (low risk)	24%	39%	37%
First responder (high risk)	25%	40%	35%
First responder (low risk)	29%	40%	31%
Teacher or school staff	17%	42%	41%
Early learning or day care provider	23%	42%	36%
Higher risk because of race/ethnicity	20%	32%	47%
Higher risk because of disability status	19%	36%	44%
Higher risk because overall health or age	16%	41%	43%
Spanish (all)	19%	43%	38%
Russian (all)	29%	29%	43%
Ukrainian (all)	17%	33%	50%
Simplified Chinese (all)	18%	21%	61%
Traditional Chinese (all)	26%	37%	36%
Vietnamese (all)	39%	33%	28%

Q34. How would you like us to consider: People who are at higher risk for spreading COVID-19 to high risk populations?			
	Consider	Strongly consider	Very strongly consider
English (all)	20%	37%	43%
Health care (high risk)	17%	38%	45%
Health care (low risk)	24%	35%	41%
Essential business (high risk)	14%	41%	46%
Essential business (low risk)	21%	35%	44%
First responder (high risk)	25%	41%	34%
First responder (low risk)	38%	26%	36%
Teacher or school staff	16%	41%	43%
Early learning or day care provider	23%	35%	42%
Higher risk because of race/ethnicity	19%	33%	48%
Higher risk because of disability status	18%	37%	44%
Higher risk because overall health or age	16%	38%	46%
Spanish (all)	21%	36%	43%
Russian (all)	45%	45%	10%
Ukrainian (all)	33%	50%	17%
Simplified Chinese (all)	21%	28%	50%
Traditional Chinese (all)	23%	45%	32%
Vietnamese (all)	33%	44%	22%

Q35. How would you like us to consider: People essential to health and wellbeing of populations at higher risk?			
	Consider	Strongly consider	Very strongly consider
English (all)	19%	37%	44%
Health care (high risk)	16%	36%	48%
Health care (low risk)	25%	37%	38%
Essential business (high risk)	15%	37%	48%
Essential business (low risk)	20%	38%	41%
First responder (high risk)	23%	39%	38%
First responder (low risk)	38%	31%	31%
Teacher or school staff	13%	41%	47%
Early learning or day care provider	22%	38%	41%
Higher risk because of race/ethnicity	19%	33%	48%
Higher risk because of disability status	15%	36%	48%
Higher risk because overall health or age	14%	37%	49%
Spanish (all)	19%	28%	53%
Russian (all)	38%	43%	19%
Ukrainian (all)	33%	0%	67%
Simplified Chinese (all)	14%	29%	57%
Traditional Chinese (all)	31%	43%	26%
Vietnamese (all)	38%	50%	13%

Q36. How would you like us to consider: People who live in areas with greater spread?			
	Consider	Strongly consider	Very strongly consider
English (all)	42%	40%	17%
Health care (high risk)	40%	41%	19%
Health care (low risk)	48%	37%	15%
Essential business (high risk)	32%	45%	23%
Essential business (low risk)	44%	41%	15%
First responder (high risk)	49%	38%	14%
First responder (low risk)	54%	33%	13%
Teacher or school staff	37%	43%	20%
Early learning or day care provider	40%	45%	16%
Higher risk because of race/ethnicity	33%	41%	26%
Higher risk because of disability status	36%	40%	24%
Higher risk because overall health or age	37%	43%	20%
Spanish (all)	28%	40%	32%
Russian (all)	52%	33%	14%
Ukrainian (all)	33%	50%	17%
Simplified Chinese (all)	46%	32%	21%
Traditional Chinese (all)	44%	35%	21%
Vietnamese (all)	31%	38%	31%

Q37. How would you like us to consider: People who have been disproportionately impacted by COVID-19 because of systemic inequities?			
	Consider	Strongly consider	Very strongly consider
English (all)	39%	33%	28%
Health care (high risk)	41%	36%	23%
Health care (low risk)	41%	31%	28%
Essential business (high risk)	29%	37%	34%
Essential business (low risk)	41%	27%	32%
First responder (high risk)	58%	27%	15%
First responder (low risk)	52%	26%	23%
Teacher or school staff	32%	34%	34%
Early learning or day care provider	39%	34%	27%
Higher risk because of race/ethnicity	27%	29%	44%
Higher risk because of disability status	37%	32%	31%
Higher risk because overall health or age	36%	36%	28%
Spanish (all)	34%	36%	30%
Russian (all)	65%	15%	20%
Ukrainian (all)	50%	17%	33%
Simplified Chinese (all)	74%	19%	7%
Traditional Chinese (all)	56%	29%	15%
Vietnamese (all)	39%	39%	22%

Intersectionality

- 39% of people who identify as a high risk health worker also identify as being at increased risk because of their race/ethnicity
- 31% of people who identify as a high risk health worker also identify as being at increased risk because of their disability status.
- 30% of people who identify as a high risk health worker also identify as being at increased risk because of their overall health or age.
- 55% of people who identify as being at increased risk because of their race/ethnicity also identify as being at increased risk because of their overall health or age.
- 18% of people who identified as being at increased risk because of their race/ethnicity also identify as being at increased risk because of their disability status.
- 83% of people who identified as being at increased risk because of their disability status also identify as being at increased risk because of their overall health or age.

Q39, Q40, Q41. Do you identify as someone who is personally at increased risk for COVID-19 because of your race/ethnicity, disability status, overall health or age?								
	Health Care – High	Health Care – Low	Business – High	Business – Low	Responder – High	Responder – Low	Teacher or staff	Early learning
Race/ethnicity	39%	13%	8%	4%	2%	0%	7%	7%
Disability status	31%	12%	8%	6%	2%	0%	5%	3%
Overall health or age	30%	15%	5%	6%	2%	0%	6%	4%


Washington State Department of
Health