

# Oregon COVID-19 Vaccination Planning Update

December 9, 2020



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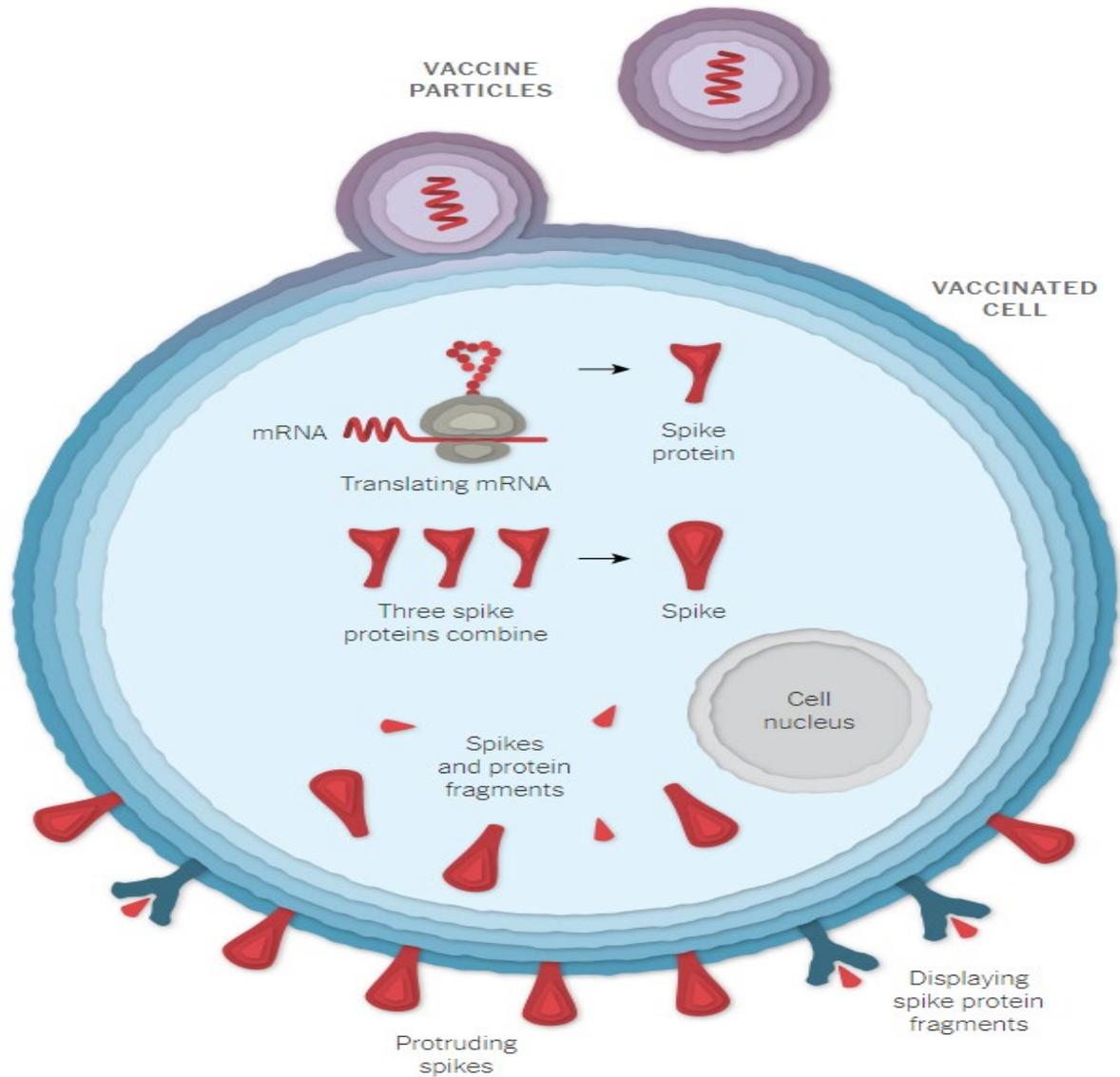
COVID-19 Vaccine Planning Unit Manager

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# Questions to be answered

- mRNA vaccines
  - How does it work?
  - How was it made so fast?
  - What are the differences between the Pfizer and Moderna vaccines?
- How does our equity framework inform our 1a prioritization?
- What groups are prioritized first and why?
- What considerations should hospitals have in planning their program?
- What is the LTCF –pharmacy partnership and why is it important?
- How is vaccine allocated?
- What factors determine which vaccine each hospital will get?
- What quantity of vaccine will each hospital get and when?
  - What about second dose planning?
  - How would a hospital or clinic order the vaccine
- What about the ultra-cold hubs?
- How can the state support vaccine missions?
- What communication strategies tools will be available?



# mRNA vaccines

## Pfizer

- 2 doses 21 days apart
- Vaccine Effectiveness = 95%
- 162 cases of symptomatic disease in placebo; 8 in vaccine group
- 10 cases of severe disease; 9 in placebo, 1 in vaccine
- Effectiveness in those over 65 years old = 94%
- Requires ultra- cold transport

## Moderna

- 2 doses 28 days apart
- Vaccine Effectiveness=94.1%
- 185 cases of symptomatic disease in placebo; 11 in vaccine group
- 30 cases of severe COVID and 1 death, all in placebo group
- No difference in effectiveness by age or ethnicity
- Normal freezer temp

# Pfizer News 12/8/20-

- FDA released 100 pages of data From Phase 3 clinical trials showing
  - 52% effective after 1<sup>st</sup> dose
  - 95% effective after second dose
  - Equally effective regardless of age, race, ethnicity, weight or sex
- Data confirms no vaccine related serious adverse reactions reported
- Post vaccination side effects are common and should be taken into consideration in planning vaccination program and staffing
  - Side effects after second dose in the 16-55-year-old group:
    - 50% fatigue
    - 1/3- headache
    - 1/4- chills
    - 1/4 myalgias
- Pfizer says that the US will not be able to purchase more of its vaccine (more than the original 100 million doses) until mid-summer because it has obligations to other international buyers.

# COVID-19 Vaccine: Phase 1a

Phase 1a distribution is broadly defined at the federal level as including:

- Health care personnel
- LTCF residents

Oregon has flexibility to define who is included in phase 1a. OHA is working with various partners to finalize how we define health care personnel broadly for inclusion in this phase, as well as consideration of our diverse congregate care settings.

OHA is continuing to center our focus on health equity as we work with our partners to consider our definition of recipients in phase 1a.

# Health Equity

Health equity must be at the center when considering the allocation of scarce critical resources in the face of a public health crisis. OHA defines health equity as follows:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices

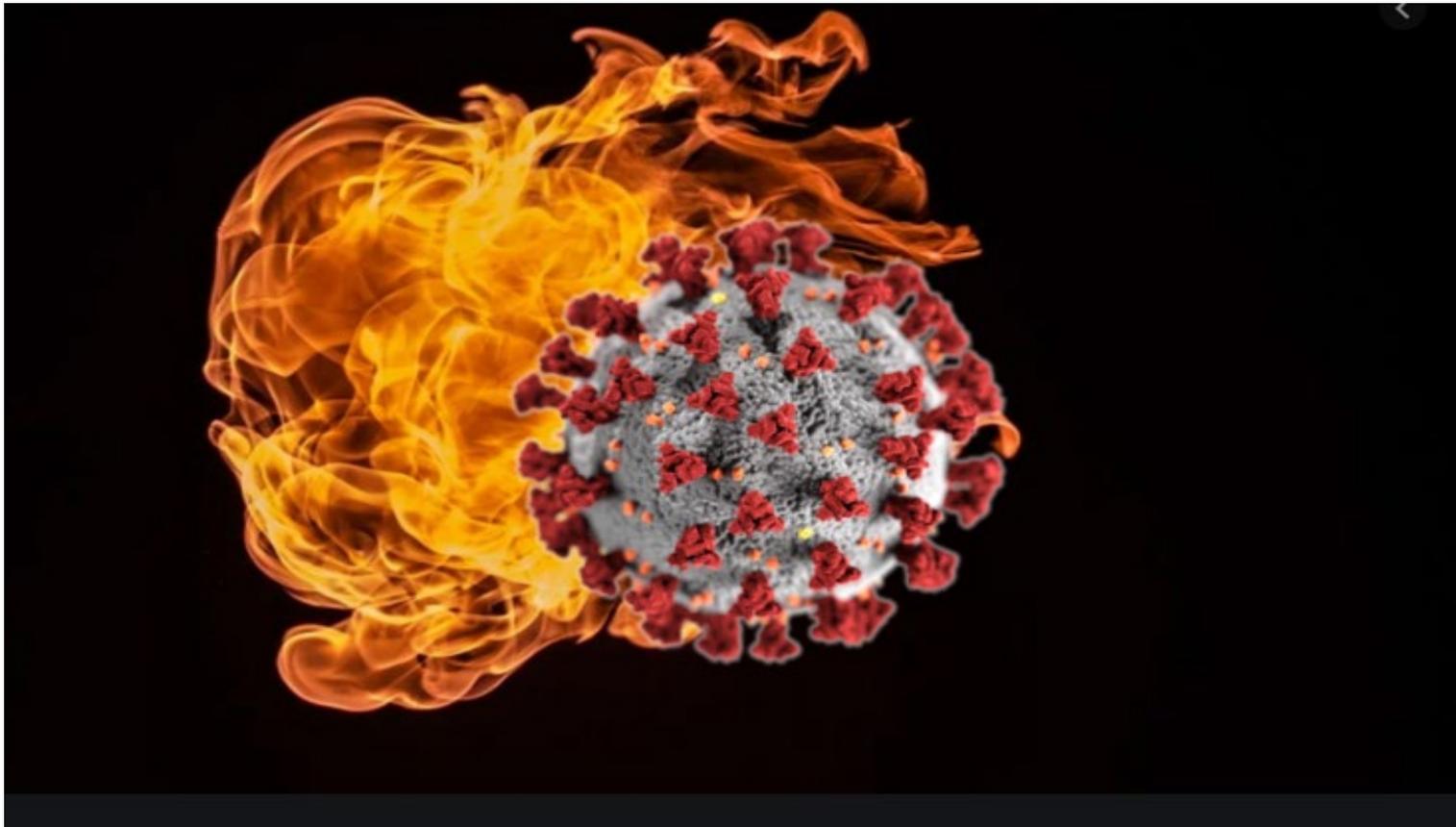
# Phase 1a Distribution Priorities

Beyond defining the phase 1a group, OHA is working to make sure the following priorities are ensured during vaccine distribution:

- **Access** to vaccine for those who want to be vaccinated in phase 1a
- **Informed consent** takes place
- **Linguistically accessible and culturally responsive information** is available about the COVID vaccine

These priorities are critical to be responsive to the diversity of people living in Oregon, and to mitigate historical and contemporary injustice and stigma of communities of color, tribal communities, people with disabilities, and longstanding mistrust of the system and distrust of vaccines.

# Oregon's Latest Wildfire



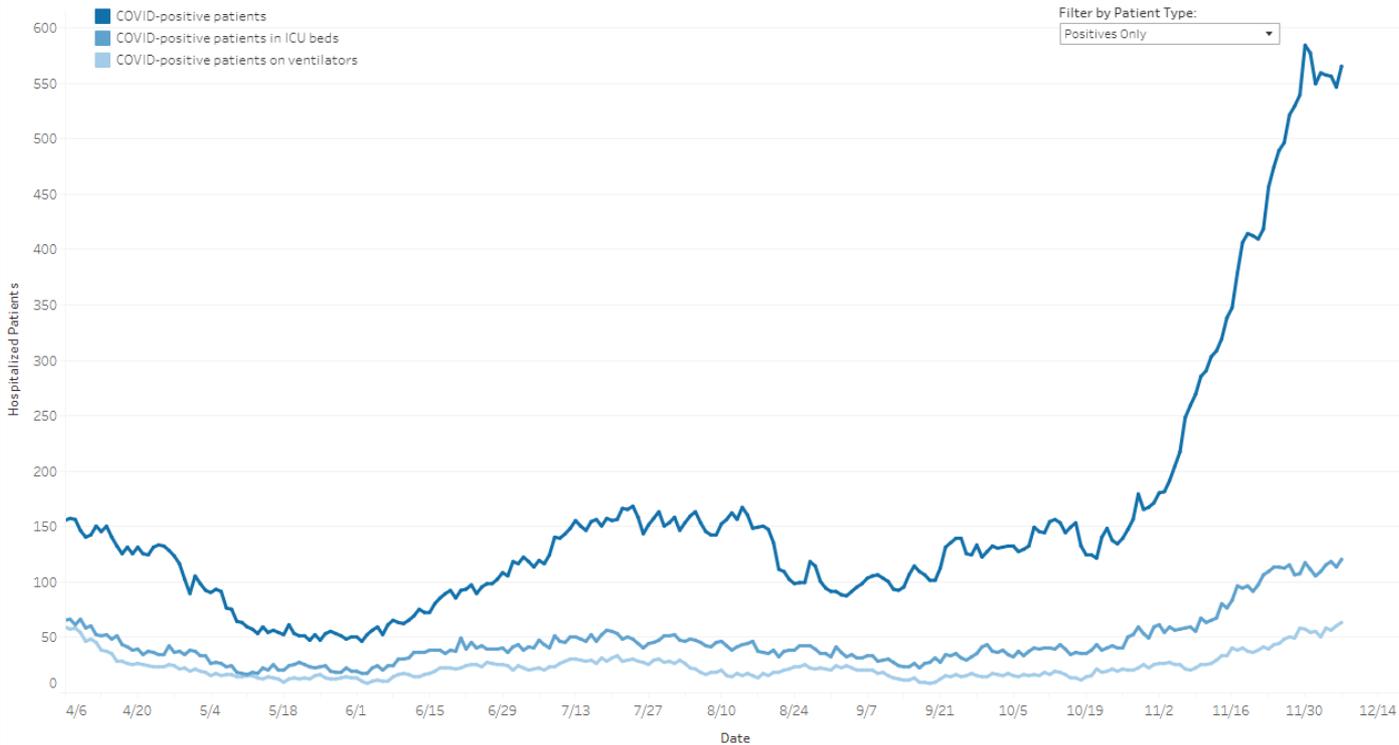
# Prioritization 1a



# Oregon's Hospital Situation

## Oregon's Hospitalization Trends by Severity

This chart shows daily COVID-19 hospitalizations and whether patients were in the ICU or on ventilators, as reported to Oregon's Hospital Capacity Web System (HOSCAP)<sup>1</sup>. It initially displays only those who tested positive, but you can view all suspected or confirmed patients<sup>2</sup> using the dropdown menu below. Click on a legend item to highlight it in the chart (ctrl+click to select multiple items).



# Phase 1a Distribution: Hospitals

Hospitals will be included in phase 1a, including all employees (clinical and non-clinical), contracted individuals, volunteers and students, and including acute care psychiatric hospitals.

This includes all health care professionals and all other employee or contracted staff types e.g., including but not limited to administrative, dietary service, and environmental service staff.

Also including in this group:

- ***Traditional Health Workers*** who provide services in a hospital.
- ***Health Care Interpreters*** who provide services in a hospital.

# Consideration for hospitals

As hospitals prepare to roll out access to COVID vaccine as it becomes available for your employees, contractors, students and volunteers, OHA recommends you consider the following:

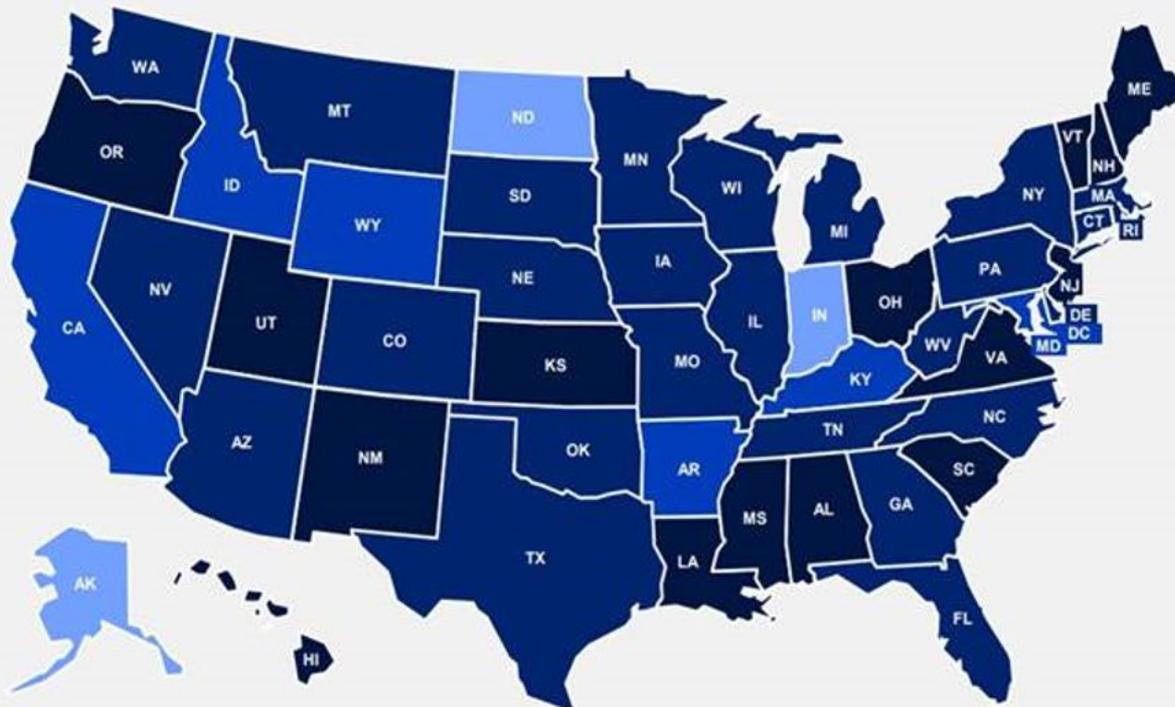
- Prioritizing staff who are critical for maintaining hospital capacity to serve the greatest number of patients, and reduce the need to implement crisis standards of care, for example:
  - Staff working in certain hospital settings (e.g., intensive care units, emergency departments); or
  - Specific types of medical providers (e.g., respiratory therapists, nurses, or other critical care specialists)
- Prioritize staff with most potential for direct exposure to SARS-CoV-2, whether through workplace exposure or community transmission
- Staggering access to the vaccine among staff to reduce staffing shortages in face of potential post-vaccination side effects

# Skilled Nursing Residents and Staff



# Federal Pharmacy Partnerships

## Skilled Nursing Facilities (SNFs) Enrolled in Pharmacy Partnership for Long-Term Care Program (as of 11/15)



100% of SNFs enrolled
95-99% of SNFs enrolled
90-94% of SNFs enrolled
80-89% of SNFs enrolled
<80% of SNFs enrolled

99% of total SNFs nationwide have enrolled (N=15,353)
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States with 100%+* enrollment: AL, DE, HI, KS, LA, ME, MS, NH, NJ, NM, OH, OR, SC, UT, VA, VT
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Lowest enrollment: AK (85%) ND (83%) Puerto Rico (67%)
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\* States >100% enrollment: Numerator may include non-CMS-certified SNFs. Denominator is only CMS-certified<sup>2,4</sup>

# Preliminary Vaccine Allocations

## Vaccine allocations - preliminary

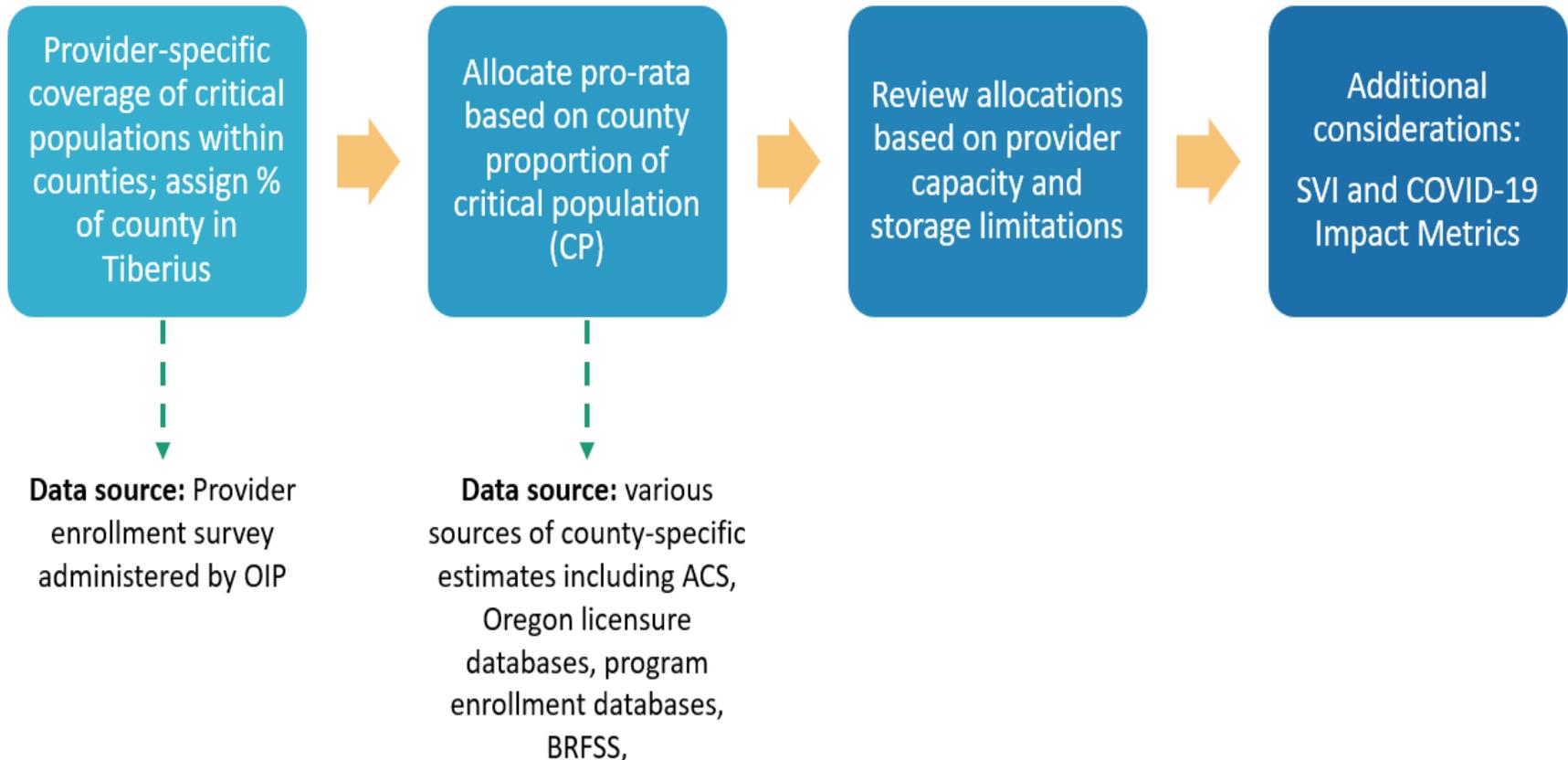
Oregon Allocations	Dec 15	Dec 22	Dec 29
Pfizer	35,100	40,950	48,750*
Moderna	-	71,900	31,700*

*\*includes the second dose for patients that received vaccine from the prior distribution*

## Doses needed to activate LTCF vaccination

LTCF Partnerships	Week 1	Week 2	Week 3
SNFs	10,725	5,850	5,850
Other ALFs	40,000	20,000	20,000

# Process for C19 Vaccine Allocations



Provider	County	Critical population estimate (site)	% of county	Critical population estimate (county)	% of state	Allocated doses (10,000 total)
Hospital X	County A	2,500	62.5%	15,000	15%	937
Clinic Y	County A	500	12.5%			188
Pharmacy Z	County A	1,000	25%			375
Total		4,000 (county)	100%	100,000 (state)	100%	1,500 doses (county)



If Oregon's statewide allocation of a given vaccine is 10,000 doses:

- (1) County A will receive 15% of state allotment (**1,500 doses**) based on critical population (CP) estimate for the county
- (2) The 1,500 does to be divided among the 3 providers in the county that indicated serving the phased CP on the provider enrollment survey
  - Doses allotted to each site within county A based on the **proportion of CP served by each site**
  - Proportion is multiplied by total county doses to provide the **site-specific allotment**
- (3) Final checks:
  - Compare site allotment to site throughput (flu doses per week during peak season)
  - Storage capacities
  - Rounding for minimum dose requirements for the given vaccine

# Considerations for C19 Vaccine Allocations

- Storage capabilities, capacity and throughput
  - Pfizer allotments will be prioritized to larger sites with higher throughput and ultracold storage capabilities
    - Minimum dose order: 975 doses
  - Moderna will be prioritized to sites with lower throughput without ultracold storage
    - Minimum dose order: 100 doses
- Prime and boost dose allocations
  - Tiberius distribution system maintains all provider-specific distributions (ease of allocating boost doses to match prime dose allocations)
  - Will likely need to account for boost doses in estimates of forthcoming statewide allocations (*pending clarification from CDC/feds*)

# Ultra Cold Storage Hubs

- Goal: Develop regional hubs in major hospital systems that can receive Pfizer vaccine, store, and share regionally at regular refrigeration temperatures
- Target start: January
- Recruiting ~9 hospitals with ultra cold storage.
- Facilities: To be announced after further discussions with facilities.
- Ultra cold may be complicated, but we must Maximize Oregon use of all vaccines.

# State-supported Vaccination Missions

- Contract with AMR. Need to verify total capacity (# teams, volume)
- MetroWest (and subcontracted EMS companies): Amending testing contract
- Not for widespread use. Targeted missions.
- May consider additional contractors for mobile or fixed clinics.
  - Prefer taking advantage of vaccine administration payments from commercial insurance, Medicare, Medicaid and CHIP, Provider Relief Fund (HRSA, for uninsured)

# Vaccination Gap Assessment

- Assess potential roles for regional Hospital Preparedness Programs (HPP) Health Care Coalitions
- Explore health care organizations' existing vaccination plans and gaps (may conduct survey, or in partnership with associations)
- Examine plans for health care organizations without internal vaccination capacity
  - Encourage local partnerships
- For phase 1a, but look ahead to all phases

# Listening to community

“Western medicine hasn’t been created or studied around the lives of people from other cultures. Historically it’s been very white, leaving out a lot of people from other backgrounds. How can the Latino community trust that the vaccine was created with appropriate consideration to their lifestyles?”

- Listening session participant

# Communications

- **Goal:** Promote COVID-19 vaccination and achieve community immunity using culturally responsive strategies.
  - Maintain commitment of 39 percent of Oregonians “certain” to take vaccine.
  - Harden commitment of 49 percent “not certain” to get vaccine.
- **Objectives:**
  - **Build confidence:** Inform Oregonians about the safety and effectiveness of the new COVID-19 vaccines.
  - **Educate and vaccinate:** When, where, how and by whom Oregonians can get vaccinated.
  - **Manage expectations while building demand:** Inform Oregonians about OHA’s plan for rapid, equitable statewide distribution of vaccines, the priority populations for receiving the vaccines, and why.
  - **Maintain prevention measures:** Wearing a mask and physically distancing, must continue as the vaccines are being rolled out.
  - **Community engagement:** Support authentic and equitable community engagement and demonstrate OHA’s commitment to community buy-in.

# Communications

## Strategies:

- **Generate earned media** to raise public interest in the COVID-19 vaccine and keep Oregonians informed and engaged throughout vaccine distribution.
- **Mount major paid media campaign:** Build positive social pressure to support vaccine uptake using culturally responsive, targeted and tailored messages and messengers to reach a wide and diverse range of communities.
- **Leverage the influence of social media:** Organize influencers to reach hesitant communities, counter misinformation and establish vaccine as a social norm.
- **Engage providers as messengers:** Establish provider confidence in the vaccine, empower providers as effective and credible messengers, demonstrate provider uptake of the vaccine.

# Resources for providers

- COVID-19 vaccine website
- Provider webpage
- Twice-weekly “Office Hours”
- Regular webinars
- Weekly written updates
- Provider toolkit (Friday 12/11)
  - FAQs
  - Messaging
  - Culturally competent campaign materials
  - Social media collateral



## Visit our COVID-19 Vaccine website

<http://healthoregon.org/covidvaccine>

Spanish:

<http://healthoregon.org/vacunacovid>

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