COVID-19 Vaccination Plan

WISCONSIN
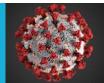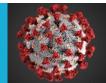
[JURISDICTION] COVID-19 VACCINATION PLAN

Table of Contents

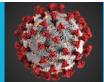## Record of Changes

Date of original version:

Date Reviewed	Change Number	Date of Change	Description of Change	Name of Author

Instructions for Jurisdictions

The COVID-19 Vaccination Plan template is to assist with development of a jurisdiction's COVID-19 vaccination plan. Jurisdictions should use this template when submitting their COVID-19 vaccination plans to CDC.

The template is divided into 15 main planning sections, with brief instructions to assist with content development. While these instructions may help guide plan development, they are not comprehensive, and jurisdictions are reminded to carefully review the *CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations* as well as other CDC guidance and resources when developing their plans. Jurisdictions are encouraged to routinely monitor local and federal COVID-19 vaccination updates for any changes in guidance, including any updates to the *CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations.*

Section 1: COVID-9 Vaccination Preparedness Planning

Instructions:

A. *Describe your early COVID-19 vaccination program planning activities, including lessons learned and improvements made from the 2009 H1N1 vaccination campaign, seasonal influenza campaigns, and other responses to identify gaps in preparedness.*
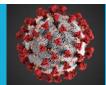
Initial Planning Activities: In 2019, staff from the Division of Public Health (the Office of Preparedness and Emergency Health Care (OPEHC) and the Immunization Section of the Bureau of Communicable Diseases) regularly met to work on pandemic preparedness activities, including completing the CDC PanVax Planning tool. Pandemic influenza tier planning data obtained from local health departments, as a part of Public Health Emergency Preparedness Cooperative Agreement grant objectives, was used to inform and populate the tool, and staff participated in two calls with CDC to review the document and results.

Since March 2020, staff from both the Immunization Section and OPEHC have been meeting on a weekly basis to review current pandemic planning efforts and identify gaps in need of attention. In addition, work groups were established in April to focus efforts in areas such as the Wisconsin Immunization Registry (WIR) enrollment and communication needs.

Lessons Learned: During the H1N1 vaccination campaign, use of the WIR was not required, leading to administration data that was collected in two different ways. This resulted in limited analysis capability and required significant staff time to combine the data and report in a timely way. Therefore, all vaccinators will be required to use one system (the WIR) to report inventory, place vaccine orders, and record administered doses for COVID-19 vaccine.

Other lessons learned include providing sufficient guidance to vaccinators about the priority groups, particularly in the early phase when vaccine is scarce. This will help ensure that there is general consistency amongst local health jurisdictions regarding the groups that should be targeted for vaccination at that time. To that end, State Disaster Medical Advisory Committee (SDMAC) workgroups have been created and have been meeting, and will provide recommendations regarding priority group definitions and allocation of scarce resources, including vaccine.

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

Between September 26, 2019 and September 2, 2020 there have been 27 separate exercises to test mass vaccination plans. Participating agencies were primarily local and tribal health departments and hospital staff, with the Wisconsin Department of Health Services (DHS) providing technical support. All exercises were compliant with Homeland Security Exercise and Evaluation Program (HSEEP) with the after action reports and improvement plans posted on a State SharePoint site.

1. Lafayette County Health Department, off-site functional vaccination exercise, September 2, 2020
2. Washington Ozaukee Public Health Department, Open POD setup drill, February 18, 2020
3. Southeast Wisconsin Healthcare Coalition Emergency Readiness Coalition, pandemic influenza tabletop exercise, December 4, 2019
4. Waushara County Health Department, immunization functional exercise, November 26, 2019
5. Kewaunee County Public Health Department, immunization functional exercise, November 19, 2019
6. Lincoln County Health Department, immunization functional exercise, November 19, 2019
7. Oneida Nation Community Health Services, immunization functional exercise, November 19, 2019
8. Oconto County Health Officer, immunization functional exercise, November 15, 2019
9. Cudahy Health Department, immunization functional exercise, November 14, 2019
10. Eau Claire City-County Health Department, off-site full scale vaccination exercise, November 14, 2019
11. Polk County Health Department, off-site full scale vaccination exercise, November 14, 2019
12. Vernon County Health Department, immunization functional exercise, November 13, 2019
13. Brown County Public Health, immunization functional exercise, November 9, 2019
14. Richland County Health and Human Services-Public Health, immunization functional exercise, November 7, 2019
15. Trempealeau County Health Department, immunization functional exercise, October 31, 2019
16. Bayfield County Health Department, school based immunization functional exercise, October 31, 2019
17. Clark County Health Department, immunization functional exercise, October 30, 2019
18. Jackson County Health & Human Services, immunization functional exercise, October 30, 2019
19. Marquette County Public Health Department, immunization functional exercise, October 30, 2019
20. Outagamie County Public Health, immunization functional exercise, October 30, 2019
21. Adams County Health & Human Services Department, immunization functional exercise, October 29, 2019
22. Forest County Public Health, school based mass vaccination functional exercise, October 28, 2019
23. Grant County Health Department, mass vaccination functional exercise, October 28, 2019
24. Manitowoc County Health Department, mass vaccination functional exercise, October 28, 2019
25. Rusk County Public Health, school based immunization functional exercise, October 25, 2019

26. Winnebago County Health Department, immunization functional exercise, October 15, 2019
27. South Central Wisconsin Healthcare Emergency Readiness Coalition, Closed POD tabletop exercise, September 26, 2019

For the 2020-2021 influenza season, 58 out of 87 local health departments planned to administer seasonal influenza vaccine at school located mass vaccination clinics. The Wisconsin Department of Health Services (DHS) supports these efforts by providing influenza vaccine, tools and templates for mass clinics, and updated CDC guidance regarding the safe implementation of clinics given COVID-19.

DHS requires all sub-awardees to utilize HSEEP when planning and conducting exercises. HSEEP utilizes a quality improvement cycle: design and develop the exercise, conduct the exercise, evaluate the exercise, and then complete improvement planning. This is equivalent to the quality circle of plan, do, check, and act.
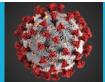
Exercises are based on plans to allow testing in a no-fault environment. Gaps in planning are addressed in a formal improvement plan with responsibilities and deadlines delineated. All after-action reports and improvement plans are posted to the DHS SharePoint Site for review by State staff and sharing with other tribal and local public health agencies.

Tribal and local public health agencies have the opportunity to discuss exercises and plan improvements on an every other week web meeting with state preparedness and immunization staff. These web meetings are recorded and posted on the SharePoint site.

DHS will gather lessons learned related to using bar code scanners for immunization clinics through its provision of on-site technical assistance at upcoming drive-through influenza vaccination clinics in early October. Information from these clinics will inform future communications and the development of best practices for how to incorporate such scanners into clinic workflow, as well as how to preserve or enhance data quality from the scanners.

While much of the planning and exercises has been with LTHD, these key findings will help inform the requirements put forth by the state to contract with an external entity(-ies) to conduct mass vaccination clinics throughout the state.

Within DHS, several aspects of the pandemic plan will be put through a table top exercise by mid-November. The exercise will test the provider registration process, information flow, and expedient provider approvals. A dry run of the allocation logistics will also be done to ensure the needed data is available, the method used is reliable, and the state allocation can be divided quickly at the provider level. Lastly, the data analysis and automation of data visualization will be tested to ensure the information can be generated on the anticipated schedule without affecting performance of the WIR. Information gained from these table tops will drive incorporation of any needed changes to these processes.

Section 2: COVID-19 Organizational Structure and Partner Involvement

Instructions:

A. *Describe your organizational structure.*

DHS is within the Executive Branch of the Governor's Office, and has nine Divisions and Offices, including:

- Office of the Secretary, including the COVID-19 Response Team (CRT)
- Office of the Inspector General
- Office of Legal Counsel
- Office of Policy Initiatives and Budget
- Division of Care and Treatment Services
- Division of Enterprise Services
- Division of Medicaid Services
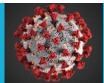- Division of Public Health
- Division of Quality Assurance

The CRT was formed in July 2020 and its Director reports to the DHS Deputy Secretary. Its charge is to provide strategic and operational coordination for the Department's involvement in the Statewide Emergency Response for the COVID-19 pandemic. It includes concentrated, cross-functional teams in the following areas:

- Testing
- Contact Tracing
- Surveillance
- Vaccination
- Harm Reduction

The DHS COVID-19 response is embedded within a state-wide response structure. Wisconsin opened its State Emergency Operations Center on March 12, 2020 and has been at Level I response since March 16. The response is governed by a Policy Group with representatives from DHS, Department of Administration, Wisconsin Emergency Management, Wisconsin National Guard, and the Governor's Office.

Within the Division of Public Health, there are eight bureaus and offices, including:

- Office of Health Informatics
- Office of Preparedness and Emergency Health Care
- Office of Policy and Practice Alignment
- Bureau of Aging and Disability Resources
- Bureau of Communicable Diseases
- Bureau of Community Health Promotion
- Bureau of Environmental and Occupational Health

- Bureau of Operations

The Emergency Preparedness Section resides within the Office of Preparedness and Emergency Health Care. The Health Emergency Preparedness Section has the responsibility to manage the Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) grant and supports all-hazards preparedness activities carried out by DPH, local and tribal public health agencies, and healthcare providers in the state of Wisconsin.

The Immunization Section and Communicable Diseases Epidemiology Section reside within the Bureau of Communicable Diseases. The Immunization Section is responsible for vaccine preventable disease surveillance and control, implementation and overseeing the Vaccines for Children (VFC) and Vaccines for Adults (VFA) programs, WIR and the Wisconsin school and childcare immunization law implementation.

The Communicable Diseases Epidemiology Section is responsible for the surveillance and control of non-vaccine preventable diseases, including COVID-19 disease response, excluding vaccine.

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

The COVID-19 Vaccination Program planning was integrated into the CRT structure in September. The integration provided visibility for the effort, ensured coordination across the statewide response, and allowed access to an array of expertise within the department and across government agencies. This alignment within the CRT also creates means for learning from systems and implementation activities in other areas of the response.
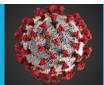
Since March 2020, staff from the Immunization section and OPEHC have been meeting weekly to prepare for the eventual arrival of COVID-19 vaccine. This group has been further refined and expanded as planning assumptions and other guidance (e.g., the playbook and plan template) have been provided by CDC. Our team is fortunate to include members who successfully navigated the 2009 H1N1 pandemic as well as other public health emergencies.

This planning team is composed of smaller workgroups which generally align with topic areas in the CDC playbook document. Workgroup team leads report to the CRT vaccine response lead, and are responsible for meeting with their respective teams.

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

Determine Priority/Critical Populations:

DHS is working with the SDMAC Ethics Subcommittee, which consists of experts from within DHS, tribal and local health departments, and the University of Wisconsin as well as leaders and

representatives from health systems and statewide stakeholder groups, to devise an ethical framework to guide the allocation of COVID-19 therapeutics and vaccines. This subcommittee has solicited public comment on its work and strives to ensure broad representation in its discussions.

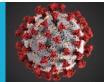Outreach to Priority/Critical Populations:

The Harm Reduction & Prevention work stream of the CRT aims to connect with high-risk and communities disproportionately impacted by the COVID-19 pandemic assuring that Wisconsin is leading with equity and taking into account mental and behavioral health considerations, social and economic supports and community assets that support community resiliency. This partnership will assure that the immunization program is able to engage, build upon, and lean on community partners to deliver immunizations in a way that demonstrates Wisconsin's commitment to leading with equity.

The Harm Reduction & Prevention lead works to partner with the various Councils appointed by the Governor's Office and supported by the Bureau of Aging and Disability Resources (BADR), including:

- Council on Physical Disabilities
- Governor's Committee for People with Disabilities
- Council for the Deaf and Hard of Hearing
- Statutory Council on Blindness (appointed by the DHS Secretary)
- Independent Living Council of Wisconsin
- Assistive Technology Advisory Council

Additionally, partnerships continue to expand including individuals from:

- Other state agencies (Dept. of Agriculture, Trade and Consumer Protection, Dept. of Corrections, Dept. of Workforce Development, Dept. of Public Instruction, Dept. of Safety and Professional Services, Dept. of Administration, University of Wisconsin System, Dept. of Natural Resources)
- Aging and Disability Resource Centers (ADRCs)
- Aging Units
- Independent Living Centers
- Wisconsin Partners
- University of Wisconsin School for Workers
- WisCon & the State Lab of Hygiene
- COVID Wisconsin Connect (app supported by the WPP grant & UW)
- Faith communities

Stakeholder Engagement:

The Vaccination Program development is being integrated into existing work with various coalitions and associations, including such organizations as the Wisconsin Association of Local Health Departments and Boards (WALHDAB), Wisconsin Public Health Association, Wisconsin Hospital Association, Wisconsin Primary Health Care Association, Wisconsin Rural Hospital Cooperative, the Healthcare Emergency Readiness Coalitions (HERC) and the Milwaukee Health Care Coordinating Committee.

Targeted planning meetings are being designed with Tribal and Local Health Departments to explore capacity, coordination, and means for successful education, outreach, and administration of vaccination efforts. Efforts are also underway to convene a cross-functional committee including representatives from DHS divisions, related government departments, health systems, non-governmental organizations, and critical partners to ensure awareness of the effort and to engage others in advocating for effective vaccination throughout Wisconsin.

Technical Assistance and Planning:

A Vaccine Administration work group has been formed that includes representatives from DHS, tribal and local health departments, and statewide associations to explore critical needs and opportunities for an efficient and effective operational response. Its work group focus on creating technical assistance for vaccinators also includes representatives from local health departments, tribal health clinics and hospitals.
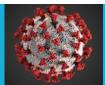
Communications:

The vaccination effort will involve the DHS Communications Team and its range of resources to advance public information efforts. These message development efforts will be informed by activities of the CRT advanced through its efforts to build relationships across stakeholder groups, reach critical populations affected by the pandemic, and advance both crisis and risk mitigation responses.

In addition, the workgroups coordinate, through the vaccine response lead, with ongoing CRT efforts, taking advantage of already established stakeholder groups to communicate to and work with stakeholder groups.

D. *Describe your jurisdiction's methods and procedures for monitoring resources, including:*
   - *Budget*
   - *Staffing*
   - *Supplies*

State health department staffing time for the COVID-19 vaccine response can be monitored through the enterprise human resources state system called STAR, which tracks employees time and which funding source that their work hours are charged to, as well as charges for supplies,

contracts and other work. Specific funding codes have been set up to track COVID-19 response activities and purchases.

Budget Policy Analysts from the Bureau of Operations are assigned to each section or office and provide regular budget updates and projections regarding funding sources, allowing for monitoring of the budget and adjustments as needed. Any contracts that will be executed for these efforts will have a contract manager assigned to monitor deliverables and funding.

E. *Identify and list members and relevant expertise of the internal team and the internal/external committee.*
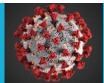
DHS COVID-19 Response Team
The team consists of the following individuals: Director (Melanie Schmidt), Deputy Director (Ruth Sullivan), Contact Tracing (Kurt Southworth), Surveillance (Traci DeSalvo), Testing (Amanda Dreyer), Harm Reduction (Amber Mullett), the Interim Division of Public Health Administrator and State Health Officer (Stephanie Smiley), and Vaccine Response (Stephanie Schauer)

See above for the partners for the Harm Reduction and Prevention partnerships

DHS Vaccine Workgroups

The internal DHS team is composed of 12 smaller workgroups which align with each of the CDC playbook topic areas. Workgroup team leads are responsible for meeting with their respective teams and reporting to the CRT vaccine response lead. These teams, which have a range of 3-6 members, include:

- WIR. This workgroup includes a number of sub groups who focus on provider recruitment and training, onboarding, technical changes, IZ Gateway and provider registration- led by Matthew Verdon. Mr. Verdon has been the WIR Systems Manager since 2007 and was part of the H1N1 response in Wisconsin.
- Communications- Elise Balzer. Ms. Balzer is a CDC Public Health Advisor to the Immunization Section and the lead health educator for the Section.
- Response to public/call center- Stacey Moyer. Ms. Moyer is the field unit supervisor within the Immunization Section and works with external stakeholders regarding immunization issues on a regular basis.
- COVID-19 Provider Education- Christie Larmie. Ms. Larmie is an Immunization Regional Representative and as part of the VFC program, she provides education and technical assistance to health care providers.
- Technical Assistance to Vaccinators- Joseph Cordova. Mr. Cordova is the Emergency Response Coordinator for Wisconsin, and has experience in this area in Wisconsin from the 2009 H1N1 pandemic.

- Stakeholder Engagement- Kimberlee Cox. Ms. Cox is the HERC coordinator for Wisconsin.
- Vaccine Allocation- Stephanie Schauer (interim). Dr. Schauer is the immunization Program manager and understands the distribution and allocation process used for routine vaccination through the VFC program.
- Vaccine/PPE/Ancillary Kit Distribution- Joseph Cordova. Mr. Cordova is the subject matter expert regarding distribution and was part of the Wisconsin response during H1N1.
- Vaccine Allocation Logistics (State)- Jackie Nelson. Ms. Nelson is the Vaccine Unit manager and is the subject matter expert regarding VTrckS, and vaccine allocation for the VFC program. She was an integral staff member for the allocation process during H1N1 in Wisconsin.
- Vaccine Reporting- Danielle Sill. Ms. Sill is the WIR epidemiologist and is the program lead for its data analysis and visualization.
- Vaccine Adverse Event Reporting- Sarah Born. Ms. Born is an epidemiologist within the program, and has background as an immunizing public health nurse in Wisconsin.
- CDC Plan Updates- Stephanie Borchardt. Dr. Borchardt has been the immunization Section preparedness coordinator and liaison since 2010.

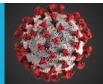*State Disaster Medical Advisory Board (SDMAC)*

This external group, convened at the request of the DHS Secretary, provides input and recommendations to DHS regarding a number of matters including the scare allocation of resources such as vaccines. The workgroup is made up of experts from across the state and represents various communities. SDMAC has three workgroups tasked with addressing the issue of allocation of scarce resources, which includes the COVID-19 vaccine. The three sub workgroups are:

1) SDMAC Ethics Subcommittee charged with developing and proposing a statement of ethical principles for the distribution of scarce resources;
2) SDMAC Vaccine Distribution Subcommittee charged with developing a recommended process for the distribution of SARS-CoV-2 vaccines across the state;
3) SDMAC Therapeutics Distribution Subcommittee charged with developing a recommended process for distribution of therapeutics in possession of the state.

Information on the workgroup meetings can be found at: https://publicmeetings.wi.gov/1/sdmac. Documents created by the group will include a two week opportunity for public comment prior to finalization.

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

Wisconsin has 85 local health departments and 11 federally recognized tribes and is considered a "home rule" state. Given the decentralized public health structure, the state will coordinate and

support COVID-19 vaccination allocation and distribution, while vaccination will occur at the local level, coordinated by local public health and including private entities such as health care systems.

In general, local health departments are responsible for determining the number of persons to be vaccinated during Phase 1, identifying who will vaccinate these groups as well as indicating any noted gaps (such as staff from skilled nursing facilities and assisted living facilities who may be included early during Phase 1). Reporting of gaps by LHD will be necessary to help inform how they might be addressed by state and/or local resources. LHDs and tribal health agencies have been doing this planning as part of the Public Health Emergency Preparedness Cooperative Agreement grant deliverables for pandemic influenza for several years and have built relationships with many of the entities in their jurisdictions. Vaccination providers will be registered through the state and a list of registered providers will be provided to local health departments for their review and to identify any missing organizations or populations.

Additionally, Wisconsin plans to participate in the federal Pharmacy Partner program, whereby skilled nursing facilities and assisted living facilities will be given an option to have a local pharmacy conduct on-site vaccination clinics for their residents. The state program will help coordinate sharing of information regarding this federal endeavor with LHDs.
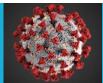
Coordination will rely on regular communication with LHDs and tribes, and use existing mechanisms already in place, including:

- Daily email to local health officers and tribal directors regarding current COVID-19 disease testing statistics, new resources and guidance
- Weekly COVID-19 webinar for local health department staff
- Biweekly Public Health Emergency Preparedness webinars with local public health staff
- Weekly emails from the Division and Department
- SharePoint site where files and documents can be shared securely between local and state public health
- Planning meetings organized by DHS and in conjunction with associations

It is anticipated that CDC will be assisting with vaccination of some multijurisdictional providers (e.g., Veterans Administration clinics and hospitals) as well as on-site vaccination in long-term care facilities (by pharmacy partners), as requested. The state will share information from these entities/systems with local public health to inform their planning.

G. *Describe how your jurisdiction will engage and coordinate efforts with leadership from tribal communities, tribal health organizations, and urban Indian organizations.*
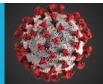
Wisconsin is home to 11 federally recognized tribes. Gail Nahwahquaw serves as director of the DHS Tribal Affairs Office and is key to communicating and coordinating with the tribal entities within Wisconsin. Ms. Nahwahquaw is assisting with conversations regarding each tribe's decision to receive vaccine directly from federal sources, or be part of the state's distribution plan.

H. *List key partners for critical populations that you plan to engage and briefly describe how you plan to engage them, including but not limited to:*
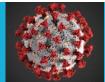
While some of our provider engagement is exclusively around COVID-19 vaccination, other activities around seasonal influenza will start to transition and include information about the COVID-19 vaccination plan.

- *Health Care Providers.* Health care systems, private providers and are key vaccinators for their health care staff, as well as the patients they serve. Primary care providers, as well as other specialty care providers will be important in identifying their high risk patients (e.g. those 65+ years, those with chronic medical conditions) and providing vaccine to them. Outreach to these entities will include direct communication to currently vaccinating entities, engagement of their professional associations (e.g. AAP, WHA), and engagement of partners such as health plans and the Division of Medicaid Services (see below for more information.)
- *Pharmacies*: Pharmacies typically administer about 25% of seasonal influenza vaccine doses administered among Wisconsin residents and are a valuable partner, particularly in rural areas where a community pharmacy may be more accessible than a medical clinic or hospital. Pharmacists are able to vaccinate individuals of all ages and are anticipated to be significant players particularly in phase 3. A strong partnership already exists with the Pharmacy Society of Wisconsin; the DPH Immunization Program meets with them monthly regarding areas of common interest and they are a key partner in providing communication to pharmacies. Additionally, the DPH Stakeholder Engagement team is working with individual chain pharmacies to determine their capacity and interest in vaccinating at the different phases of the campaign. Wisconsin plans to take advantage of the federal Pharmacy Partnership Program to provide vaccine on-site, directly to phase 1B individuals (e.g., in long term care facilities). We will work with pharmacy contacts who have proactively reached out to the program as well as those who already vaccinate and use the WIR, using existing contact lists to notify them of provider registration and determining which phases they are able to vaccinate.
- *Correctional facilities/vendors:* The Immunization program has as strong partnership with the state Department of Corrections, and supplies vaccines to them as part of the Vaccines for Adults (VFA) program for inmates. We are enrolling several county correctional facility pilot sites (among counties most impacted by COVID-19) in the VFA program to administer late-season influenza vaccine. As a result, these DOC contacts already receive regular communication from the Immunization Section; these contacts have been added to the list of stakeholder to receive information on COVID-19 vaccine.
- *Homeless shelters:* A list of all shelters, with contact information, has been created, and has been used to provide Hepatitis A and influenza education and outreach and will be used to provide information on COVID-19 vaccine. The immunization program is

engaging with several community organizations that have an existing relationship with persons experiencing homelessness to vaccinate against seasonal influenza and looking for ways to support and increase those efforts.

- *Community-based organizations:* A contact list of community organizations throughout the state that work with individuals at risk of Hepatitis A has been created and is being used to provide influenza educational resources and information; these contacts have been added to the list of stakeholder to receive information on COVID-19 vaccine to share with their clients. In addition, a funding opportunity for community-based organizations to increase seasonal influenza vaccination coverage among the populations they serve is currently underway; all applicants will be included in future educational communication regarding COVID-19 vaccine to share with their communities.

- *Medicaid Recipients:* The Division of Medicaid Services (DMS) is included as a key partner, especially regarding communication and promotion of vaccination to its participating providers and current members. Work will build on existing efforts to increase influenza vaccination rates, which includes weekly meetings where information, resource sharing, and potential opportunities for collaboration are discussed between the DMS Director of the Bureau of Clinical Policy and Pharmacy and the Immunization Program manager/Vaccine Response Lead.

- As part of the CRT, the Harm Reduction and Prevention team has many connections with partners (as described above) and will facilitate communication with these entities.

Section 3: Phased Approach to COVID-19 Vaccination

Instructions:

A. *Describe how your jurisdiction will structure the COVID-19 Vaccination Program around the three phases of vaccine administration:*
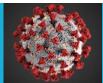
Phase 1: Potentially Limited Doses Available

As initial planning assumptions for phase 1 have indicated health care workers will likely be in Phase 1A, health care entities themselves will be key vaccinators for individuals in their organization who fit this category. In addition, LHD are coordinating (and/or may provide) vaccination to smaller entities with Phase 1A eligible individuals, who either do not have vaccinating capacity (such as a long term care facility) or a small entity that cannot use the available minimum order size (anticipated to be minimally 100 doses).

Phase 1B is anticipated to include residents of long term care or assisted living facilities, essential workers and those aged 65 years or older. Wisconsin plans to participate in the federal pharmacy partner program, which pairs these entities with a vaccinating pharmacy, who will provide on-site vaccination to the residents. LHD will once again be coordinating (and providing in some instances) the vaccination of essential workers in their communities. For those 65 years and older, it is anticipated that pharmacies and health care entities would play significant roles in ensuring this population is vaccinated. For phase 1, the state is exploring the ability to provide some mass vaccination capacity to address gaps during this phase.

All registered and approved providers will be sent communications about which priority groups are eligible for vaccination, and will be required to fill out a survey to indicate which priority groups they will be vaccinating, how many doses they will need and if they are ordering vaccine to vaccinate another entity (e.g., an LHD ordering vaccine to provide to LTC staff). Of note, at the time of this writing, Wisconsin has not determined if VAMS or another system will be used; and is dependent on the availability of further information and ability to implement. If one of these systems is employed, the plan will be revised to reflect the changes.

The vaccine requests for the priority groups will be shared with local public health jurisdictions (using a spreadsheet on the Sharepoint site) to review and compare to data collected as part of the PHEP grant deliverables, indicating if there are any phase 1 providers missing, if the number of doses requested do not look accurate and if there are any groups in phase 1 in their jurisdiction who are not receiving vaccine themselves or have a vaccinating entity. This feedback will then be used for follow up by the LHD and/or state program. Once the orders are vetted, this information will be put into an allocation tool. This tool, designed by the state, and based on guidance from ACIP and the SDMAC for allocation of scarce resources, will determine the number of doses to be allocated to each vaccinator for the priority groups at hand. The resulting number of doses for each entity will be entered into the WIR ordering module. From there, the

process will mimic what is typically done for state supplied vaccine (e.g., through the VFC program).

In brief, the ordering process is as follows: a request for vaccine, including type and number of doses, along with current inventory, is entered by the provider into the ordering module within WIR. This information is reviewed by state staff, and approved, denied or adjusted, as appropriate, in accordance with the available allocation from CDC. Providers can be notified of the status of the order (e.g., number of doses) by email or by looking in the WIR.

The order, including the shipping and contact information, is uploaded daily from WIR to VTrckS. Once the vaccine has been approved by CDC and the process to ship has started, an electronic file with the order shipping information is sent back to WIR. There, the provider can track the order and electronically accept it into their inventory once the vaccine has arrived in their office.

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

As initial planning assumptions for phase 2 have indicated vaccine supply will be more plentiful, and eligible individuals would include those in Phase 1 as well as other critical populations and eventually the general public. Therefore, the range of vaccinators will be far broader, including commercial pharmacies, health care systems and individual providers, as well as mass vaccination clinics led by local public health as well as commercial mass vaccinators.

The procedure will be similar to a situation when a vaccine is on allocation for the VFC program. All registered and approved COVID-19 vaccination providers will receive communication about the current allocation situation and groups that need to be prioritized, noting that they must ensure their orders for vaccine follow this guidance (per the CDC agreement).
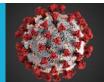
Ordering of vaccine by providers will be done through the WIR, and state staff will allocate to providers using the allocation tool that has been changed to reflect the current situation (as described above).

If certain groups are still being prioritized, information from the CDC provider registration and initial survey about which groups they are serving will inform the allocation process.

Phase 3: Likely Sufficient Supply, Slowing Demand

Planning assumptions include that this phase will continue that from phase 2, ensuring that all sectors of communities have access to vaccine, and therefore, all partners described above will continue to be needed to complete the vaccination goals.

During phase 3, all registered and approved COVID-19 vaccination providers will be able to order needed vaccine through the WIR. The process used will be similar to that for the VFC program when there is not an allocation. Steps on the provider side are similar to that described above, however, the allocation tool will not be needed (assuming allocations to the state meet the demand from Wisconsin providers.)
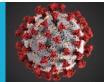
Section 4: Critical Populations

Instructions:

A. *Describe how your jurisdiction plans to: 1) identify, 2) estimate numbers of, and 3) locate (e.g., via mapping) critical populations. Critical population groups may include:*
- *Healthcare personnel*
- *Other essential workers*
- *Long-term care facility residents (e.g., nursing home and assisted living facility residents)*
- *People with underlying medical conditions that are risk factors for severe COVID-19 illness*
- *People 65 years of age and older*
- *People from racial and ethnic minority groups*
- *People from tribal communities*
- *People who are incarcerated/detained in correctional facilities*
- *People experiencing homelessness/living in shelters*
- *People attending colleges/universities*
- *People living and working in other congregate settings*
- *People living in rural communities*
- *People with disabilities*
- *People who are under- or uninsured*

Using data provided by the CDC, as well as state sources, and from local public health jurisdictions, a spreadsheet has been created that estimates the size of these groups at the state and local (if available) levels that can be used for planning purposes. This should help identify these groups. See attachment 4.1.

In addition, a spreadsheet for identification and enumeration of priority groups within a jurisdiction was originally a deliverable for LHD as part of the PHEP grant. While this was done for tiers 1 and 2 for influenza, it has now been updated for COVID-19 phases, given the current information of groups provided by CDC and others (with the recognition that these phases have not yet been determined). This will be shared with LHD for planning and outreach. See attachment 4.2.

Additionally, the Reports workgroup, which is part of the vaccine planning group, is currently exploring the mapping capability within the state GIS team; alternately, or in addition, will use Tiberius, a system that is being created by the federal government to create a visual maps of these populations at the state and jurisdictional level, as appropriate to use for microplanning purposes.

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

As part of the charge for the current SDMAC workgroup, they will be providing recommendations to further define the critical infrastructure workforce for state and local public health uses. The worksheet, appendix 4.2, will be updated to reflect this decision and shared with LHDs.
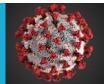
As a key responsibility of LHDs is to determine the numbers of individuals within pre-identified vaccine prioritization tiers for the allocation of scarce vaccine during a pandemic influenza outbreak. Beginning in the first budget period for the PHEP grant Local Health Departments have been required to submit estimates for each target population group of each category of Phases 1 and 2. These numbers have been updated and submitted annually via our Sharepoint site and will serve a starting point for LHD to do the same for COVID-19 vaccine (once the priority groups have been determined).

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

Informed by the recommendations from the ACIP and the State Disaster Medical Advisory Committee (SDMAC) ethics and scarce vaccine resource workgroups, a tool will be developed to take the main principles into consideration, as well as other relevant data (e.g., county population, percentage of a particular subgroup, vaccinator ability to store that particular vaccine) and using a mathematical formula, create allocations for vaccinators in the given phase. As phases or guidance changes, the DPH allocation tool will be adjusted to accommodate the current situation.
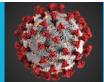
The worksheet that is being completed by local health departments will include using the U.S, Department of Labor's Occupational Safety and Health Administration information on classifying workers at risk for exposure to SARS-CoV-2. Using this information, as well as guidance from ACIP, SDMAC and other relevant sources, agencies will be asked to further classify their Phase 1A workers into risk categories and refine their local plans to prepare for the event that there is not enough vaccine for all Phase 1A workers.

D. Describe how your jurisdiction will establish points of contact (POCs) and communication methods for organizations, employers, or communities (as appropriate) within the critical population groups.
   - DPH is engaging partners, as described in Section 2 and already has established POC for these groups.
   - Efforts from early in 2020 regarding outreach to organizations who work with those at highest risk of Hepatitis A, as well as other groups has been collected. The email addresses from these groups are being added to a listserv to allow for quick communication (GovDelivery is the mass email distribution system used by the state). This includes partners such as the Hmong Institute, Lutheran Social Services of

Wisconsin and Upper Michigan, International Institute of Wisconsin (serves refugee communities), food pantries, and homeless shelters.
- Points of Contact (primary and secondary) will be collected as part of the Provider Registration process and used for routine communication via email.
- Local health departments can email a central mailbox for assistance with all COVID-19 related matters, including vaccine distribution related items. State staff have been assigned to monitor this email for questions related to identifying critical populations and report any issues that jurisdictions are having ensuring the critical populations are receiving the COVID-19 vaccination.

Section 5: COVID-19 Provider Recruitment and Enrollment

Instructions:

A. *Describe how your jurisdiction is currently recruiting or will recruit and enroll COVID-19 vaccination providers and the types of settings to be utilized in the COVID-19 Vaccination Program for each of the previously described phases of vaccine availability, including the process to verify that providers are credentialed with active, valid licenses to possess and administer vaccine.*
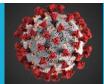
We will use existing communication channels, such as mass email distributions to notify stakeholders, including current WIR users, VFC and VFA providers and local and tribal public health. Additionally, we will engage the Public Health/Healthcare Coordinating council (which includes organizations such as the Wisconsin Association of Local Health Departments and Boards (WALHDAB), Wisconsin Public Health Association, Wisconsin Hospital Association, Wisconsin Primary Health Care Association, Wisconsin Rural Hospital Cooperative and the Milwaukee Health Care Coordinating Committee to let their membership know when registration is open and to encourage enrollment. We will also work with partners such as the Division of Quality Assurance (to reach long term care and assisted living facilities), the Division of Medicaid Services, the Pharmacy Society of Wisconsin, and the membership of the Wisconsin Council on Immunization Practices (see https://www.dhs.wisconsin.gov/immunization/wcip.htm for the full membership), which includes a variety of partners, such as the Wisconsin chapter of the American Academy of Pediatrics, to reach out to potential vaccinators.

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

Informed by the recommendations from ACIP and SDMAC, and information from the provider registration process as well as the survey for vaccine needs for priority populations, vaccine will be allocated to those entities serving the population/priority groups.

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

We are working with the DHS Office of Health Informatics to develop an electronic platform to collect and compile registration information. The current plan is to produce a CSV file from information collected in the registration tool. The template and reporting instructions from CDC on 10/2 is informing the process.

Several staff have access to SAMS and we will determine the best fit for submission in accordance with the reporting timeliness requirements.

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

To verify providers, we will access the Wisconsin Department of Safety & Professional Services website to check for active & valid provider license numbers and access the Office of Inspector General/OIG website to check for any infractions against those providers.

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

General Process:
Upon or after a provider registers, the training team will be alerted of the provider registration. At which point we will work directly with the provider and assess their respective training needs. With high provider participation in the State, many providers already report vaccines either through an interface with the Electronic Health Record (EHR) system or direct entry into the IIS. However, not all providers order vaccine or manage their inventory through the IIS.

Topics:
- Vaccine ordering
- Inventory management
- Client search and entry and recording of immunizations using various facets of the system, such as mass vaccination and utilization of barcoding capabilities.
- Reporting – select reporting such as Reminder/Recall for 2nd dose.

Delivery:

Given that the provider staff time will be a challenge, we will provide the training using a combination of existing training modules within our IIS, recorded webinars, and resource guides. We will consider offering live open question and answer forums, if the providers indicate it would be beneficial to talk directly with a trainer.

We will continue with scheduling our standard "IR Administrator" trainings, which are 4 hour virtual instructor led classes. This will be an option that is reserved for those that have the time and preference for learning in that setting. Depending upon interest and volume we may need to increase the number of class offerings.

Tracking:

As part of the registration process, the provider will attest that they have staff who are trained and have the access required to order vaccine, manage inventory, and report the administered doses all in the IIS.

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

We are in the process of assessing our provider registration, training and onboarding workflow to determine the best point at which to have providers complete the CDC Supplemental COVID-19 Vaccine Redistribution Agreement. Part of this will be determining how the approval process will be completed.

G. *Describe how your jurisdiction will ensure there is equitable access to COVID-19 vaccination services throughout all areas within your jurisdiction.*
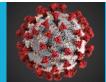
Equitable access is an identified priority for the planning discussions.

We are gathering information and initiating conversations with tribal and local health departments to devise an approach that considers community-specific needs.

To augment current local efforts and ensure that all subgroups within a community have access to vaccines, the state is pursuing procurement for mass vaccination and service provision to work and plan with local health departments to conduct vaccination clinics in the community, focusing on underserved populations. Contractors will be encouraged to employ new technology and approaches that facilitate access and promotes safe vaccination practices in the era of COVID19 (such as on line registering and drive through clinics). The procurement process will emphasize provision of culturally competent services (e.g., to non-English speakers) and ability to promote ready access for sectors of the community without health insurance or transportation.

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

Over the last several years, the Immunization Section's work to increase the number of adult immunizers in the state has included a focus on pharmacies. DPH has a strong partnership with the Pharmacy Society of Wisconsin, which has helped identify immunizing pharmacies, shared in our outreach efforts, organized pharmacy focused training and worked with us to develop onboarding processes focused at decreasing the time needed to onboard pharmacies. At this point we have over 650 pharmacies registered in WIR and will continue to leverage the relationship with the Pharmacy Society of Wisconsin who is committed to encouraging pharmacists to participate in this vaccination effort.

Section 6: COVID-19 Vaccine Administration Capacity

Instructions:

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

We have used the CDC PanVax tool to estimate our jurisdiction's ability to vaccinate 80% of our population (2 doses administered 28 days apart) within 12 weeks. This tool is currently being updated and therefore we will plan to enter our inputs into the updated tool when it becomes available. Differences between vaccinating against pandemic influenza vs. COVID-19 that the updated model will likely need to take into account include:

- Children will not be included in the first priority group therefore Vaccines for Children Providers, unless they also see adult patients, are unlikely to be a significant contributor to our initial vaccine administration capacity.
- For phases 2 and 3, school-located mass vaccination clinics may be fewer than initially planned depending on whether a school is offering in-person or virtual learning and the school's willingness to allow local health department staff into their building to vaccinate. Additionally, it is unclear when a vaccine that is licensed for children will be available.
- Local health departments are entered into our tool as vaccine providers at school-located mass vaccination clinics, temporary mass vaccination clinics or PODs, as well as administering pandemic vaccine at the local health department which may need to be reduced given time and staffing constraints on the part of LHD due to COVID-19 disease activities (e.g., contact tracing, outbreak investigation)
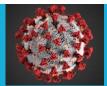
Provider registration will inform our vaccine administration capacity and will be more accurate though the data is less likely to inform initial planning activities due to the timing of this step.

While the timing of arrival of the COVID-19 vaccine is uncertain and may overlap with the delivery of influenza vaccine, early efforts for seasonal influenza mass vaccination campaigns will inform the planning regarding the capacity to vaccinate against COVID-19.

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

Engaging potential COVID-19 vaccinators who do not already use the WIR has begun and has been informed by previous gaps in pandemic influenza vaccination identified through use of the PanVax Tool and initial planning assumptions which describe groups likely to be included in phase 1 of vaccination. We have reached out to these groups to encourage them to become WIR users with the knowledge that entry of doses administered within 24 hours would be a requirement of organizations providing COVID-19 vaccine. The WIR team is experiencing an increase in training and onboarding requests and has hired additional staff to help accommodate the increase.

Additional providers of state-supplied vaccine have been enrolled to administer late-season adult influenza vaccine which will become available sometime during November through January. These

providers (e.g., clinics, pharmacies, correctional facilities) are immunizers and use WIR though have not previously received state-supplied vaccine. We plan to leverage these new partners to administer COVID-19 vaccine.

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

Instructions:

A. *Describe your jurisdiction's plans for allocating/assigning allotments of vaccine throughout the jurisdiction using information from Sections 4, 5, and 6. Include allocation methods for populations of focus in early and limited supply scenarios as well as the variables used to determine allocation.*
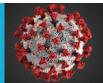
The state will follow the recommendations of the CDC's Advisory Committee on Immunization Practices on which population groups to vaccinate first. Informed by recommendations from the ACIP and the State Disaster Medical Advisory Committee (SDMAC) ethics and scarce vaccine resource workgroups, a tool will be developed to take the main principles into consideration, as well as other relevant data (e.g., county population, percentage of a particular subgroup, vaccinator ability to store that particular vaccine). The tool will use a mathematical formula to allocate vaccine for vaccinators in the given phase. As phases or guidance changes, the DHS allocation tool will be adjusted to accommodate the current situation. Of note, the variables that will be used are still under discussion by the SDMAC workgroup, which plans to finish by late October.

When vaccinators register, they will have to identify what population group they plan to administer vaccine to. Only vaccinators that have identified these population group will be allowed to order vaccine. As vaccine allotments increase the population groups will be expanded with additional vaccinators being allowed to order vaccine.

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

When vaccinators register to be COVID-19 Vaccine vaccinators they will complete a survey which will include questions on their cold chain management procedures and vaccine storage specifications and capacity. DHS will provide cold chain management checklists and training materials for vaccinators.

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

COVID-19 Vaccine ordering will be a three-step process.

Step 1: For phase 1: approved vaccine providers, through a survey, will request the amount of vaccine desired to vaccinate the priority group at hand, and provide, which population group is being targeted. Information from the provider registration will be noted, such as ability to maintain cold chain, etc.

For phases 2 and 3: A request for vaccine, including type and number of doses, along with current inventory, is entered by approved vaccine provider into the ordering module within WIR.

Step 2: The order is reviewed by state staff, and approved, denied or adjusted, as appropriate, in accordance with the available allocation from CDC.

Step 3: During Phase 1 and 2 the State will enter the allocated amount that the provider will receive based on the amount of vaccine that is provided to Wisconsin. The vaccine order will be entered directly into WIR Registry and the end of each day the information will be uploaded into VTrckS for processing. Training will be provided to State Staff who will be responsible for entering this information into WIR. It is the goal to have all allocated vaccine entered into WIR and uploaded into VTrckS within 24 hours of receipt of the allocation.
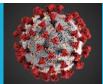
During Phase 3, providers will enter their requests directly into WIR. State staff will approve those orders based on allocated needs and the projected needs of the provider. As in Phase 1 and 2, each day's orders will be uploaded from WIR into VTrckS for processing. Step-by-step guidance will be provided on how to place orders for COVID-19 vaccine directly into WIR.

The order, including the shipping and contact information, is uploaded daily from WIR to VTrckS. Once the vaccine has been approved by CDC and the process to ship has started, an electronic file with the order shipping information is sent back to WIR. There, the provider can track the order and electronically accept it into their inventory once the vaccine has arrived in their office. Providers can be notified of the status of the order (e.g., number of doses) by email or by looking in the WIR.

In addition, local health departments and tribal clinics may need additional supplies beyond what is in the ancillary kits that come with the vaccine in order to conduct safe clinics and be able to follow current infection control guidance. As part of the COVID-19 supplemental funding, DHS will purchase the following: surgical/N95 masks, face shields, alcohol wipes, band aids, gloves and appropriate disinfecting supplies for clinics.

D. *Describe how your jurisdiction will coordinate any unplanned repositioning (i.e., transfer) of vaccine.*
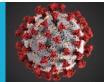
The final process has yet to be determined. Providers will be required to complete the CDC document and have approval to reposition vaccines. The inclusion of the form will be part of the provider registration process, with completed forms submitted to the Immunization section

for approval. Once approved, the program will communicate back with the entity and add them to the approved list held at the state level.

E. *Describe jurisdictional plans for monitoring COVID-19 vaccine wastage and inventory levels.*
The Immunization section, vaccine unit will monitor vaccine administration and inventory levels of all vaccine providers through WIR. Current inventory doses on hand will be required when providers submit orders and orders will not be processed if the information is missing. The inventory on hand will be taken into consideration when filling an order.

The program is currently exploring what changes could be made to the existing system of wastage reporting and monitoring (as used for the VFC program) to use for the COVID-19 vaccination plan. In the beginning of the vaccine campaign, we anticipate that vaccine wastage of greater than five doses will be reported to the state and initiate action, including reporting of vaccine wastage/spoilage to the CDC.

Section 8: COVID-19 Vaccine Storage and Handling

Instructions:

A. *Describe how your jurisdiction plans to ensure adherence to COVID-19 vaccine storage and handling requirements, including cold and ultra cold chain requirements, at all levels:*

All vaccinators will have a cold-chain standard operating procedure that will address the specific storage requirements of COVID-19. DHS will make available a template cold-change standard operating procedure. Vaccinators will agree to have a plan or procedure in place before receiving vaccine. All vaccinators cold-chain standard operating procedure must be provided upon request of DPH. As vaccine storage and handling is an important component of a well-planned response, the Department, in effort to support LHDs in their ability to conduct off-site clinics and ensure proper vaccine storage and transport will provide a transport container and a digital data logger to each LHD or tribal clinic. This will be provided as part of the COVID-19 (VFC Ops) supplemental funding awarded to Wisconsin.

Individual provider locations
Vaccinators that provide routine vaccinations will follow their procedures for vaccine storage, temperature monitoring and documentation. Should a COVID-19 vaccine require ultra-cold storage the vaccinator must provide a written plan to DPH for ultra-cold storage.

Satellite, temporary, or off-site settings
All off-site vaccination clinics must have constant temperature monitoring during transit and while at the of-site clinic by the use of data loggers or temperature monitors that can alarm if the temperature exceeds vaccine storage limits. Procedures will be documented in their cold-chain standard operating procedure.

Planned redistribution from depots to individual locations and from larger to smaller locations
Redistribution of vaccine must have constant temperature monitoring during transit by the use of data loggers. Policy and procedures for redistribution must be in accordance with the vaccine manufactures specification for vaccine storage. Vaccinators that plan for redistribution of ultra-cold vaccines must have their standard operating procedure approved by DPH before vaccine will be shipped them.

Unplanned repositioning among provider locations
Redistribution of vaccine must have constant temperature monitoring during transit by the use of data loggers. Vaccinators should contact DPH prior to moving the vaccine.

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

Redistribution of vaccine must have constant temperature monitoring during transit by the use of data loggers. Policy and procedures for redistribution must be in accordance with the vaccine manufactures specification for vaccine storage. Vaccinators that plan for redistribution of ultra-cold vaccines must have their standard operating procedure approved by DHS before vaccine will be shipped them.
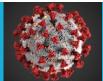
Section 9: COVID-19 Vaccine Administration Documentation and Reporting
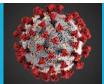
Instructions:

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

The WIR has been in use since 1999 and is widely used by vaccinators throughout the state to record administered vaccine doses, to guide clinical decision making with the forecaster (indicating what vaccines are needed and when), to run reports regarding vaccine coverage for a given practice or jurisdiction, as well as to run reports for clients who are due or overdue for immunizations. It has an inventory management feature and is used for ordering vaccine for the Vaccines for Children and Vaccines for Adults programs. Additionally, it has a mass vaccination module for quick entry of data and allows for the use of bar code scanners. It is a web-based tool and can be used directly through a user interface, or can be linked to electronic medical records for the seamless sharing of data between systems. VFC providers and pharmacists who vaccinate individuals <18 years of age are required to submit data to the WIR; all other providers are not required, but participation is very high among immunizers throughout the state.

At the time of this writing, Wisconsin is still determining whether it will use an additional product to supplement what the WIR does, and the data collected. Options include the CDC Vaccine Administration Management System (VAMS), purchase another commercial product, or rely on the IIS alone. VAMS is a mass vaccination tool being developed by CDC with the primary use being for phase 1 mass vaccination clinics.

Function	VAMS	WIR
Patient registration	x	
Schedule clinic appointments	x	
Records administered doses	x	x
Manage and track inventory	x	x
Allow for near real-time analyses of WI residents		x
Identify priority populations, including number of doses needed by organization	x	
Reporting functions	x	x
Forecast second dose (vaccine type and date)	?	x
Provide full immunization record for individual		x
Estimate of phase 1 providers needing training	All	Some
Availability/accessibility of information beyond COVID-19 campaign	Unknown	Yes

If a commercial product is determined to be the desired path, essential requirements of the system would include the ability for the public to do on-line remote registration, consent and self-scheduling for vaccination services. For vaccinators, such as local public health departments and other providers, the system would facilitate clinic management, such as inventory tracking

and the ability to bill insurance, as well as reporting administration data in a timely manner to WIR. Clinic summaries and reporting functions would be highly desired.

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

Specifications are being reviewed and the final submission method is still being determined. Anticipate using Connect at this point.

Describe how your jurisdiction will ensure each COVID-19 vaccination provider is ready and able (e.g., staff is trained, internet connection and equipment are adequate) to report the required COVID-19 vaccine administration data elements to the IIS or other external system every 24 hours.
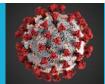
The provider registration will entail ensuring the vaccinating entity has access and ability to use the WIR. The workflow will include user interface training or data exchange onboarding before approving the provider.

WIR is an internet-based application so a base requirement for access is an internet connection. Additionally, minimum hardware requirements are discussed as part of the training. We plan to encourage and prioritize HL7 real-time exchange in data exchange onboarding, as it improves both timeliness and data quality, but understand the possibility of providers needing to send batch messages. We plan to have discussions with those providers on the frequency of batch submissions in order to meet the 24 hour requirement. User interface providers will be reminded of the 24 hour reporting requirement.

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

Wisconsin, per the federal requirement, will require entry of COVID-19 vaccine into the WIR within a 24 hour period. Real time entry of vaccine will be encouraged through use of Wisconsin's mass vaccination tool (such as VAMS; see section 11.A), or provider means of entry into an EHR that is linked to the WIR.

Wisconsin already has a large number of providers sending data via data exchange already, and we will continue to offer this option, having brought on additional staff to help with the anticipated surge. New providers will have the option to gain access to the WIR either through the web (direct manual entry into WIR) or through data exchange (electronically linking with an electronic medical record). However, as the onboarding process can take some time to establish and test; therefore, we will train all pandemic providers that are new to WIR in mass vaccination

entry, as an alternate option if data exchange cannot be established before doses are distributed.

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

We will be creating a report to measure timeliness of receipt of information based on day of administration. The details of the report will be determined, and we expect to reuse portion of an existing query through WIR's provider report card in order to generate this report and monitor compliance with the requirements.

We are determining frequency, responsibility for outreach to providers.

E. *Describe how your jurisdiction will generate and use COVID-19 vaccination coverage reports.*
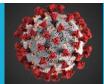
Wisconsin has a team of epidemiologists and research analysts that will be tasked with updating COVID-19 vaccination information. COVID-19 vaccine data will be pulled and updated daily, via Tableau. Wisconsin has a COVID-19 Tableau dashboard that includes a training environment, internal environment, and external environment, and once the process is initially established, all data updates thereafter will happen automatically. As data requests are received by internal staff and external individuals, the immunization program will evaluate which information they can share publically and add them to the external dashboard to reduce the amount of time epidemiologists and research analysts spend on the same types of data requests. Along with the data visualizations, Tableau will allow anyone with access to the data page to download the raw data themselves.

Wisconsin has two different Tableau dashboard environments, an internal and external environment. The internal environment will house the same data visualizations as the external environment plus additional visualizations that will only be viewable to program staff and leadership. The Tableau dashboard for vaccines will be housed on the DHS COVID-19 webpage at dhs.wisconsin.gov/covid-19 once the vaccine becomes available.

Wisconsin has created a data standard for publishing COVID-19 related information and the Immunization section will follow that standard. Currently, the communications display guide is being updated and the Immunization section will follow the updates and change colors, titles, font sizes, and graphs accordingly to match.

Staff Scheduling
The epidemiologists and research analysts will work in rotation to update the dashboard once a day and update data every third weekend of the month. Days will be assigned, with the ability to
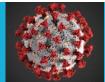
switch with others if the staff member will not be available for that day. This allows staff to have multiple days during the week to focus on their regular work duties, providing them with one day intermittently when they will need to focus primarily on COVID-19 data.

Data Updates

All data will be extracted from WIR's Datamart, which is updated nightly. The data will be extracted using free-hand SQL in Business Objects so staff do not have to physically be present to extract the information. Business Objects will allow the creation of queries and schedule the analysis to be done in during off hours (e.g., at night) and be available to staff members upon sign in so that WIR's performance is not impacted.

The data staff member will take the information from the multiple queries and update the Excel spreadsheets as appropriate. Each Excel spreadsheet will be connected to Tableau, so the dashboard will update automatically. The staff member will check the data for accuracy, review that the Tableau dashboard updated correctly, and be available to answer questions about the data throughout the day, as well as pull information for data requests that come in and are not included in these dashboards.

The Reports workgroup is exploring whether Tableau Prep Builder, a tool that can be used to clean data, calculate variables, and edit can be used for reports, as it would reduce staff time needed to do these tasks.

Section 10: COVID-19 Vaccination Second-Dose Reminders

Instructions:

Describe all methods your jurisdiction will use to remind COVID-19 vaccine recipients of the need for a second dose, including planned redundancy of reminder methods.
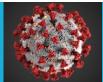
The current reports available in WIR allow for the generation of lists of individuals and their contact information who have incomplete vaccine series and need additional doses. Changes were recently made to WIR to collect and store phone number type (e.g. cell phone, home telephone), which compliments the already existing report that includes the client addresses. These options allow providers, LHDs, and tribal clinics to reach out to clients in a number of different ways to remind them about needed vaccinations.

Moreover, additional changes are planned to increase the filter options in the reminder recall report, such as including an option to select an individual based on the vaccine trade name and to select individuals who are due for a second dose of COVID-19 vaccine only. These changes are designed to give the reports more specificity and will accommodate the situation with COVID-19 vaccine recipients needing to receive the same vaccine for their first and second doses. This will allow clinics to select and outreach specifically to individuals who may be due for a second dose of a particular vaccine (and not others).

The implementation is targeted for December 2020, though if the planned changes cannot be completed, we are exploring ways to treat the individual vaccines as separate vaccine groups and utilize "invoke-on-use" functionality to only target individuals due for the second dose. This would only be considered if it would not adversely impact first dose forecasting and analysis.

We anticipate using text or email methods, as allowable, for reminders. Should those methods not be feasible, we will leverage prior experience with auto dialer calls for reminder/recall purposes.

Lastly, also as part of the COVID-19 supplemental funding, we will make updates to the client immunization record that patients can access and print so they have a record of what vaccines have been received as well as when additional doses are needed (such as a second dose of COVID-19 vaccine). This functionality will benefit from several changes to be more user friendly (e.g., available as a PDF), to include the current DPH branding and to include the COVID-19 vaccines.

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

Instructions:

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

Wisconsin developed an integrated mass vaccination option for use during H1N1 that focused on quick, accurate, real-time entry. The module was used successfully during the H1N1 immunization effort and has continued to remain in use as an option for seasonal influenza entry. Updates have been made to collect and forecast separate antigen and adjuvant information (should they need to be tracked separately), to allow for collection of all elements of a vaccination event using a barcode scanner (ordering authority, clinician, vaccine, expiration date, lot number, body site, route, etc.) and are in the process of implementing the option to search for an individual by scanning a driver's license or state issued ID.
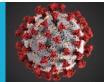
This combined functionality, provides an option that when properly integrated into the workflow, would support fast, real-time, accurate reporting, while allowing staff to be unimpeded by personal protective equipment.

The use of temporary expiration dates on vaccines does present a potential problem when using a barcode scanner, as it would not accurately match inventory that has been updated with the correct expiration date (from the CDC website). We are working on both technical and workflow options to resolve this.

We are working with our vendor on contingency plans for outages that would prevent access to WIR. Contingency plans on the local level would be addressed by the organization responsible for the vaccination event.

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

WIR will be able to capture the information below through the user interface and/or through data exchange and/or through Mass Vaccination Module. There are no current plans to add to WIR the following fields: chronic medical conditions, occupation or membership in other critical population groups to WIR. This is due to the short time frame, prioritization of other necessary COVID-19 related work for the WIR and these categories not being clearly defined in a timely manner to allow for addition.

Columns – Description

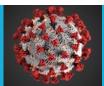Data Element – The Data Element within the IIS Database.

User Interface – Whether Data Element is present and displayed within the User Interface.

Data Exchange – Whether Data Element is allowed to be submitted through Data Exchange.
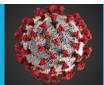
Mass Vaccination – Whether the Data Element is allowed to be submitted through Mass Vaccination Module.

CDC Required Optional – CDC Data Element Status of being required or Optional to be reported to the CDC.

Data Element	User Interface	Data Exchange	Mass Vaccination	CDC Required Optional
IIS Recipient ID - Auto-generated	Y	Y	Y	Required
Chart Number	Y	Y	N	
Social Security Number	Y	Y	Y	
Patient Last Name	Y	Y	Y	Required
Patient First Name	Y	Y	Y	Required
Patient Middle Name	Y	Y	Y	Required
Patient Suffix	Y	Y	Y	Required
Mother's Maiden Last Name	Y	Y	Y	
Mother's Maiden First Name	Y	Y	Y	
Patient Date of Birth	Y	Y	Y	Required
Patient Gender	Y	Y	Y	Required
Patient Race	Y	Y	Y – Except New Patient	Required
Patient Street Address	Y	Y	Y	Required
Patient Other Address	Y	Y	Y	Required
Patient City	Y	Y	Y	Required
Patient State	Y	Y	Y	Required
Patient Zip Code	Y	Y	Y	Required
Patient Country Address Code	N - Defaults	Y – Not stored	N - Defaults	Required
Patient Address Type	N	Y – Not stored	N	Required
Patient Primary Phone Number	Y	Y	Y	
Patient Primary Phone Number Type	Y	Y	Y	
Patient Secondary Phone Number	Y	Y	Y	
Patient Secondary Phone Number Type	Y	Y	Y	
Patient Email Address	Y	Y	Y	

Patient Ethnicity	Y	Y	Y – Except New Patient	Required
Patient Multiple Birth Indicator	N	Y	N	
Patient Birth Order	N	Y	N	
Patient Death Date and Time	N	Y	N	
Patient Death Indicator	N	Y	N	
Patient Send Reminder/Recall Notices	Y	Y	Y	
Patient Send Reminder/Recall Notices Effective Date	N	Y – Not stored	Y	
Patient Protection Indicator	Y	Y	Y	
Patient Protection Indicator Effective Date	N	Y – Not stored	N	
Patient Registry Status	Y	Y	Y	
Patient Registry Status Effective Date	N	Y – Not stored	N	
Patient – Responsible Person Last Name	Y	Y	Y	
Patient – Responsible Person First Name	Y	Y	Y	
Patient – Responsible Person Middle Name	Y	Y	Y	
Patient – Responsible Person Relationship	Y	Y	Y	
Patient – Responsible Person Street Address	Y	Y	Y	
Patient – Responsible Person Other Address	Y	Y	Y	
Patient – Responsible Person City	Y	Y	Y	
Patient – Responsible Person State	Y	Y	Y	
Patient – Responsible Person Zip	Y	Y	Y	
Patient – Responsible Person Country	N	Y	N	
Patient – Responsible Person Address Type	N	Y – Not stored	N	
Patient – Responsible Person Primary Phone Number	Y	Y	Y	
Patient – Responsible Person Primary Phone Number Type	Y	Y	Y	
Patient – Responsible Person Secondary Phone Number	Y	Y	Y	
Patient – Responsible Person Secondary Phone Number Type	Y	Y	Y	
Patient – Responsible Person Email Address	Y	Y	Y	

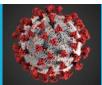|				
Patient – Responsible Person Reminder/Recall Notices	Y	Y	Y	
Patient – History of disease as evidence of immunity	Y	Y	N	
Patient – Diseases with serological evidence of immunity	Y	Y	N	Optional
Patient – Vaccination Contraindication	Y	Y	N	
Patient – Vaccination Precaution	Y	Y	N	
Patient – Vaccination Special Indication	Y	Y	N	
Comorbidity Status (Y/N) (CDC Element)	N	N	N	Optional
Patient Missed Vaccination Appointment (Y/N) (CDC Element)	N	N	N	Optional

IIS will be able to capture the following information specific to the COVID-19 Vaccine Administration listed below.

- Columns – Description
- Data Element – The Data Element within the IIS Database.
- User Interface – Whether Data Element is present and displayed within the User Interface.
- Data Exchange – Whether Data Element is allowed to be submitted through Data Exchange.
- Mass Vaccination – Whether the Data Element is allowed to be submitted through Mass Vaccination Module.
- CDC Required Optional – CDC Data Element Status of being Required or Optional to be reported to the CDC.

Data Element	User Interface	Data Exchange	Mass Vaccination	CDC Required Optional
Placer Order Number	N	Y – Not Stored	N	
Filler Order Number	N	Y – Not Stored	N	
Entered By	N	Y – Not Stored	N	
Ordering Provider Last Name	Y	Y	Y - Admin	
Ordering Provider First Name	Y	Y	Y – Admin	
Ordering Provider Middle Name	Y	Y	Y – Admin	
Ordering Provider Suffix	Y	Y	Y – Admin	
Ordering Provider Prefix	Y	Y	Y – Admin	
Entering Organization	Y	Y	Y	

Date/Start Time of Administration	Y	Y	Y	Required
Date/End Time of Administration	N	Y	N	
Vaccine Group Code of Administration	Y	Y	N	
CPT Code of Administration	Y	Y	N	
CVX Code of Administration	Y	Y	N – Can be mapped from Trade Name	Required
Trade Name of Administration	Y	Y	Y	
NDC of Administration	Y	Y	Y – Admin	
Administered Amount	Y	Y	Y – Admin	
Administered Units	Y	Y	Y – Admin	
Administered Notes(00-Administration, 01-Historical)	Y	Y	Y	
Administering Provider Last Name	Y	Y	Y – Admin	
Administering Provider First Name	Y	Y	Y – Admin	
Administering Provider Middle Name	Y	Y	Y – Admin	
Administering Provider Suffix	Y	Y	Y – Admin	Required
Administering Provider Prefix	Y	Y	Y – Admin	
Inventory Location Site	Y	Y	Y – Admin	Required
Substance Lot Number	Y	Y	Y	Required
-Lot Number: Unit of Use and/or Unit of Sale	Y	Y	Y	Required
Substance Expiration Date	Y	Y – Not Stored	Y – Admin	Required
Substance Manufacturer	Y	Y	Y	Required
Completion Status	Y	Y	Y	
-Vaccination Refusal	Y	Y	N	Optional
Action Code	Y	Y	Y	
Administration Route	Y	Y	Y – Admin	Required
Administration Site	Y	Y	Y – Admin	Required
Vaccine Funding Program Eligibility	Y	Y	Y – Admin	
Vaccine Purchased With	Y	Y	Y – Admin	
Vaccination Reaction	Y	Y	N	
Vaccination Adverse Event Outcome	Y	Y	N	
VIS Publication Date	Y	Y	N	
VIS Presentation Date	Y	Y	N	
Administered at location: type(CDC Element)	Org Type or Registration	Org Type or Registration	Org Type or Registration	Required
Administration Address: Address	Y	Y	Y	Required
Administration Address: Other Address	Y	Y	Y	
Administration Address: P.O. Box	Y	Y	Y	
Administration Address: City	Y	Y	Y	Required
Administration Address: State	Y	Y	Y	Required

Administration Address: Zip Code	Y	Y	Y	Required
Administration Address: County	Y	Y	Y	Required
Dose Number	Y – Data Mart	Y – Data Mart	Y – Data Mart	Required
IIS vaccination event ID - Auto-generated	Y	Y	Y	Required
Sending organization	N	Y	N	Required
Vaccination series complete	Y – Data Mart	Y – Data Mart	Y – Data Mart	Required

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

Since its inception, the WIR has included immunization information for individuals of all ages, and is able to routinely handle a significant increase in data during influenza season.

Some testing of the capacity to handle larger than usual numbers of incoming messages has been tested by the WIR vendor, and discussions continue to develop and enhance routine system performance checks and contingency plans to ensure that large and/or steady increases in data will not adversely affect system performance.
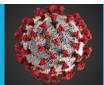
Storage:

During a recent hardware upgrade, changes were made to allow for relatively easy increases in storage capacity as needed. We are working with our vendor to monitor storage capacity and will enact a plan to increase capacity before the need becomes critical.

Reporting:

Both provider-generated (user interface) reports and direct database reporting (e.g., SAS) have the potential to impact the system. WIR employs a datamart structure, using this environment for reports (versus recording immunizations, which is done in the production environment) so the impact is generally on other running reports. This is an area we need to evaluate, as we do anticipate an increase in report use. Outside of system capacity consideration, we are making changes to our reminder recall reports, which should allow for more focused (less resource intensive) queries. This would involve a provider education component as well.

Planned changes:

We have a project to make improvements to our HL7 data exchange which were identified by the American Immunization Registry Association's (AIRA) Aggregate Assessment and Reporting Tool (AART). The project was originally intended to be completed in the spring of 2021. We are reviewing the planned changes that could positively impact our pandemic effort and considering
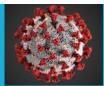
splitting the project into two implementation phases in order to complete the modifications sooner (possible December 2020 implementation date).

D. *Describe plans to rapidly enroll and onboard to the IIS those vaccination provider facilities and settings expected to serve healthcare personnel (e.g., paid and unpaid personnel working in healthcare settings, including vaccinators, pharmacy staff, and ancillary staff) and other essential workers.*
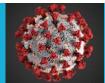
We are working on categorizing the provider organizations based on the following criteria in order to manage our onboarding queue:

- WIR Submission Status:
  - Provider organizations not already submitting immunization data to WIR.
  - Provider organizations already submitting immunization data to WIR transitioning EMR/EHR vendor solutions and disruption in service would occur.
  - Special projects identified to address specific issues with a single or multiple interfaces to address IIS program concerns or initiatives.
  - Upgrade provider organizations submitting immunization data via HL7 2.5.1 R1.4 messaging to WIR to HL7 2.5.1 R1.5 messaging standards.
  - Upgrade provider organizations submitting immunization data only HL7 2.5.1 R1.5 messaging to WIR to include query messaging via HL7 2.5.1 R1.5 messaging.
  - Provider organizations submitting immunization data and query messaging via HL7 2.5.1 R1.5
- Provider Organization Types
  - Hospitals
  - Clinics
  - Local Health Departments
  - Pharmacies
  - Employee Occupational Health
  - HMOs
- Facility Organization Size
  - Large 15+
  - Medium 5-15
  - Small 0-5
- Registration Date
- Volume of immunization data
- Vaccine For Children (VFC) provider
- Participation in the Meaningful Use program

New COVID-19 provider registration(s) coming in from a different source will add a level of complexity to the already existing queue; however, we have identified the following for how we will approach and prioritize those providers.

- Identify which COVID-19 vaccination providers are approved to receive and administer COVID-19 vaccine.
- Evaluate IIS access and current data exchange capabilities for vaccination providers with the existing queue.
  - Evaluation of IIS access:
    - Those without IIS access need to be trained on how to manually enter immunization doses administered into the IIS as well as how to manage their vaccine inventory.
    - Those with IIS access will have to be evaluated to determine if they have access to manage their inventory and access will need to be updated as needed.
  - Evaluation of data exchange capabilities:
    - Evaluate existing queue as well as the IIS to determine if a production connection is already established and being utilized to submit immunization data to WIR.
      - If the existing queue displays the production connection is already established make a connection from the COVID-19 provider enrollment to the existing queue registration to show that connection is already established.
        - No need to approach date exchange connection.
        - Mark COVID-19 provider enrollment as having data exchange established.
      - If the existing queue does not have a production connection already then identify if the organization is established within the IIS already and if data exchange has been established.
        - Data exchange has been established no need to approach data exchange connection.
        - Data exchange has not been established add to a COVID-19 data exchange onboarding list.
      - Evaluation of the organizations provider type will then be assessed to determine prioritization of COVID-19 data exchange onboarding.
        - Hospitals
        - Clinics
        - Local health departments
        - Pharmacies
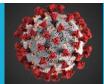   - Employee Occupational Health
        - Mass Vaccinators

- - HMOs
- Evaluation of which phase the entity will be vaccinating
    - Phase 1
    - Phase 2
    - Phase 3
- Evaluation of hub interface/large provider organization interface
    - Hub
    - Large Provider
    - Small Provider
    - Individual Providers
- Evaluation of the facility organization size
    - Large 15+
    - Medium 5-15
    - Small 0-5
- Volume of anticipated COVID-19 administration volume
    - Large
    - Medium
    - Small
- Determination of method of data exchange will have to be examined by those prioritized.
    - EMR/EHR Flat File Data Exchange Output or capture
    - EMR/EHR/System Data Exchange HL7 Capabilities
    - VAMS Tool (Utilization of the IZ Gateway)

There are already specifications as well as documentation specific to Flat File Data Exchange and HL7 Data Exchange with our system currently as well as a workflow process map of what is needed in order to test and then conduct data exchange with providers so utilizing that documentation will be of assistance already.

There will be added documentation needed (e.g., signatures for the BAA and establish their connection to the VAMS tool as well as utilization of the IZ Gateway communication) as well as training.

Rapid onboarding of providers not already submitting data exchange can be very risky and cause data quality issues. The best method that we could approach mass onboarding via data exchange in some capacity would be working to prioritize hub interfaces similar to the VAMS tool and utilization of the IZ Gateway, or other hub interfaces that are already established and have been in communication with us for a long period of time and working to get those additional providers on-boarded via those platforms if they are using those platforms of EMR/EHR systems. Otherwise organizations will be trained to use manual entry via the UI as a backup method of submitting data to WIR.

E. *Describe your jurisdiction's current status and plans to onboard to the IZ Gateway **Connect** and **Share** components.*
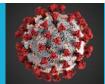
Current Status:

IZ-Gateway Connect:

1. IIS has signed DUA. -Completed
2. IIS has attended the IZ-Gateway meeting 8/25/2020 for the Third Group of onboarding participants. -Completed
3. IIS has documented the IIS Credential information for the Test Region currently for the IZ-Gateway on 8/28/2020 and received confirmation on that back. -Completed
4. IIS requested and received back Organization Security and Confidentiality Agreements for the IZ-Gateway to establish the IZ-Gateway as an Organization within the IIS. –Completed
5. IIS submitted specific certificate exchange documentation that is required currently to be able to submit to the IIS via Web Services to the IZ-Gateway for review and next steps. – Awaiting Certificate Signing Request (CSR) from IZ-Gateway as we require a signed certificate by our CA be submitted in order to connect to us.
6. IZ-Gateway has requested that the Client Certificate/Client Certificate Chain they provided the IIS be established in the IIS Trust Store for them to be able to access the WSDL. In process of determining how to proceed with getting this installed within our IIS environment.
7. Still exploring options to allow IZ-Gateway access to our Test Region. Security policy review on IIS end may need to be reviewed as well as additional development potentially including a WSDL dedicated to the IZ-Gateway based on a different method of authentication.

IZ-Gateway Share:

We are currently exploring options that would allow us to use IZ-Gateway Share. As of now, the development (and timeline) necessary to implement this has been prohibitive. Additionally, we would need to determine the impact (and our ability to address them) of data quality issues that could result from the connection.

Onboarding Plans:

The WIR team is planning on establishing the IZ-Gateway Connect connection to the Dev IZ-Gateway to our IIS Testing Region for testing and validation of data submission information then we would work on establishing that connection in our production environment as well. We primarily would like to focus our efforts on VXU messaging currently in order to be able to receive Immunization information from the IZ-Gateway for potential implementation of VAMS.

F. *Describe the status of establishing:*
1. *Data use agreement with the Association of Public Health Laboratories to participate in the IZ Gateway.*
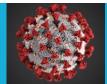   DUA agreement signed and submitted 9/29/20.
2. *Data use agreement with CDC for national coverage analyses.*
   Still awaiting the agreement from the CDC.
3. *Memorandum of Understanding to share data with other jurisdictions via the IZ Gateway Share component.*
   Inter-jurisdictional Data Exchange Memorandum of Understanding was signed previously and the new version signed 7/7/20.

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

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

Monitoring Data Quality:

A report will be developed to monitor data quality that can be run in a regular manner to assess the quality of data being submitted based on the specific CDC IIS data requirements for COVID-19 vaccine administration document dated 9/14/2020 (broken into 2 different categories demographics and vaccination).

Demographics will include percentage of what is being stored for the patients who have received a COVID-19 vaccine compared to the overall COVID-19 patient denominator on the following information (for the CDC required data elements and as time allows for the optional data elements.

Data Element	CDC Required Optional
IIS Recipient ID - Auto-generated	Required
Patient Last Name	Required
Patient First Name	Required
Patient Middle Name	Required
Patient Suffix	Required
Patient Date of Birth	Required
Patient Gender	Required
Patient Race	Required
Patient Street Address	Required
Patient Other Address	Required
Patient City	Required
Patient State	Required
Patient Zip Code	Required
Patient Country Address Code	Required

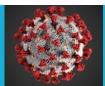|	
Patient Address Type	Required
Patient Ethnicity	Required

Vaccination will include percentage of what is being stored for the COVID-19 Vaccine Administration compared to the overall COVID-19 Vaccine Administrations base on the following information for the CDC Required Data Elements and as time allows for the Optional Data Elements as well.

Data Element	CDC Required Optional
Date/Start Time of Administration	Required
CVX Code of Administration	Required
Administering Provider Suffix	Required
Inventory Location Site	Required
Substance Lot Number	Required
-Lot Number: Unit of Use and/or Unit of Sale	Required
Substance Expiration Date	Required
Substance Manufacturer	Required
Administration Route	Required
Administration Site	Required
Administered at location: type(CDC Element)	Required
Administration Address: Address	Required
Administration Address: City	Required
Administration Address: State	Required
Administration Address: Zip Code	Required
Administration Address: County	Required
Dose Number	Required
IIS vaccination event ID - Auto-generated	Required
Sending organization	Required
Vaccination series complete	Required

Running this report on a regular basis will allow us to address any identified data quality concerns with a specific organization and to conduct outreach to encourage end users to enter information we need to report on. Running this report will also allow us to determine if enrolled COVID-19 vaccination providers are reporting the appropriate data elements.

Additional potential data elements that are going to be reported on a regular basis are listed below.

- Total number of administered COVID-19 vaccine doses reported
- Total number of inventory deducted COVID-19 administered doses reported
- Total number of doses reported within 2 days of COVID-19 administered doses
- Total number of COVID doses on hand in inventory
- Number of COVID doses missing tradename (prompt outreach/cleanup will be necessary if we have providers submitting without proper tradenames).
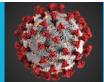
- COVID-19 vaccine series completion data based on age of clients/address/race/ethnicity

Additional Items to possibly report and review for data quality issues to be addressed on user entry of information.

- Percentage of clients updated without address
- Percentage of clients updated without phone number
- Percentage of source data being submitted
  - Manual Entry/Mass Vaccination
  - Data Exchange
  - IZ Gateway
- Inventory Statistics
  - Percentage of administered doses reported via inventory deduction
  - Doses reported as error correction
  - Doses reported as administered
  - Doses reported as spoiled/wasted
  - Doses rejected
- Data Exchange – rejected vaccination data
- Merge counts weekly compared to prior year

Additionally a current tool called the Watch Tool may be used to evaluate incoming vaccine codes as we begin to implement COVID-19 vaccine in WIR to make sure information is getting populated correctly through data exchange.

As time allows we will produce data visualization tools and create reports based on a weekly/daily snapshot using SQL and to increase accuracy in data reporting and allow us to address any issues in a timely manner.

Section 12: COVID-19 Vaccination Program Communication

Instructions:

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

Note 1: The communication workgroup is using the current seasonal flu activities to increase relationships with community based organizations (specifically non-profit organizations that serve under-served communities), health care payers (insurance companies), and federally qualified health centers.

Note 2: To effectively communicate with internal DHS (e.g., Division of Medicaid Services, Women Infants and Children program, Division of Quality Assurance, etc.), bi-weekly meetings will be coordinated through the Office of the Secretary which will include each division leadership team. Updates about COVID-19 vaccine supply and distribution will be discussed in a round-robin format and leaders will be asked to disseminate information to staff and the entities they serve.

Throughout this section we will refer to the following types of communications:

- Email: GovDelivery is the email platform used at DPH. Our contacts (55,000) include both vaccinators, and vaccine stakeholders (please see attached list of stakeholders). In addition, as we enroll or identify potential COVID-19 vaccinators, we will include them on our list serves.
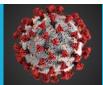- Social media: The DHS Communications Team manages the DHS Facebook, Twitter, LinkedIn, NextDoor, TikTok, and YouTube accounts, with Facebook and Twitter having the most followers. Followers are from all jurisdictions across Wisconsin. Also has access to the Wisconsin specific page of Project Vector, which tracks trends in social and traditional media in real time regarding vaccines and COVID-19.
- Webinars: DPH hosts regular calls and webinars with local health officers, long term care, and health care providers. Vaccine updates will be plugged into those existing mechanisms.
- Podcasts or other pre-recorded platforms: This is a new platform that we are considering. We understand that providers are busy and reading emails can be arduous. We are exploring using a podcast-type of platform to share information with a regular cadence.
- Website: DHS maintains web content for COVID-19 and will develop COVID-19 vaccine webpages. The current COVID-19 disease pages get thousands of hits per month and are often promoted via traditional and social media.
- Call center: In phases 1a, 1b, and early on in phase 2, a key channel for communicating to both vaccinators and the public is via a call center. The structure of the call center will be based upon lessons learned from past crises. Staff supporting the call center will be provided just in time training, a script/ FAQ developed by Program SMEs. The types of questions will be

shared with the communications workgroup via daily updates. The communications workgroup will develop broad messaging based upon these inquiries that will be shared out via social media and other appropriate channels.

Pre-vaccine phase: In late October, the workgroup intends to disseminate messaging to stakeholders and the public about the vaccine development process, in general. The purpose is to make stakeholders and the public aware of (generally) how vaccines are developed, gain FDA approval, and are recommended by CDC, as well as the role of ACIP and post licensure safety monitoring.

Messaging will be shared via email, social media, and on webinars with stakeholders who will be encouraged to share with their communities they serve. We intend to continue sharing messages through all COVID-19 vaccine program phases.

Note: Throughout all phases, the communication workgroup will work with SMEs to disseminate appropriate messaging to vaccinators.

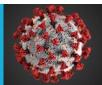**Phase 1**: Communication Plan for when vaccine is limited.

Phase 1A Vaccinators, local health departments, long term care staff, pharmacies and tribal health clinics: The communication workgroup will work with SMEs in other workgroups to develop appropriate messaging to be sent out via email.

As vaccination providers enroll in the WI COVID-19 Vaccine Program, we will collect main point of contact email addresses for each entity. Those emails will be added to our distribution email lists. These emails will be our primary communication method to vaccinators. As vaccine becomes available, recommendations from ACIP are announced, and the SDMAC has provided guidance, we will notify the Phase 1A vaccinators of **who** is recommended to receive the initial vaccine doses and **when** they can expect to receive vaccine.

To have a one-stop resource for vaccination providers, we will update our websites to reflect current recommendations, vaccine storage handling, and administration, links to VISs and EAU fact sheets, answers to frequently asked questions (from the public), and safety information as it becomes available. As information from FDA, OWS, CDC, or the state advisory board changes, our webtechs will work to update the website accordingly throughout all phases of the COVID-19 Vaccine program.

Phase 1A Stakeholders and General Public: We have an enthusiastic group of stakeholders who are eager to support our efforts. The communications workgroup will come up with a plan to engage and maintain that enthusiasm throughout the COVID-19 Vaccine delivery process (since we anticipate this extending over several months, enthusiasm may wane).

As early vaccine becomes available and the initial priority groups are announced at the national and state-levels, the communication workgroup will notify our stakeholders (as listed in the attachment) via email (our normal method for communication) and include any resources and materials for answering questions and disseminating COVID-19 vaccination (leaning on those

materials developed through OWS, CDC, and other federal entities and made to fit Wisconsin's audiences). A key piece will be to translate materials by DHS into Spanish, Hmong, Somali, and Pennsylvania Dutch, and American Sign Language.

Potential gap: Unfortunately, translations typically take several weeks and there is concern that the information will not reach the communities in a timely fashion.

When the first doses of vaccine are available for administration, DHS will send out a press release (in English and Spanish), and likely follow-up with a press conference. Additionally, vaccine updates will likely be a regular topic of the media briefings that are typically held at least twice a week.

Phase 1B Vaccinators, local health departments, long term care staff, pharmacies and tribal health clinics: As vaccine supply increases, and additional priority populations are recommended, the communication workgroup will continue to communicate updates to enrolled COVID-19 vaccinators through email (and potentially a podcast).

Key messages will include, but not limited to:

- Reminders about proper vaccine storage and handling
- Vaccine administration requirements
- Recommended populations to receive the vaccine
- Encouraging reminder/recall through the WIR or EMR for products requiring a 2-dose series
- Adherence to staff and patient safety procedures
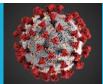- Reporting adverse events to VAERS

Phase 1B Stakeholders and General Public: Similar to Phase 1A, we will notify our stakeholders via email and include any resources and materials for answering questions and disseminating COVID-19 vaccine information (leaning on those materials developed through OWS, CDC, and other federal entities and made to fit Wisconsin's audiences). We will work to continue to translate materials through DHS into appropriate languages.

The communications team will continue to follow the patterns outlined above as supply increases and target populations broaden.

Phase 2: As vaccine supply increases, and becomes available to the general public.

Phase 2 Vaccinators, local health departments, long term care staff, pharmacies and tribal health clinics: As the number of vaccination providers increases, the Communication workgroup will work closely with SMEs to communicate reminders and updates about vaccine supply.

Phase 2 Stakeholders and general public notification: Communicating that vaccine supply is available to the general public, and where they can go to get it, will take a large outreach effort as outlined below.

Stakeholders: We will lean on the network of stakeholders that we've built and will continue to build as the vaccine campaign continues. As resources allow, we will build a just in-time training (similar to our seasonal flu training and lists of resources) and disseminate to community entities conducting outreach. As a program, we've adopted the stance that message dissemination is best when it comes from community leaders. Therefore, we will provide a messaging framework through resources (sourced from OWS, CDC, and other national partners) and trainings (vaccine facts, myth-busting, how and where to get vaccinated) that can be adapted by communities to best fit their needs.

Social media: Because social media can be a platform for disinformation, we will be judicious in our use as a means of messaging to the public. In this phase, we will likely lean on YouTube and Facebook Live events to disseminate information and answer the public's questions.

Traditional media statewide: DHS conducts on-going press conferences to update the media with key messaging. Additionally, the data workgroup and communication workgroup will collaborate on messaging that will be displayed on the website. Our goal is to include/update our key messages on our website that statewide media can use (i.e., cut and paste) for their news stories.

Local-media: The communication workgroup will provide message maps, press release templates, and social media messaging to local and tribal health departments (similar to our process during influenza season) regularly that includes any statewide key messages and can be edited to include local key messages as well.
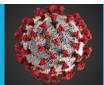
If funding is available for a statewide education campaign, the Immunization Program will lean on our past experience with contracting with a vendor to create a statewide communication/education campaign. The target audiences will align with national vaccine recommendations, will expand reach in parallel with those recommendations, and will use appropriate platforms to best reach those audiences.

Note: Throughout phases 1A, 1B, and 2, we will emphasize that the recommendations for targeted populations will expand as vaccine becomes available and we will direct the public to CDC's self-assessment website to determine if they are recommended to receive a vaccine.

Phase 3: Vaccine supply meets demand. The details for this phase are less clear at this point since the timing, and guidance from national partners (OWS, CDC) is not yet available. Generically, we will share national partner messaging and make it applicable to Wisconsin.

Likely at this phase, the communications workgroup will be rolled into the routine Immunization Program workflow. Messaging to the public will likely look similar to our annual flu campaigns.

Messaging to vaccinators will focus on incorporating COVID-19 vaccination into routine vaccination schedules and appointments.
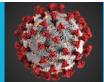
B. *Describe your jurisdiction's expedited procedures for risk/crisis/emergency communication, including timely message development as well as delivery methods as new information becomes available.*

Emergency communications go through the following approval process after being drafted: Immunization Program Manager→Bureau of Communicable Diseases Director→COVID-19 Response Team→DHS Office of the Secretary (DHS OS)

The communications workgroup has identified a liaison with the DHS Office of the Secretary who is tasked with ensuring appropriate approvals are given and that items are disseminated in a timely way. This structure has served us well in past communications efforts (i.e., measles cases, annual influenza, and other education campaigns). In general, the communications workgroup has a well-established relationship with the DHS Office of the Secretary Communications Team who often provide recommendations and ideas for amplifying message dissemination.

Additionally, we rely on members of the DHS Office of the Secretary to act as our program's Public Information Officers, coordinate media inquiry responses, manage press conferences, and work with the workgroup to write remarks (talking points) for officials.

Section 13: Regulatory Considerations for COVID-19 Vaccination

Instructions:

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

Once a vaccine has been licensed/approved, the communications workgroup and provider education workgroups will provide training and education regarding the specifics of the vaccine, such as storage, handling, and clinical guidance. This will also include information about the EUA fact sheets and VIS and reinforce the importance of using EUA and VISs.

The Education workgroup is currently developing an educational resource that will be given to all COVID-19 vaccination providers, including information about storage and handling, clinical guidance, as well as other requirements (such as the use of the EUA factsheet or VIS).

The Communication workgroup will provide constant reminders to health care providers via email and webinars to share up to date EUAs and VISs. As updated versions become available, we will send to the main points of contacts that each entity listed when they enroll as a COVID-19 vaccination provider. Additionally, a mailbox where providers can email questions, including those about the EUA fact sheet and VIS, will be available, with subject matter experts providing answers.
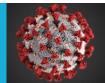
Describe how your jurisdiction will instruct enrolled COVID-19 vaccination providers to provide Emergency Use Authorization (EUA) fact sheets or vaccine information statements (VISs), as applicable, to each vaccine recipient prior to vaccine administration.

We will rely on the educational materials that OWS and CDC are developing to train health care providers. We anticipate these materials will be available prior to vaccine delivery and that they will be a requirement to enroll in the Wisconsin COVID-19 program. Once we are able to review the materials, we will decide the best platform (most likely a pre-recorded webinar). We will track via a spreadsheet which providers have completed vaccine storage, handling, and administration training.

All materials including links to fact sheets, VISs, and training materials (if applicable) will be made available on the Wisconsin Immunization Program website.

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

Use of EUA fact sheets and/or VIS among COVID-19 vaccination providers will be included as part of provider training conducted in advance of vaccine distribution.
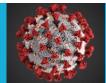
Section 14: COVID-19 Vaccine Safety Monitoring

Instructions:

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

The link to VAERS is currently on the Immunization Program's website, and VAERS information is included in VFC enrollment and training; these routine activities will continue. As COVID-19 vaccination providers are enrolled, VAERS training will be included in the trainings and resources provided as part of this process. Additionally, a one-page document explaining VAERS and the reporting process has been created and will be disseminated to public health and medical providers. Links to VAERS will be sent to medical providers via email listserv and health alert messages and local health departments and tribes will be encouraged to educate providers within their jurisdiction.

Section 15: COVID-19 Vaccination Program Monitoring

Instructions:

A. *Describe your jurisdiction's methods and procedures for monitoring progress in COVID-19 Vaccination Program implementation, including:*
   - *Provider enrollment*
   - *Access to COVID-19 vaccination services by population in all phases of implementation*
   - *IIS or other designated system performance*
   - *Data reporting to CDC*
   - *Provider-level data reporting*
   - *Vaccine ordering and distribution*
   - *1- and 2-dose COVID-19 vaccination coverage*

Provider Enrollment

We will be running regular reports from data collected by the provider registration tool.

Access to COVID-19 vaccination services by population in all phases of implementation

WIR does not currently collect place of employment or occupation. DHS will need to use another system (VAMS or another tool outside of WIR) to capture the vaccination status of people prioritized to receive vaccine based on their occupation. This information can be approximated, using the administering entities organization type as a proxy, and using population estimates of a particular group, or what was provided in the provider registration and survey process to estimate the coverage in these areas.

For age groups, race/ethnicity, and location, we will use WIR data to monitor those who have received vaccine and where the gaps are. More information on this, is included in Section 9.
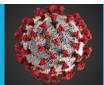
IIS or other designated system performance

The WIR team has weekly meetings with our vendor during which we address system performance concerns and there is a process in place to address unexpected outages in a timely manner.

Data Reporting to CDC

As a CDC IIS Supplemental (CC4) awardee and prior IIS sentinel site awardee for 10 years, Wisconsin has created robust data extraction and submission processes to send data to the CDC. Due to the similarity of data variables between COVID-19 submissions and CC4, Wisconsin plans to use the same query and process with the updated COVID-19 variables (once the Wisconsin Data Governance Board approves of it and a DUA is signed.)

As is done with the CC4 submissions, the data will be extracted during the off-hours so to not impact system performance. The data will be available the next morning for the team to review and submit to CDC via a secured connection.

One of the issues experienced with the CC4 data submissions is that the files are large and need to be broken into sections in order to efficiently generate the data sets in a timely manner. We anticipate needing to employ similar processes for COVID-19 data.

An additional issue being addressed is the ability to access and send the data given that staff are working remotely.

Provider-level data reporting

Provider-level data reporting will be tracked via the data quality portion of this plan. Currently, we have two data quality tools used by Wisconsin state staff to review provider reporting: the provider report card and the watch tool. However, we aim to expand upon these tools and create a data quality specific dashboard that would include a list of the required variables for COVID-19 data submission, timeliness of data entry, and percent of null variables that we could monitor on a frequent basis. To learn more about the data reporting, please refer to the Data Quality section within this plan. We do not plan to have an external facing publication of this data and it would only be used for internal purposes.
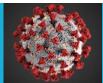
Vaccine ordering and distribution

Once vaccine is available, the Wisconsin team will use the vaccine ordering functionality that is used by the VFC program. Vaccine ordering will take place within WIR, state staff will approve or adjust orders as necessary, and then upload the information to VTrckS. Order fulfillment information will be sent from VTrckS and populate the WIR, where state staff as well as providers can monitor the status of the order.

Wisconsin in their daily updates and weekly reports will begin by providing information on vaccines allocated and then switch to vaccines ordered during the later phases of the vaccine response.

Monitoring 1- and 2-dose vaccination coverage

Daily, Wisconsin will generate COVID-19 vaccination rates, including one dose and series complete. Note: series complete is preferred over 2 doses as that will not include invalid doses due to interval excursions or mismatched vaccine types (dose 1 and 2 not the same type/manufacturer). Therefore, the variable that calculates vaccine completion taking into account trade name used, ages at vaccination, and interval between doses, to provide as a coverage estimate will be used. Wisconsin will post all data for number of vaccines administered, as well as, coverage by vaccine trade name as there will likely be multiple different trade names allocated per state.

In addition to the Tableau dashboard, Wisconsin plans to send data via an e-mail distribution list to stakeholders on at least a weekly basis, such as in the format of a Week-At-A-Glance document. This document will include information from the Tableau dashboard and serve as a summary with talking points and 'need-to-know' information. This document will also be posted on our website and can be used by the media for talking points during their news reports.

B. *Describe your jurisdiction's methods and procedures for monitoring resources, including:*
- *Budget*
- *Staffing*
- *Supplies*

State health department staffing time for the COVID-19 vaccine response can be monitored through the enterprise HR state system called STAR, which tracks employees time and which funding source that their work hours are charged to. Similarly, charges for supplies are monitored through this same system. Budget Policy Analysts from the DPH Bureau of Office Operations are assigned to each section or office and provide regular budget updates and projections regarding funding sources, allowing for monitoring of the budget and adjustments as needed.

C. *Describe your jurisdiction's methods and procedures for monitoring communication, including:*
- *Message delivery*
- *Reception of communication messages and materials among target audiences throughout jurisdiction*

The GovDelivery system that is used for bulk emails to stakeholder lists has analytics within the tool that can determine open rates, delivery success, and these are monitored with each missive that is sent. Additionally, by monitoring the email box where questions about vaccines can be submitted, the common questions can be used to inform the updating of FAQ, etc.

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

Immunization program staff will attend the standing daily local health department health officer calls which are already in place to gather information on what is happening at the local level including vaccine hesitancy, vaccine storage and handling issues, and public perceptions.
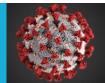
Additionally, staff will routinely access the Wisconsin page of Project Vector, part of the Public Good Project, to monitor social media and media topics being discussed around COVID-19 vaccine in Wisconsin.

Regular analyses, as described earlier, will be used internally, as well as incorporated into already existing communications and the website that are part of the current COVID-19 response to help inform stakeholders.
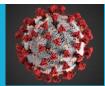
E. *Describe the COVID-19 Vaccination Program metrics (e.g., vaccination provider enrollment, doses distributed, doses administered, vaccination coverage), if any, that will be posted on your jurisdiction's public-facing website, including the exact web location of placement.*

The following data metrics will be captured and put on our public-facing website:

      i.   Number of vaccine doses allocated to Wisconsin by week

ii. Number of vaccine doses administered in Wisconsin total
iii. Number of vaccine doses administered in Wisconsin by trade name
iv. Percent of population vaccinated with one dose of COVID-19 vaccine
v. Percent of population complete with their COVID-19 vaccine series (2 doses in the correct intervals and of the same trade name)
vi. Percent of individuals vaccinated with COVID-19 vaccine by gender
vii. Percent of individuals vaccinated with COVID-19 by race and ethnicity
viii. Percent of individuals vaccinated by age group (age group will mimic the VAERS reporting age groups for consistency purposes)
ix. Number of providers that have administered at least one dose of COVID-19 vaccine
x. Percent of vaccine doses given by organization type with focuses on the following organization types : mass vaccination clinics, nursing home/assisted living, local health departments, pharmacies, medical clinics
  1. Note: WIR's organization type is used for reporting purposes and was not created to identify the actual type that a provider is (i.e. pediatrics, STD, occupational health.) Therefore, this information will be collected via the provider registration tool and used external to WIR.
  2. With correct organization type, there will still be circumstances when the organization type might not be correct. The organization type sent to WIR and created in WIR is based off who administers the vaccine and not where they administer the vaccine. For instance, a pharmacy administering vaccine at a nursing home would be recorded under the "pharmacy" organization type instead of "nursing home."

xi. Number of vaccines administered at the different organization types
  1. Limitations for this are the same as above.
xii. Wisconsin state map of vaccination coverage
  1. Shading on the map will represent vaccination coverage and the number within each county will represent the total number of individuals who have completed their COVID-19 vaccine series. Web location of vaccination metrics: https://www.dhs.wisconsin.gov/covid-19/index.htm

- Limitations:
  i. The WIR does not collect underlying medical conditions or the occupations of individuals vaccinated and therefore does not have a way to identify those needing a reminder or recall notification based on these criteria.
  ii. Some of the variables related to underlying conditions and place of employment are not collected in WIR and could potentially be collected in another system (VAMS or others). However, it is unclear which product Wisconsin will use for the other optional and required variables that Wisconsin currently cannot collect in WIR.
  iii. There are a few counties in Wisconsin which have multiple city or location-based health departments in which they are responsible for the citizens of that area. Currently, the WIR only records the county; work is planned to include local health

jurisdiction, but at this time, it is unclear when that work will be completed given other priorities. A work-around for this exists, but requires significant staff time and is subject to some error.

Instructions: *Jurisdictions may choose to include additional information as appendices to their COVID-19 Vaccination Plan.*

Appendices:

4.1 Critical Populations- State Planning

4.2 Critical Populations- Template for Local Health Jurisdictions