GUIDANCE EXCERPT

WA STATE COVID-19 VACCINE ALLOCATION GUIDANCE

PHASE 1A ONLY

The Washington State Department of Health has developed this guidance for COVID-19 vaccine allocation and prioritization to facilitate harmonized planning for distribution across Washington State. This guidance is the result of several months of engagement with expert groups and community partners to gather input and ideas (more details coming in full guidance). Given current information and federal guidance, we are providing guidance on Phase 1a that incorporates this input while staying aligned with the principles and criteria noted below. We are continuing to develop the other phases. The guidance will be updated to provide details on the other phases based on:

- New information from clinical trials
- New federal guidance and vaccine recommendations
- Ongoing feedback from impacted communities, partners, sectors, and industries

In all circumstances, although reinfection appears uncommon during the initial 90 days after symptom onset, prior confirmation of COVID-19 infection will not exclude any individual from eligibility for COVID-19 vaccine and serologic testing is not being recommended prior to vaccination.

GOAL: To reduce severe morbidity and mortality and negative societal impact due to the transmission of SARS-CoV-2

ETHICAL PRINCIPLES	PROCEDURAL PRINCIPLES	CRITERIA
• Maximum benefit • Equal concern • Mitigation of health inequities	• Fairness • Transparency • Evidence-based	• Risk of acquiring infection • Risk of severe morbidity and mortality • Risk of negative societal impact • Risk of transmitting infection to others

Washington State Department of Health

PHASE 1

Currently, we are limiting Phase 1 of the allocation framework to Phase 1a including the following populations:

- **High-risk workers in health care settings** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **High-risk first responders** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **Residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance**

Phase 1a

Phase 1a focuses on (a) high-risk workers in health care settings and high-risk first responders in order to protect our medical care response capacity and (b) residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance aiming to avoid hospitalizations, severe morbidity, and mortality. The table below identifies the desired objectives for this phase and guidance regarding what type of workers would be prioritized for vaccine allocation in this phase. We are providing recommendations that closely align with the Advisory Committee on Immunization Practices (ACIP) and include risk stratification given limited vaccine.

CDC has provided initial COVID-19 vaccine supply projections for the first two months. Assuming Washington state receives approximately 2 percent of the total projections (Washington's approximate proportion of total U.S. population), our state might expect between 150,000 to 350,000 doses in the first month and between 500,000 to 1 million doses in the second month (inclusive of second doses). Also note that many residents of long-term care facilities will be served via a federal pharmacy program that will begin in late December, and the program will draw down from the Washington state vaccine allotment. Given limited vaccine, clinical judgment should be applied to identify who is at greatest risk using the guidance below while recognizing that any workers in health care settings and first responders who are not prioritized in this phase would be considered critical workers in future phases. The guidance includes considerations for such sub-prioritization. Furthermore, agencies may consider staggering vaccine schedules of teams to avoid potential clustering of worker absenteeism related to systemic reactions. Beyond ACIP, this guidance was developed based on input and review by a number of experts including Washington advisory groups (Vaccine Advisory Committee, Disaster Medical Advisory Committee, COVID-19 Science Advisory Working Group, Association for Professionals in Infection Control), health care providers, and local health jurisdictions (including health officers).

PHASE 1A **OBJECTIVES**	PHASE 1A **GUIDANCE**

To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations	*Per ACIP guidance:*
	Healthcare personnel[1] - including first responders - who have direct patient contact (within 6 feet) and are unable to telework including:
	• Personnel who provide services to patients or patients' family members
	• Personnel who handle infectious materials
	• Can include inpatient or outpatient settings
	Personnel working in residential care, long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance
	
	In the context of limited vaccine, this guidance includes the following sub-prioritization considerations to inform clinical judgment to identify those most at risk:
	• Personnel without known infection in prior 90 days
	• Workers in sites where direct patient care is being delivered to confirmed or suspected COVID-19 patients, including sites where suspected patients are directed for COVID testing and care
	  ○ Example setting: hospital sites managing suspected/confirmed COVID patients; emergency departments; urgent care; clinics (walk-in, respiratory); home; isolation and quarantine facility
	  ○ Examples types of workers: health care workers; technicians; security; environmental, janitorial, and facility staff; non-remote translators; counselors; home health aides, caregivers, and companions
	• Workers performing high-risk exposure procedures with suspected or confirmed COVID-19 patients
	  ○ Example procedures: endotracheal or cough inducing intubation; cough induction or cough inducing procedure (e.g., nasogastric tube); bronchoscopy; suctioning; turning the patient to the prone position; disconnecting the patient from a ventilator; invasive dental procedures and exams; autopsies; respiratory specimen collection; cardiopulmonary resuscitation; upper endoscopy; laparoscopic surgery; placement of chest tubes for pneumothorax
	• Workers exposed to/handling potentially SARS-CoV-2 containing specimens
	• COVID-19 testing site staff at high risk of exposure to suspected COVID-19 patients
	• First responders at highest risk of exposure to suspected or confirmed COVID-19 patients via high public exposure and procedures
	  ○ Licensed emergency medical service frontline staff regardless of agency (e.g., fire, ambulance, hospital)
	  ○ Emergency workers providing patient transport/ambulatory support regardless of agency
	  ○ Personnel working in the field to provide oversight of these emergency medical service positions

[1] **Healthcare personnel (HCP)** refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. These HCP may include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted among from HCP and patients.

	• Workers with elevated risk of acquisition/transmission with populations at higher risk of mortality or severe morbidity
	  o Workers at long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance (e.g., healthcare, environmental facility management, counselors, dining staff, etc.)
	  o Home health aides, caregivers, companions
	  o Workers with patients undergoing chemotherapy, chronic renal disease, dialysis, etc.
	• Workers (including pharmacists and occupational health staff) administering vaccines to Phase 1a, 1b, and 1c populations
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	Residents of long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance and are unable to reside independently in the community:
	• Example: skilled nursing facilities – facility engaged primarily in providing skilled nursing care and rehabilitation services for residents who require care because of injury, disability, or illness
	• Example: assisted living facilities – facility providing help with activities of daily living; residents often live in their own room or apartment within building/group of buildings
	• Examples of possible settings: adult family homes; group homes for people with disabilities (physical, developmental, intellectual); mental/behavioral health institutions; residential homeless shelters
	
	Where sub-prioritization is needed, consider:
	• Skilled nursing facilities caring for the most medically vulnerable residents and of a congregate nature so they face the joint risk factors of severe disease/mortality and transmission due to their living settings
	• After skilled nursing facilities, consider broadening to other facilities, including:
	  o Assisted living facilities and adult family homes
	  o Residential care communities
	  o HUD 202 low-income senior housing
	  o Intermediate care facilities for individuals with developmental disabilities
	  o State Veterans Homes

Phase 1a Additional Guidance

- We specifically use the terminology "workers in health care settings" and not "health care workers or personnel" because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services).
- Special attention should be paid to workers in health care settings who are at high risk of exposure and may have inconsistent or limited use of PPE as well as those working in settings with inadequate environmental controls for recommended air exchange.

Implementation Consideration

Vaccine administration sites have expressed interest in avoiding the burden of assessing eligibility. A consideration is for employers of workers in healthcare to provide their high-risk workers a voucher or letter including the person's name and phase 1a eligibility status. This voucher or letter could be shown with a badge and/or ID at a vaccine administration site. The Department of Health is developing a template for such a voucher that may be utilized. In addition, the Department of Health is exploring to pilot a tech solution that would allow people to self-assess their eligibility. It would send confirmation for eligibility in phase 1a to be shared at the administration site along with a badge and/or ID.

ABOVE IS AN EXCERPT FROM THE GUIDANCE. MORE INFORMATION WILL BE PROVIDED WHEN AVAILABLE.
DATE: 12/10/2020