

COVID-19 Vaccination Plan

VERMONT

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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.*

The Immunization Program Manager, working with the State Epidemiologist and the Deputy Commissioner of Health identified the need to bring together a COVID-19 Vaccine Planning Team with representation from state government including multiple divisions in the Vermont Department of Health (VDH), the Agency of Digital Services (ADS) and Vermont Emergency Management (VEM). There was also representation from the University of Vermont Medical Center Infectious Disease and the Vaccine Testing Center. The initial goals of the COVID-19 Planning Team were to:

1. Expand current systems to ensure statewide access to COVID-19 vaccine. Vaccine will be provided to priority groups through mass vaccination clinics initially, and then the public through routine immunization services.
2. Create a system to monitor the allocation, distribution, administration, and ongoing evaluation of COVID-19 vaccine statewide.
3. Expand access to pediatric and adult influenza vaccine in Fall/Winter 2020 to limit morbidity and mortality due to flu and additional stress on the health care system. Utilize school-located vaccine clinics (SLVC's) for outreach to those <19 years and targeted community clinics for high-risk adults.
4. Develop a comprehensive communication plan to promote the uptake of flu and COVID-19 vaccines, with specific outreach to vulnerable populations.
5. Use the Homeland Security Exercise and Evaluation Program for continuous program evaluation and improvement.

The Team began twice monthly meetings on July 9, 2020. Three sub-groups (IT/Immunization Registry, Logistics and Communications) were formed to address the wide range of planning needs. These groups have been very active, meeting weekly to plan for the COVID-19 vaccination campaign.

The primary lesson learned from the H1N1 flu vaccination effort in 2009 was to manage Vermonters' expectations for vaccine availability, and offer clear, frequent, and forthcoming information using tested Crisis and Emergency Risk Communication (CERC) principles. Many other lessons on communications were also noted and are being integrated into planning. There were delays in entering vaccines administered into the Vermont Immunization Registry (VT IIS). Many of these issues have been resolved. Work is continuing to ensure that all COVID-19 vaccines administered are reported within 24 hours, per guidance from the Centers for Disease Control and Prevention (CDC).

Proposed Timeline

November 1

- Begin enrollment of health care facilities (HCF)/providers/pharmacies in the COVID-19 Vaccination Program
- Prepare to onboard HCF/providers as soon as enrollment forms have been completed; ensure ability to meet CDC requirements
- Continue to refine the critical populations definition – Vermont COVID-19 Vaccine Advisory Committee reviews allocation proposal

When COVID-19 vaccine becomes available:

- Distribute initial vaccine allocation to address those identified in Phase 1A; utilize closed/open POD's for mass vaccination approach (CDC)
- Offer open mass vaccination clinics through VDH for those that can't be reached through hospitals, pharmacies or closed POD's
- Utilize the Immunization Registry and CDC Vaccine Administration Management software to monitor vaccination uptake and conduct reminder recall for second dose, if indicated

When vaccine allocation increases

- Expand vaccine availability by allocating doses to enrolled PCP's

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.*

The Vermont Department of Health employs the Homeland Security Exercise and Evaluation Program (HSEEP) to validate plans. The HSEEP program includes a progressive exercise approach and a continuous quality improvement process. The Vermont Department of Health employs the Homeland Security Exercise and Evaluation Program (HSEEP) to validate plans. The HSEEP program includes a progressive exercise approach and a continuous quality improvement process. Given the condensed timeframe and the rapid, ongoing changes to planning assumptions, the Department will utilize the HSEEP framework to build and sustain capabilities and maintain readiness. Through ongoing, scenario driven discussions the plan will be revised to adapt to the changing landscape. After action reports will be produced throughout the response.

Section 2: COVID-19 Organizational Structure and Partner Involvement

Instructions:

A. *Describe your organizational structure.*

The VDH is a centralized public health organization that operates as the only governmental public health organization in the State of Vermont.

VDH is in the State's Agency of Human Services. VDH includes the Division of Health Surveillance, where both the Public Health Statistics Section (includes the Immunization Registry) and Infectious Disease Section (includes the Immunization Program) are located. The Immunization Program Manager reports to the State Infectious Disease Epidemiologist and the Registry Manager reports to the Health Statistics Director.

The Health Operations Center (HOC) is used by the health department to coordinate a local response to any major emergency or disaster situation. VDH has statutory authority for all citizens and regions. The VDH HOC has been fully activated since early March. The HOC connects directly with 12 Local Health Office Emergency Operations Centers and the State Emergency Operations Committee (SEOC) using an online incident management system and a Voice Over Internet Provider. Redundant and interoperable forms of communication are also maintained if these systems were to fail.

VDH works collaboratively with the SEOC and the Joint Information Center when activated. The SEOC acts as a Multi-Agency Coordination Center within the State Multi-Agency Coordination System and is responsible for coordinating and assigning agency responses in a multi-agency or multi-jurisdictional environment through pre-identified State Support Functions (SSF). VDH leads the Health and Medical Services Partner Desk and Supports the Agency of Human Services in their lead in the Mass Care, Emergency Assistance, Housing and Human Services Partner Desk.

B. *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.*

Vermont is a small state, where the medical and public health communities have close ties and collaborate on all important health issues. To ensure timely input from key partners in the state, a COVID-19 Vaccine Implementation Advisory Committee is being formed which will include wide representation from the Crisis Standards of Care Group and those who serve populations at greatest risk for COVID-19.

C. *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.*

As noted in Section 1A, the COVID-19 Vaccine Planning Team was convened in July 2020. The Team includes professionals in the areas of epidemiology, statistics, communications, infectious disease, IT, preparedness and logistics. The importance of having back-up representation is well understood and integrated into planning at every level.

Identify and list members and relevant expertise of the internal team and the internal/external committee.

See Appendix B for list of COVID-19 Vaccine Planning Team Members.

COVID-19 Vaccine Implementation Advisory Committee

Selected members of the Vermont Crisis Standards of Care Work Group will provide the foundation for the COVID-19 Vaccine Implementation Committee, with representation from multiple other areas to ensure all critical populations are represented. Representation includes:

American Red Cross, New Hampshire and Vermont Region
Association of Africans Living in Vermont
Bi-State Primary Care Association
Brattleboro Retreat
Disability Rights Vermont
Governor's COVID Tech Advisor
Porter Medical Center
University of Vermont Medical Center
University of Vermont Health Network
Vermont Board of Medical Practice
Vermont Care Network
Vermont Department of Disabilities, Aging and Independent Living
Vermont Department of Health
Vermont Department of Mental Health
Vermont Developmental Disabilities Council
Vermont Emergency Management
Vermont Ethics Network
Vermont's Free & Referral Clinics
Vermont Health Care Association / Mountain View Center
Vermont Healthcare Emergency Preparedness Coalition (VHEPC)
Vermont Legal Aid/Healthcare Advocate
Vermont Medical Society
Vermont Partnership for Fairness and Diversity
Vermont Pharmacists Association
Vermont Psychiatric Care Hospital
Vermont Public Health Association
Vermont State Nurses Association
VNAs of Vermont
VT Assoc. of Hospitals and Health Systems
VT Chap. Am. College of Emergency Physicians / Northeast Vermont Regional Hospital
Vermont Coalition to End Homelessness

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

As noted, the VDH is a centralized public health organization. The Office of Local Health (OLH) is one of six VDH divisions. The OLH Central Office provides administrative management and oversight of the work of 12 [Local Health Offices](#) that serve populations that range from about 25,000 to 163,000. The leaders for each of the 12 Local Health Offices participate in monthly expanded team meetings and are actively involved in the work of the currently activated Health Operations Center. In addition, the State Emergency Operations Center coordinates all other state level assistance to be provided during this effort including logistical needs such as transport, security, storage, procurement, personnel to support the work of the Health Department, and are a direct link to the Emergency Management Directors in each city/town. Emergency managers in each town will have input into planning.

E. *Describe how your jurisdiction will engage and coordinate efforts with leadership from tribal communities, tribal health organizations, and urban Indian organizations.*

The Abenaki were only recognized as a tribe by Vermont state government in 2011. Four Abenaki tribes in Vermont are recognized by state government: Elnu, Missisquoi, Koasek and Nulhegan. No Vermont tribe has federal recognition.

The Health Equity and Community Engagement Team is exploring ways to leverage emergency response funding to provide community-based initiatives that support indigenous Vermonters and communities impacted by the pandemic.

F. *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:*

- *Pharmacies*
- *Correctional facilities/vendors*
- *Homeless shelters*
- *Community-based organizations*
- *State Emergency Operations Center*

Hospitals – There are 14 hospitals in Vermont. The Commissioner of Health speaks with their leadership at weekly meetings organized by the [Vermont Association of Hospitals and Health Systems](#). The Immunization Program Manager met with the chief medical officers for all Vermont hospitals in September to discuss their role in reaching essential healthcare workers and other critical populations.

Pharmacies – The Immunization Program has a strong working relationship with the Executive Director of the Board of Pharmacy and the Pharmacy Director for the Department of Vermont Health Access (DVHA); both are active members of the Immunization Funding Advisory Committee. DVHA is responsible for administering the Vermont Medicaid health insurance program and Vermont's state-based exchange for health insurance. VDH, in collaboration with Vermont Information Technology Leaders (VITL), is actively working with all pharmacies to support efforts to report vaccines administered within 24 hours.

Community-based facilities – Community-based organizations will be essential in reaching those 65 years and older. VDH is collaborating with the Department of Disabilities, Aging and Independent Living (DAIL) in planning to ensure COVID-19 vaccination services will be accessible to those living in assisted living facilities, senior residences and the community. In addition to DAIL and other key State partners, we will coordinate closely with organizations that serve people who are disproportionately affected by COVID-19 to understand and address potential barriers to vaccine accessibility and uptake. Through the COVID-19 response to date, our Health Equity and Community Engagement (HECE) team has grown existing relationships with community partners and established new connections to organizations that do this important work. Ensuring that all Vermonters have access to both transparent information about a vaccine, and the vaccine itself, is critical.

Correctional facilities - In Vermont, the Department of Corrections (DOC) and the Health Department are housed within the Agency of Human Services. In the past year, the Immunization Program worked closely with the DOC and their vendor for healthcare services to provide and administer hepatitis A vaccine as part of outbreak prevention efforts. During the COVID-19 pandemic, testing has been routinely provided in correctional facilities by Health Department staff. Due to additional federal funding, the Immunization Program was able to provide the DOC flu vaccine this year for use inmates and staff.

VDH is actively working with the DOC to enhance immunization reporting, to ensure they will be eligible for enrollment in the COVID-19 Vaccination Program.

Homeless Shelters - Extensive work has been done to address the needs of people experiencing homelessness during the pandemic. Outreach to ensure access to testing for people experiencing homelessness has been successful. We also have a successful history of outreach to facilities that provide services to this population for other vaccination efforts, including H1N1 and hepatitis A. We will build on these experiences and modify this model, working with key community partners as needed, to ensure access to testing for this population.

State Emergency Operations Center - The SEOC acts as a Multi-Agency Coordination Center within the State Multi-Agency Coordination System and is responsible for coordinating and assigning agency responses in a multi-agency or multi-jurisdictional environment through pre-identified State Support Functions (SSF). The HOC and SEOC have demonstrated the ability to effectively coordinate efforts in response to health and other emergencies.

Section 3: Phased Approach to COVID-19 Vaccination

Instructions:

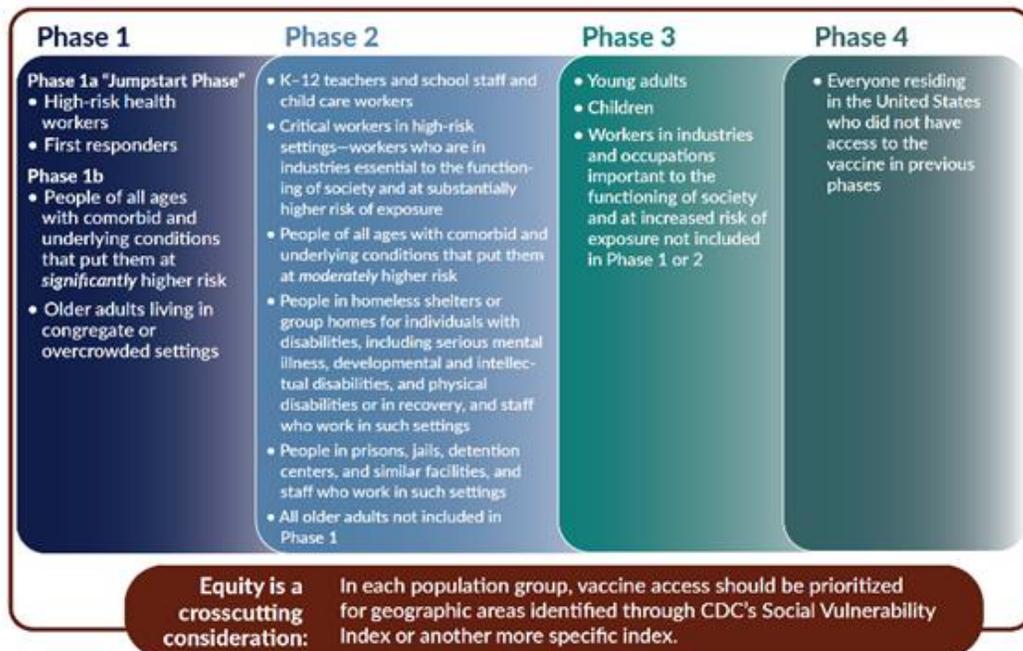
- A. Describe how your jurisdiction will structure the COVID-19 Vaccination Program around the four phases of vaccine administration:

Phase 1: Potentially Limited Doses Available

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

Phase 3: Likely Sufficient Supply, Slowing Demand

Phase 4: More Supply than Demand



Phase 1A and B:

To reach those populations identified in 1A and 1B, mass vaccination clinics will be provided across the state through a variety of vaccine clinic models. The current plan under development will:

- Determine the number in each designated critical population
- Enroll all health care facilities or organizations that will receive/administer COVID-19 vaccine as a COVID-19 Vaccination Provider.
- Facilities/organizations that enroll in the program and can vaccinate health care workers (hospitals) will be asked to conduct clinics.
- Facilities/organizations that have signed a Memorandum of Agreement to provide vaccination services to an identified "critical" population and meet all requirements will provide vaccine through a closed Point of Distribution (POD) will be utilized to reach critical populations.
- Based on *current* CDC guidance, residents of long-term care facilities (LTCF's) will be vaccinated by one of two national chain pharmacies that CDC will contract with. Further details are expected soon.

- VDH will determine the need for mass vaccination clinics (Open PODs) to address any gaps or regional needs. Open POD locations that have been previously designated will be used as allocation to provide these services.
- GIS mapping will be utilized to determine coverage and access needs
- VDH will work with the pharmacies, EMS providers, Federally Qualified Health Centers, Visiting Nurse Associations and others to supplement vaccine administration efforts

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

In Phase 2, access will be expanded to provide COVID-19 vaccination fully utilizing Vermont's strong medical home system. The current system used by the Vermont Vaccination Program to provide over \$16 million in vaccines annually to primary care providers, will be used to supply COVID-19 vaccination. In addition, pharmacies will be enrolled to expand access for adults 18 years and older.

Activities offered in Phase 1 may need to be continued and could include the addition of large drive-through clinics. Access may be expanded to specific population groups, depending on demand and access issues.

The Medical Reserve Corps (MRC) will be utilized for staffing support, as needed and available. The MRC are currently supporting influenza vaccine clinics in some areas of the state, gaining recent experience with vaccination clinics.

Phase 3: Likely Sufficient Supply, Slowing Demand

The primary care medical home system and pharmacies will be key players in ensuring access to COVID-19 vaccine in Phase 3. By Phase 3, it is expected that a majority of primary care providers (PCPs) currently enrolled in the Vermont Vaccine Program will be enrolled in the COVID-19 Vaccination Program.

Data will be essential in determining vaccination levels among various populations, to plan for targeted outreach in Phase 3, if indicated. The Vermont Immunization Registry and GIS mapping will be utilized to assess COVID-19 vaccination rates statewide and by county and town.

Use of PCP's to conduct outreach in rural and more urban communities, has been effective in expanding access to influenza vaccine this Fall. Funding for operational support to PCP's to offer off-site clinics has been shown to increase access to young children and school age children. Mass vaccination efforts will be limited to special situations.

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

Vermont used the CDC Critical Populations list and further defined these groups based on available state data. The estimates for each group were gathered from local sources where possible (i.e. State agencies, including the Department for Children and Families, DAIL, DOC, Agency of Agriculture and others. CDC estimates will be used when local data is not available.

GIS mapping and the Vermont Social Vulnerability Index will be employed to determine where each of the groups exist to ensure that each are reached through a vaccination method (pharmacy, provider, and/or closed/open POD).

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

Vermont is working with Vermont Emergency Management to determine the critical infrastructure workforce. Addendum 6 of the State of Vermont Governor’s Executive Order 01-20 that initially described “essential workers” in the State of Vermont during the State of Emergency will also be used in determination of the critical infrastructure workforce. The COVID-19 Vaccine Implementation Advisory Committee will also be asked to review the definition and provide feedback.

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

The COVID-19 Vaccine Implementation Advisory Committee will include members from the Vermont Hospital Emergency Preparedness Coalition, Crisis Standards of Care Clinical Advisory Group and others. This committee will be asked to provide guidance on critical populations subgroups, if initial

allocations of vaccine to Vermont are limited. This recommendation will be brought to the Commissioner of Health for final review/determination

- 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.*

VDH conducts outreach to a multitude of partners on a wide variety of public health concerns. Points of contact for many of the organizations or employers for critical population groups have been identified. There are also many advisory groups and coalitions coordinated through VDH, through which outreach can be expanded. VDH will coordinate efforts with the Agency of Human Services and Vermont Emergency Management.

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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.**

The Immunization Program will reach out by email to all potential COVID-19 vaccination providers and target the appropriate settings that maximize the number of people who can be vaccinated. The providers include currently enrolled practices, hospitals, LTCF's, pharmacies, congregate settings, Visiting Nurses Associations (VNA), and others. In addition to email, the Vermont Immunization Bulletin will be used to spread awareness of the COVID-19 vaccination program and promote enrollment.

By November 1, Vermont will enroll COVID-19 vaccination providers. With support from Agency of Digital Services (ADS), the enrollment will capture all required information from Sections A and B of the COVID-19 (Vaccination Program agreement). The number of 2019-2020 flu vaccine doses administered will be confirmed through the VT IIS. Confirmation of valid medical license numbers will utilize the National Provider Identifier (NPI) Registry, List of Excluded Individuals/Entities (LEIE) and the Vaccine Tracking System (VTrcks).

- 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.**

We will prioritize enrollment in the following order to reach the critical population groups first.

- Hospitals
- Vermont Department of Health
- Pharmacies
- Long Term Care Facilities
- Primary Care Practices
- VNA and Home Health Agencies
- Vermont Department of Corrections (if indicated)

- 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.**

Data will be exported from SurveyGizmo as a Comma Separated Values (CSV) file twice a week and submitted to CDC via SAMS-authenticated mechanism.

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

We will verify each medical license in the NPI registry and LEIE database. Facilities will be contacted if an incorrect or invalid medical license was listed.

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

CDC training resources and immunization program developed training materials will be used. Each practice will receive by e-mail a set of quick guides covering the following topics: Advisory Committee on Immunization Practices (ACIP) COVID-19 vaccine recommendations; ordering, receipt and management of vaccine inventory; COVID-19 vaccine storage and handling; vaccine administration; documentation and reporting; temperature excursion protocol; adverse event reporting; Vaccine Information Statement (VIS)/ Emergency Use Authorization (EUA) protocol; and how to submit the facility information for COVID-19 vaccination clinics. Training will be tracked via Excel spreadsheet and include all other enrollment data.

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).

Health Department Local Health Offices (LHO) and the Immunization Program will serve as redistribution centers to accept transfers of excess vaccine, and orders that will be redistributed in quantities of less than 100 doses. The LHO will redistribute under the direction of the Program.

F. Describe how your jurisdiction will ensure there is equitable access to COVID-19 vaccination services throughout all areas within your jurisdiction.

Vaccine allocation will be based on population data, with attention to critical populations. Vaccine administration data from the Immunization Registry will be closely monitored and reviewed at a granular level by county, town and health service area. In addition, the vaccine doses administered by enrolled site will also be monitored and redistribution will be required. The Immunization Program is collaborating with the Health Equity and Community Engagement Team to ensure access to disadvantaged communities and people of color. GIS mapping and Social Vulnerability Indices will be employed to identify areas with limited access and direct distribution efforts.

G. 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.

Pharmacies that have not contracted directly by CDC will be recruited to enroll in the Vermont COVID-19 Vaccination Program by e-mail with a link to the enrollment forms. Pharmacies must adhere to the same requirements as any other facility receiving the COVID-19 vaccine. They may be requested to provide on-site vaccination clinics at assisted living facilities or residential housing for seniors. We will continue to work with the Vermont Board of Pharmacy to recruit as well.

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.

Potential Providers (Vaccinators)	Estimated Number of Vaccinations per week (100% participation)	Estimated Number of Vaccinations per week (80% participation)	Estimated Number of Vaccinations per week (50% participation)
Hospitals (14)	8,400	6,720	4,200
Chain Pharmacies (5)*	2,250	1,800	1,125
Outpatient Clinics-Adult (50)*	20,000	16,000	10,000
Outpatient Clinics-Children (50)*	20,000	16,000	10,000
FQHCs (11)*	4,400	3,520	2,200
PODs-Closed (20)**	2,000	1,600	1,000
PODs-Open (12)**	14,400	11,520	7,200
Home Health Care Providers(227)	113,500	90,800	56,750
Long Term Care Facilities (202)	Included in the pharmacy numbers		
Department of Corrections (7)	2,130	1,704	1,065
Totals per week	187,080	149,664	93,540

Note: These are preliminary numbers and will change as we onboard providers.

*Weekly provider throughput provided by the CDC

**Weekly provider throughput numbers came from past exercises with PODs

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

This information indicates that it will be essential to facilitate enrollment and support efforts to address known barriers (i.e. 24-hour reporting). The enrollment process will need to be closely monitored to support organizations and practices in completing all steps necessary to be enrolled as a COVID-19 provider. The enrollment team will follow-up with those invited to participate until they are either fully enrolled or decline participation.

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.*

VDH will collect data to define all critical populations and sub-populations. This data gathered will determine vaccine allocation with attention to priority groups, including disadvantaged populations. Phase 1A will focus on hospitals and long-term care facilities, specifically. GIS mapping will be employed to identify areas with limited access and direct distribution efforts.

In addition to the National Academies Report on Equitable Allocation and the Johns Hopkins Framework, the CDC Advisory Committee on Immunization Practices recommendations for critical populations will be reviewed to determine which groups are prioritized for vaccine. Initially, we will work with Vermont's hospitals, pharmacies, and local health offices to ensure access to COVID-19 vaccine in mass vaccination settings, as indicated. Advanced EMTs and paramedics will have their scope of practice expanded to administer vaccines to eliminate possible barriers for priority populations to receiving vaccine.

The Immunization Program's Vaccine Manager has over 20 years of experience and had a lead role in H1N1 vaccination ordering and distribution. She will lead the team that will place orders and distribute vaccine consistent with approved guidance, while factoring in variables (storage capacity, clinics planned, current inventory). All COVID-19 vaccine orders will be placed through the Vermont Vaccine Inventory Management System (VIMS) and uploaded to VTrckS. An ADS IT team is currently engaged in VIMS system enhancements and awaiting CDC guidance on changes to CDC External Information System (ExIS) file specifications for COVID-19 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.*

The cold chain capability of each site enrolled to provide COVID-19 vaccine will be assessed during the enrollment process. Each newly enrolled site will be provided continuous temperature monitoring devices known as "LogTags". They will be required to submit 3 days of consecutive temperatures in range and a picture confirming the placement of the glycol bottle in the center of the refrigerator or freezer. For those practices who routinely receive vaccine from the Immunization Program and use Wi-Fi cloud based data loggers provided by the Immunization Program, the Audit Node report will be run and data will be reviewed at the practice and by the central office. Practices using their own approved monitoring system will be required to submit a report showing temperature monitoring and documentation. Sites that are unable to show temperatures in range will not receive vaccine until they are able to meet the cold chain requirements. Immunization Program staff will work with them to adjust until the storage units are able to hold temperatures in range. A tracking spreadsheet will be used to track and document the assessment of the cold chain capability for each site. Prior to allocation/assigning allotments, that data will be reviewed to avoid sending vaccine to a site that cannot maintain required storage conditions.

- 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.

The Vermont Vaccine Inventory Management System (VIMS) is accessed through the Vermont Immunization Registry (VT-IMR). All users must have an active, individual user account and password. Once a provider is enrolled to receive vaccine, this process to set up an account begins.

1. The provider must be registered with the Immunization Program and have a PIN assigned to access VIMS.
 - a. The original provider file is created in all databases.
 - b. If necessary, for COVID-19 vaccine, the fund type split template is updated and uploaded to VTrckS
 - c. Prior to placing a vaccine order in VIMS, providers must verify that their shipping information, hours of delivery and contact information are correct and must notify the Program of changes to their information in the editable fields of their request form. Changes are then manually updated in databases.

Initially, due to limited supply, COVID-19 vaccine will be ordered by the jurisdiction on behalf of the receiving provider. Initially, this will be limited to providers/organizations enrolled as an open or closed PODs and Phase 1 providers. Once a regular supply of COVID-19 vaccine is available, the program will allow enrolled providers to place their orders via VIMS.

All provider transactions entered (adjustment, reconciliation, order) in VIMS are reviewed and approved by Immunization Program staff.

2. All COVID-19 vaccine orders will be reviewed and adjusted as needed during the daily order approval process.
 - a. Enhancements are being made to the VIMS system to capture COVID-19 vaccine allocations. Until the enhancements are deployed to production, vaccine allocation will be tracked via an Excel spreadsheet.
 - b. A file extract is initiated every weekday afternoon and uses the External Information System (ExIS) interface to upload the transaction data to VTrckS
 - c. Immunization Program staff then log into VTrckS and finalize the file uploads.
 - d. Daily vaccine shipment data is extracted from VTrckS and uploaded to VIMS so that providers can manage inventory.

- D. Describe how your jurisdiction will coordinate any unplanned repositioning (i.e., transfer) of vaccine.

Vaccine transfers between practices (or Local Health Offices) are approved and monitored by the Immunization Program. To this end, the program will ensure that the receiving provider have signed and agreed to conditions in the *CDC COVID-19 Vaccine Redistribution Agreement* and have a fully completed and signed *CDC COVID-19 Vaccination Provider Profile* form. Also, validated cold-chain procedures must be in place in accordance with manufacturer's instructions and CDC's guidance on COVID-19 vaccine storage and handling. The physical transfer will be conducted by the location requesting the vaccine.

Vaccine transfers must be entered into the VIMS system by the practice that is providing the vaccine. This transaction removes doses from their inventory and adds it to the recipients once an Immunization Program staff follows up with each practice to ensure the vaccine repositioning has occurred.

E. Describe jurisdictional plans for monitoring COVID-19 vaccine wastage and inventory levels.

The Vaccine Inventory Management System (VIMS) is the platform that assists with managing and maintaining vaccine purchases and inventory at participating practices. This system allows the Immunization Program to monitor the inventory of a practice, as of the last time a provider reconciled. Providers will be required to reconcile COVID-19 vaccine inventory prior to placing a COVID-19 vaccine order.

Every effort is made to minimize waste, however it can and does happen. Providers must report waste in VIMS. Instructions for submitting waste are published on the Vermont Department of Health website and providers will be reminded of the procedure.

Provider training materials are available on the VDH website. The VIMS User Guide will be updated with procedures for COVID-19 vaccine ordering, reconciliation, and waste. Information on vaccine recovery will be shared with providers when made available by CDC.

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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 ultracold chain requirements, at all levels:

Adherence to the COVID-19 vaccine storage and handling requirements will be ensured by having a well-trained staff at each location receiving and administering COVID-19 vaccine. Additionally, on-site staff will review temperature monitoring data daily and the Immunization Program staff will review in real-time for sites that use our cloud-based Wi-Fi system. Sites managing COVID-19 vaccines will run inventory management reports each morning and before each vaccine order to avoid waste and ensure the vaccine supply remains viable. Vaccine distribution will be arranged following the verification of each provider's location and ability to meet vaccine storage unit requirements.

Ultracold capacity for storage of vaccines has been assessed by survey and potential distribution plans will be based on this information. If COVID-19 vaccine requiring ultracold storage were approved by the FDA and recommended by the CDC, the Immunization Program would be able to order it, using locations that meet the ultracold requirements. Sites that have ultracold capacity will need to submit temperature monitoring data to the Immunization Program prior to receiving vaccine. Temperature monitoring devices for ultracold vaccine storage units may be provided by the Immunization Program.

- **Individual provider locations** – Sites currently enrolled use cloud-based Wi-Fi data loggers. Trained staff on-site run a temperature monitoring data report twice a day (AM/PM) and document the MIN/MAX once a day to confirm temperatures stay in range at all times and identify and handle temperature excursions in a timely fashion. Sites using continuous monitoring devices without Wi-Fi capability will download and review data weekly, in addition to once daily documentation on the paper temperature log. Each site will email a picture of the inside of the vaccine storage unit to confirm the glycol bottles proper placement. [The Storage and Handling Quick Guide](#) is posted on the Immunization Program website and shared with practices after they complete the COVID-19 enrollment form, but before receiving COVID-19 vaccine. Other CDC developed training materials will be used, when available.
- **Satellite, temporary, or off-site settings** – These sites will adhere to the above requirements and obtain appropriate transportation equipment, such as portable units and qualified pack outs. The Immunization Program will provide data loggers for temperature monitoring at no cost to the practice. Inventory management is even more critical when taking vaccine off-site, and practices will be advised to only transport the anticipated number of COVID-19 vaccines to be administered. Those administering vaccine will monitor and document temperatures on hourly temperature logs until the vaccine is used up or back to the permanent storage. Temperature monitoring data will be downloaded and reviewed after each clinic is concluded. In the case of a temperature excursion, the Immunization Program will be contacted, the temperature data emailed, and the vaccine assessed for viability.
- **Planned redistribution from depots to individual locations and from larger to smaller locations** – For planned and unplanned redistribution, the same requirements apply as for

transportation of the vaccine. Portable storage units, qualified pack outs and appropriate coolers will be used. The Immunization Program-provided data logger will monitor the vaccine until it reaches the appropriate vaccine storage unit. Hourly temperature logs will be used to monitor and document the Min/Max temperature every hour. Temperature data will be downloaded after the vaccine reaches the storage unit. In case of a temperature excursion, Immunization Program will need to be contacted. The redistribution plan will be communicated and coordinated ahead of time with the Immunization Program vaccine distribution staff members.

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

Before confirming their order of the COVID-19 vaccine shipment, each site will need to submit 3 consecutive days of in-range temperature readings and a picture of the glycol bottle placement in the storage unit. For those using cloud-based Wi-Fi data loggers, the Immunization Program will run a report to assess temperature readings for the past 3 consecutive days.

DRAFT

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.*

Vermont will use a hybrid approach to collecting data about vaccine doses administered. This includes use of the CDC Vaccine Administration Management System (VAMS) as well as established reporting systems to Vermont Immunization Registry (VT IIS) that meet CDC data reporting requirements, as outlined in the COVID-19 Provider Agreement. Existing systems include entering administration data into an electronic health record and sending to the Immunization Registry via HL7 or directly entering these data into the VT IIS.

All Vermont hospitals except the Veteran's Administration (VA) currently submit vaccinations via HL7 messaging. Additionally, three large pharmacy chains utilize HL7, as do most medical providers. We are currently engaging with pharmacies that do not submit via HL7 to onboard with that type of submission or, barring that, increase the frequency at which their immunizations are submitted.

Provider systems that are unable to meet the CDC data reporting requirements will be offered the VAMS system.

The Agency of Digital Services is actively working to implement the CDC Web Services Description Language (WSDL) so that data captured via VAMS can be imported to the VT IIS from the Immunization Gateway.

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

Vermont state law only allows the VDH to provide Immunization Registry information to the CDC "in summary, statistical, or other form in which particular individuals are not identified..." 18 V.S.A. § 1129. An alternative approach would be that the Vermont IIS generate and report de-identified data and submit it via secure data transfer (SFTP) as is done with other existing CDC projects that require data submission (e.g., the NIS/IIS CC4 project). The Agency of Digital Services is assessing the requirements for development of an auto-generated report, which would streamline the requirement for daily reporting.

- C. *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.*

Vermont's Immunization Registry has the capacity to enroll new users and the Immunization Registry program is already actively enrolling users for sites likely to administer COVID-19 Vaccine in the first phase of the response.

An established backup phone system with staff triage to provide additional support for new user requests will be utilized to assist COVID-19 vaccination providers as needed. The staff line is currently supported M-F 7:45am – 4:30pm. Support request volume will be monitored to assess if additional staffing or hours of operational support are needed. The Vermont Immunization Registry has numerous tutorials and training

videos that users may access for support. The support materials are located within the IMR application for easy access.

The VT IIS requires access to the internet and can be used with a personal hotspot (i.e. an iPhone.) In locations where cell phone and internet coverage are not available, the IMR application is unavailable. To date, this has not been an issue. To connect, one of three browsers must be used: Mozilla Firefox, Microsoft Edge, or Internet Explorer.

D. 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.

Vermont law requires all vaccinators in the state to report the immunizations they administer. When providers sign the COVID-19 Vaccination Program Provider Agreement, they are agreeing that they will adhere to the conditions outlined in the agreement, including reporting of data regardless of the setting in which the vaccination takes place. The Immunization Program will not allow providers to conduct off-site clinics for COVID-19 if they are unable to meet the requirements.

The Department of Health, in collaboration with partners such as the Vermont Information Technology Leaders (VITL), is working to onboard additional sites to HL7 messaging, helping to ensure that as many providers are reporting in near real-time as possible. Direct reporting will be used for some smaller sites, but it is likely that some third-party batch files will still be submitted. These files will not meet the 24-hour reporting requirement. We hope to limit the number of providers in this category and for those that do, efforts are underway to increase the frequency at which they submit their files.

Vermont also has an IT/Data Workgroup, representing agencies from varied parts of state government working together to increase the proportion of providers that will be able to reporting within the 24-hour time frame. These activities include, but are not limited to: connection to the IZ Gateway via the CDC WSDL, implementing the use of VAMS for providers without connection to the IIS, increasing capacity for accepting and merging third-party batch files, streamlining HL7 onboarding processes, and assessing business rules within the IIS system for opportunities to allow more efficient acceptance of immunization records via HL7.

E. 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.

The Vermont IIS will be used to monitor provider level data and doses reported in several ways, including both those reported via VAMS and those reported via other established mechanisms. New reports will be created to ensure the Vermont IIS' ability to assess the number of doses administered, as required by the CDC reporting requirements. As reporting requirements become more clear, additional reports will also be identified and developed.

For sites with an established reporting connection to the Vermont IIS, existing reports within the Vermont IIS will also be used to report on immunizations administered overall and by site. For sites that have an established connection to the Vermont IIS reports will also be generated by site.

For open and closed PODs that use VAMS for scheduling and reporting, and which are added to the Vermont IIS system via the IZ Gateway, the IIS will create and run queries allowing for assessment of doses administered at the sites and compare them with doses distributed via VIMS.

As needed, we will also utilize tools within VAMS to monitor immunizations given through that system separate from those captured in the Vermont IIS via other mechanisms.

Compliance with documentation and reporting requirements has not historically been a problem for the Vermont IIS. If needed in this response, the Vermont IIS will engage with departmental leadership and legal counsel on any actions needed to ensure compliance.

F. Describe how your jurisdiction will generate and use COVID-19 vaccination coverage reports.

Vaccination coverage reports are expected to be used to identify gaps in vaccine uptake and target vaccination efforts. It is also expected that reports will be used in combination with outbreak data as the response moves forward. Additional uses will likely be identified in the future.

In anticipation of these uses, the IIS staff is working in concert with ADS to develop a dashboard system. While still in development, at a minimum, the dashboard is expected to demonstrate the number of individuals who have been vaccinated, by demographic variables. Demographics under consideration include, age, sex, race and ethnicity, hospital service area, county, and town.

The Vermont IIS also has existing reporting tools that will be leveraged for reporting throughout the COVID-19 vaccination response. For example, the VT-IIS includes a report that allow practices to run coverage reports on any age group of patients. Creation of new reports within the VT IIS are also under consideration. For example, reporting on CVX code and their uptake within different locations or within different populations.

As more details become available (e.g., (CVX codes, scheduling guidance for each formulation) we will work update the VT IIS forecasting algorithm (HLN's Immunization Calculation Engine) to update settings so that COVID-19 specific forecasting reports can be run in the VT IIS.

Section 10: COVID-19 Vaccination Second-Dose Reminders

Instructions:

- A. *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 VT IIS has utilized a centralized reminder recall process for many years. The standard approach has been limited to specific child age cohorts, and a postal reminder. However, the functionality for running a recall is built into the VT IIS application and can be run for any age group and will generate either mailing labels or a line list with phone numbers.

We also have the ability to run reports from the VT IIS data warehouse to identify and contact persons who received one dose of vaccine, but not the second, and to centrally identify situations where immunizers may have administered an incorrect (wrong formulation) or invalid (too soon) dose. Medical practices can run invalid dose reports for their patients as well.

In addition to the centralized reminders, any primary care medical practice also has the capacity to run a recall list (same mailing label/line list capability) from within the VT IIS specifically for their patients who are not up to date. In addition, they may run a list of their patients who have received a dose of COVID-19 vaccine, and the date of that dose. A provider tutorial was developed to assist VT IIS users in using this report. Moving forward the IIS will monitor support needs and develop additional tutorials as needed.

A limitation of the VT IIS is that new immunizing sites (like fire department or other employer pop-up clinics) are not “medical practices” in the IIS, and they do not have access to the recall reports for the people they immunized. However, we anticipate that most of these sites will be using VAMS to schedule patients and report immunizations, so recall functionality will be available to them via that system.

All recall strategies require pre-existence of a CVX code and ACIP recommendation, with enough lead time for our forecasting algorithm (HLN’s Immunization Calculation Engine) to be updated.

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.*

Vermont was a pilot site for the VAMS application and plans to utilize that solution as an option for reporting, especially at sites without previous relationship with the VT IIS.

Vermont also has a well-established and highly utilized IIS. Nearly all Vermont hospitals and most primary care sites are directly reporting immunizations in their electronic health record via HL7 message. Existing provider systems that meet CDC data reporting requirements, outlined in the COVID-19 Provider Agreement, will be utilized. Provider systems that are unable to meet the CDC data reporting requirements will be offered the VAMS system.

Vermont is working with Vermont Information Technology Leaders (VITL), Vermont’s Health Information Exchange (HIE), to onboard as many new HL7 senders as possible prior to the release of COVID-19 vaccine.

Vermont is also offering the option of direct reporting (manual entry) into the VT IIS application, and has developed short video tutorials for training new users. Direct entry will be utilized in low volume applications.

The VT IIS continues to seek data from all possible sources including administrating site and health insurers (billing data). The VT IIS is prepared for (and has experience with) the HL7 feed going down.

The Vermont IIS is robust, but if the internet is not available, it is not accessible. We anticipate this occurring rarely and in such situations paper records would be utilized, with data entry used to enter the information into VAMS or the VT IIS.

- 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.*

Administered at location: facility name/ID

Administered at location: type

Administration address (including county)

Administration date

CVX (Product)

IIS Recipient ID*

IIS vaccination event ID

Lot Number: Unit of Use and/or Unit of Sale

MVX (Manufacturer)

Expiration Date

Recipient address*

Recipient date of birth*

Recipient name*

Recipient sex

Sending organization

Vaccine administering provider first name

Vaccine administering provider last name

Vaccine administering provider suffix

Vaccine administering site (on the body)

Vaccine expiration date

Vaccine route of administration

Vaccination series complete

Recipient ethnicity (note: provision of this variable is anticipated, pending fixes to existing HL7 mapping process)

Recipient race (note: provision of this variable is anticipated, pending fixes to existing HL7 mapping process)

Vaccination Refusal (Y/N)

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.

Vermont has executed a Data Use Agreement (DUA) with the Association of Public Health Laboratories for Connect and Access with the IZ Gateway. We await the release of the CDC DUA addressing reporting to the CDC for national coverage analyses. Vermont has a state law which limits sharing of identifiable data and we will adhere to these statutes.

Vermont is working to install the CDC WSDL to enable receipt of VAMS data from the IZ Gateway. HL7 version 2.5.1 is currently used by the VT IIS with uni-directional capacity. The Agency of Digital Services development team is working to assure our systems can report all required data. However, we need final specifications from CDC regarding the format and means for reporting these data.

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.

The Immunization Program has developed a plan for enrollment of facilities, beginning with those that will provide vaccine to those in Tier 1A and 1B. The COVID-19 Vaccine Planning group is working out the logistics for ensuring enrolled providers can submit vaccines administered within 24 hours. Ordering will be completed through the Vaccine Inventory Management System (VIMS). Engagement with the VT IIS depends on whether the site will use VAMS or the VT IIS for reporting. Anyone using the VT IIS to report may apply for a username and password – and nearly all sites that gave immunizations prior to COVID-19 already have accounts. We

have established a triaged phone line to manage increased volume of calls for access, password resets, and records requests.

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

Vermont has an executed DUA for Connect. At this time Vermont will not participate in the Share component due to limitations with current state statute. Agency of Data Services staff are working to implement the CDC WSDL enabling our ability to Connect. Our expectation is that CDC will complete onboarding

F. Describe the status of establishing:

- 1. Data use agreement with the Association of Public Health Laboratories to participate in the IZ Gateway*

Vermont's Legal team executed the DUA for Connect, but not Share.

- 2. Data use agreement with CDC for national coverage analyses*

Vermont is waiting for this DUA from CDC.

- 3. Memorandum of Understanding to share data with other jurisdictions via the IZ Gateway Share component*

Vermont has chosen not to implement the IZ Gateway Share at this time. The VT IIS has an existing interstate data exchange agreement with New York State.

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

If the information has been captured on paper, direct entry into an electronic health record, VAMS, or the VT IIS is always an option. Vermont has the capacity to import a flat file and has published minimum requirements for creating such a file.

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.

Vermont has specialized software designed to identify data issues, and a process for auto-merge match of duplicate records. Our import processes are designed to prevent duplicate information (both at the patient and the vaccine level) from being imported. Each import is followed by the generation of an import report that summarizes the number of records imported, those not imported (and the reasons why), and those that errored out of the process. Our team of analysts have years of experience in identifying potential issues, including but not limited to unusual number of immunizations for a patient, bad lot numbers, and number of immunizations from a particular site.

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.

a. Communication Channels

Type	Channels/Description
Earned media	Press conferences
	Press release
	Media interviews
	Social media
	Front Porch Forum (statewide community forum)
Paid media	Paid digital campaign (i.e. social media and search ads)
	Paid traditional media (i.e. TV, radio)
Newsletters	“Vermont Immunization Bulletin” – <i>Monthly newsletter from the Health Department’s Immunization Program</i>
Website	COVID-19 Vaccine web page
	Frequently Asked Questions
Print materials	Materials for providers, patients, etc.
Health Alert Network	VDH System to communicate with healthcare providers
Joint Information Center	System utilized to amplify messages

b. Phase 1: Potentially Limited Doses Available

i. Goals

1. Build an understanding of vaccine safety and efficacy to foster acceptance of the vaccine when it is more widely available
2. Maintain and grow Vermonters’ confidence in the Health Department as a reliable and trustworthy messenger

3. Provide communication support for provider outreach efforts for potential Phase 1 vaccine providers
 4. Identify and engage other trusted messengers to provide information to specific populations, especially those prioritized for vaccine
- ii. Key Audiences
1. Priority populations with the greatest risk and burden of COVID-19 and those who refer them to or administer the vaccine. The latter could include people in congregate settings (LTCFs, prisons), people experiencing homelessness, front line/essential workers, and people at higher risk of severe illness from COVID-19.
- iii. Key Partners
1. Regional hospitals
 2. Vermont Child Health Improvement Program (VCHIP)
 3. Blue Cross and Blue Shield of Vermont
 4. OneCare Vermont
 5. Blueprint for Health
 6. Support and Services at Home (SASH)
 7. VNAs of Vermont
 8. Long-term care facilities
 9. Vermont AAP
 10. Bi-State Primary Care Association
 11. Organizations serving people experiencing homelessness
 12. Partner State agencies and departments

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

- i. Goals
1. Encourage broad acceptance of the COVID-19 vaccine, especially among people who are at a higher risk for severe illness
 2. Provide communication support for provider outreach efforts
- ii. Key Audiences
1. Priority populations with the greatest risk and burden of COVID-19 and those who refer them to or administer the vaccine. The latter could include people in congregate settings (LTCFs, prisons), people experiencing homelessness, front line/essential workers, and people at higher risk of severe illness from COVID-19.
 2. Young adults/college-aged students
 3. Decision-making parents/guardians of minor children
 4. Communities of color
- iii. Key Partners
1. Regional hospitals
 2. Vermont Child Health Improvement Program (VCHIP)
 3. Blue Cross and Blue Shield of Vermont
 4. OneCare Vermont
 5. Blueprint for Health
 6. Support and Services at Home (SASH)

7. VNAs of Vermont
8. Long-term care facilities
9. Vermont AAP
10. Bi-State Primary Care Association
11. Organizations serving people experiencing homelessness
12. Colleges
13. Partner State agencies and departments
14. Professional associations (e.g. Chambers of Commerce)
15. Vermont League of Cities and Towns
16. Organizations working with new Americans, refugees, and tribal communities

d. Phase 3: Likely Sufficient Supply, Slowing Demand

- i. Goals
 1. Encourage ongoing vaccine uptake as needed
 2. Provide communication support for provider outreach efforts
- ii. Key Audiences
 1. Vermont adults
- iii. Key Partners
 1. Regional hospitals
 2. Vermont Child Health Improvement Program (VCHIP)
 3. Blue Cross and Blue Shield of Vermont
 4. OneCare Vermont
 5. Blueprint for Health
 6. Support and Services at Home (SASH)
 7. VNAs of Vermont
 8. Long-term care facilities
 9. Vermont AAP
 10. Bi-State Primary Care Association
 11. Organizations serving people experiencing homelessness
 12. Colleges
 13. Partner State agencies and departments
 14. Professional associations (e.g. Chambers of Commerce)
 15. Vermont League of Cities and Towns
 16. Organizations working with new Americans, refugees, and tribal communities

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.*

Our Crisis and Emergency Risk Communication (CERC) Team was activated early in the COVID-19 response and stands ready to respond rapidly to all communications needs related to COVID-19 vaccine development and distribution. The CERC Team includes nearly 30 staff who lead various channels of our work, including:

- Media relations
- Social media

- Marketing
- Public email communication
- Translations and Accessibility
- Website updates

Our team has well-established processes for ensuring fast and accurate information sharing through all channels as new information becomes available. A leadership team meets daily to discuss messaging priorities and works to ensure that messaging is shared appropriately across various channels (including the Joint Information System).

We are also working with media and marketing experts who have experience with developing and implementing the Health Department's current COVID-19 prevention messaging strategies. That collaboration will continue through our vaccine promotion efforts.

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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.*

All providers that enroll to receive COVID-19 vaccine will receive materials outlining their responsibilities. One of those items will be the Emergency Use Authorization (EUA) fact sheets. Vermont's Immunization Bulletin (VIB) is sent out monthly to all enrolled providers. This will be one avenue used to communicate where to find and how to utilize an EUA fact sheet for providers and their patients. The link to the EUA will be sent to all enrolled providers electronically and training that will occur for all practices enrolling to receive COVID-19 vaccine will emphasize the requirement to provide the most updated version to a patient before vaccine is administered.

Once a vaccine information statement (VIS) is created, which will happen when the vaccine is added to the Vaccine Injury Table, it will be required, by the State of Vermont, that all enrolled providers distribute it before a vaccine is given. Once a VIS is produced, the Vermont Department of Health will make it available on the website. When the Vaccine for Children (VFC) program compliance site visits are restarted, all site visitors will ensure that a practice has up to date VISs to give to patients. The State of Vermont requires that when a vaccine provider administers a vaccine, the version of the VIS is updated in the Vermont Immunization Registry (IMR). This will be required for COVID-19 vaccine once a VIS is created and distributed.

- 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.*

All providers enrolling to receive COVID-19 vaccine will be instructed to provide either a EUA fact sheet or a VIS for COVID-19 vaccine to the patient or parent/guardian prior to administering the vaccine. When these materials are released, they will be sent electronically to all enrolled practices and made available on the Health Department website

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).*

Currently, the state of Vermont requires that all adverse events following any vaccination are reported to the Vaccine Adverse Event Reporting System (VAERS). The COVID-19 Vaccination Program Provider Agreement denotes that vaccination providers who receive and administer COVID-19 vaccine “must report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).” All providers who receive COVID-19 vaccine will complete and sign this agreement, ensuring all know they are required to report adverse events following vaccination to VAERS. During the enrollment process, practices receive education on the VAERS system, including how to access, how and when to report, and who can report an adverse event following a vaccination. Specific Immunization Program staff are assigned to oversee the communication and training of all providers enrolling to give COVID-19 vaccine to ensure that enrollment training includes VAERS.

Materials that are developed by the CDC or VDH will be disseminated to all practices enrolled to administer COVID-19 vaccine, as well as those materials available on the VDH website. The VDH website has a section entitled “Immunization and Health Care Professionals.” This section contains a resource tab, which links to the VAERS online reporting system. CDC or VDH-made materials will be available on this website around additional resources on reporting adverse events following vaccination.

When compliance visits resume, site visitors will review VAERS in person at every compliance site visit during the education portion offering paper materials on the system, as well as online access information.

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

As indicated by Vermont's successful efforts to contain COVID-19 disease, there is full support to successfully implement the COVID-19 Vaccination Program through all levels of state government and the medical community.

By creating a Vaccination Branch within the VDH Health Operations Center, the Immunization Program has access to the staffing, resources and support needed to plan and implement a comprehensive vaccination program. The Vaccination Branch includes four sections: immunization program operations, technical response, POD (mass vaccination) planning and data management. Staff are being onboarded to fully support this work.

For key areas such as enrollment, IIS and other system performance and data reporting to the CDC - detailed tracking spreadsheets are utilized at weekly meetings to identify leads, assess progress, set timelines and identify areas that are "at risk". If "at risk", barriers are noted, and the plan is reassessed.

Describe your jurisdiction's methods and procedures for monitoring resources, including:

Large scale health emergencies are managed by the Health Department's Health Operations Center (HOC), which is currently activated. The HOC follows standard FEMA Incident Command and Control procedures. The department utilizes the on-line emergency management platform called Web EOC and Microsoft Teams sites to track and manage resources.

- Budget-VDH Finance Section Chief keeps track of the budget
- Staffing-The Health Operations Center has a COOP/HOC Staffing team that procures staffing needed for this incident
- Supplies- The Health Operations Center has a Logistics Section responsible to procure any needed logistical items. If that section cannot procure what is needed, then the request is sent up to the State Emergency Operations Center Medical Logistics Section to procure.

B. 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 Crisis and Emergency Risk Communications (CERC) Team within the Health Department's Health Operations Center, monitors communications in a variety of ways to understand and assess the success of our messaging, including but not limited to:

- Evaluation of social media metrics for paid content (Click Through Rates, Impressions, Reach, Frequency, etc.)
- Monitoring of Health Department web page traffic and other key analytics (e.g. time spent on page, bounce rate, etc.)
- Monitor public inquiries to our COVID-19 Main Call Center and Public Inquiries Inbox to assess public concerns and perceptions to inform our messaging when appropriate
- Monitor questions from media outlets
- Constantly evaluate messaging based on the evolving nature of the COVID-19 response and implement course corrections as needed

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

VDH is a centralized public health department with an Office of Local Health, with 12 Local Health Offices. Situational level monitoring is conducted using data and information reported by the Local Health Offices, community surveys and GIS mapping. Public health statistics also provides extensive information on local areas Routine meetings are held with the 12 LHO's to identify emerging issues, gather information and develop plans. Close coordination was required during a pertussis outbreak and in recent effort to prevent a hepatitis A outbreak.

D. *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.*

Work is underway to develop an internal and public facing dashboard to share key information with all stakeholders. The dashboard will build upon the current [Vermont COVID-19 Dashboard](#).

Metrics for the COVID-19 Vaccination Campaign in Vermont have not been finalized at this time but will likely include:

- Enrollment by facility type, location
- Doses distributed by facility type, location
- Doses administered (from the Immunization Registry)
- COVID-19 vaccination coverage by county, LHO and HAS
- Adverse events reported in VAERS by degree of severity and age

Appendix A: Acronyms

ACIP	Advisory Committee on Immunization Practices
ADS	Agency of Digital Services
AHS	Agency of Human Services
AL/ALF	Assisted Living Facility
CDC	Centers for Disease Control and Prevention
DAIL	Department of Disabilities, Aging and Independent Living
DOC	Department of Corrections
DUA	Data Use Agreement
DVHA	Department of Vermont Health Access
EUA	Emergency Use Authorization
FQHC	Federally Qualified Health Center
GIS	Geographic Information System
HOC	Health Operations Center
HSEEP	Homeland Security Exercise and Evaluation Program
LEIE	List of Excluded Individuals/Entities
LTCF	Long Term Care Facility
MRC	Medical Reserve Corps
NPI	National Provider Identifier
OLH	Vermont Department of Health Office of Local Health
PCP	Primary Care Provider
POD	Point of Distribution
SAMS	Secure Access Management System
SEOC	State Emergency Operations Center
SFTP	Secure File Transfer Protocol
SLVC	School-located Vaccine Clinic
SNF	Skilled Nursing Facility
VAERS	Vaccine Adverse Event Reporting System

VAHHS	Vermont Association of Hospitals and Health Systems
VAMS	Vaccine Administration Management System
VDH	Vermont Department of Health
VEM	Vermont Emergency Management
VFC	Vaccines for Children
VHEPC	Vermont Hospital Emergency Preparedness Coalition
VIMS	Vaccine Inventory Management System
VIS	Vaccine Information Statement
VITL	Vermont Information Technology Leaders
VNA	Visiting Nurses Association
VT IIS	Vermont Immunization Registry
VTckS	Vaccine Tracking System
VVP	Vermont Vaccine Program
WSDL	Web Services Definition Language

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