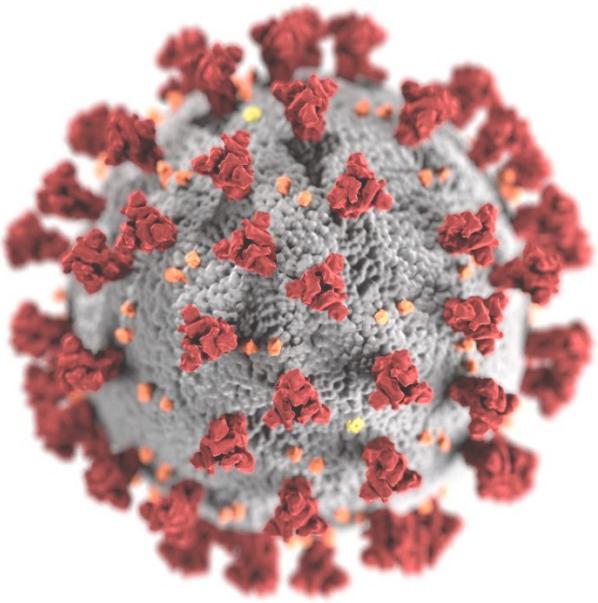
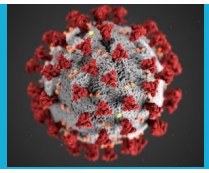


COVID-19 Vaccination Plan

MICHIGAN

MDHHS
Michigan Department of Health & Human Services

10/16/2020 | VERSION 1.0



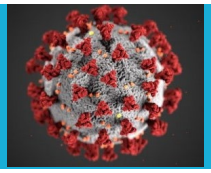
COVID-19 Vaccination Planning for Michigan

The Centers for Disease Control and Prevention (CDC) has asked the health departments in all states, including the Michigan Department of Health and Human Services (MDHHS), to submit a COVID-19 Vaccination Plan. The Interim Draft plan was submitted to CDC Friday, Oct. 16. It is important to note this plan will be modified and enhanced as we learn more details about the vaccines. There are still many unknowns so some of the details cannot yet be finalized.

Michigan is waiting to learn when the vaccines will be made available; how much vaccine will be made available and how quickly sufficient quantities will be available for the general public; how the vaccine will be allocated to Michigan; what the storage and handling requirement will be on the vaccines; and what the priority groups will be for this vaccine.

The plan lays out how we will operationalize the distribution of the COVID-19 vaccine in Michigan and how we will engage our vaccination partners to assure, over time, that we have the ability to protect all individuals who wish to receive the vaccine. It will be a phased approach based on the priority groups determined by the Advisory Committee for Immunization Practices at the Federal level. Since initial supplies of vaccines will be insufficient to meet the needs of the entire population, they will be prioritized. As more vaccine becomes available, vaccination efforts will be expanded until eventually all individuals in Michigan will have the opportunity to receive the vaccine.

Michigan has and will continue to work with a wide variety of stakeholders to develop the draft plan. As we continue to meet with these stakeholders, we will enhance the plan and be prepared to vaccinate and protect as many individuals as possible. Vaccines are the best defense we will have to protect the public.



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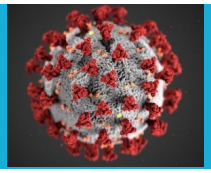
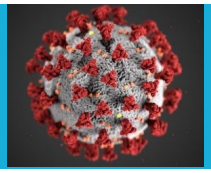


Record of Changes

Date of original version:

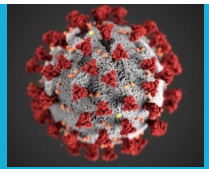
Date Reviewed	Change Number	Date of Change	Description of Change	Name of Author



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:

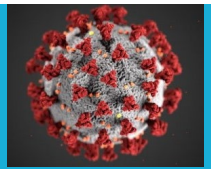
Lessons learned and improvements made from the 2009 H1N1 vaccination campaign H1N1 After Action Reports and a summary that was distributed and presented to statewide stakeholders in September 2010 guided our Michigan lessons learned planning for improvements.

i. Michigan identified that we needed pharmacy involvement earlier in the H1N1 response. We also needed to streamline enrollment into the Michigan Care Improvement Registry (MCIR), the statewide immunization registry and into the H1N1 vaccine program. As a result of this identified weakness, we now have pharmacies that are entering vaccine doses into MCIR routinely. All large chain pharmacies now submit data to the IIS electronically and most independent pharmacies are submitting data directly to the IIS. Pharmacy white paper link (https://www.mcir.org/wp-content/uploads/2014/08/MDHHS-Pharmacy-White-Paper.pdf). This pharmacy white paper is a collaboration between MDHHS and the Michigan Pharmacy Association (MPA) is produced annually and highlights the partnership and the integral role pharmacies play in the immunization neighborhood.

ii. The Michigan Pharmacy Association is a state partner in the Michigan Advisory Committee on Immunization. Bureau of EMS, Trauma, and Preparedness (BETP) has a long-standing contract with MPA with a dedicated pharmacist POC that support emergency planning and response. As of the end of September 2020, pharmacies are the largest provider of flu vaccines in Michigan for the current 2020/2021 influenza season; 42% of all flu doses reported to the Michigan Care Improvement Registry have been reported by pharmacies. The established relationship and reporting to MCIR will allow for a more streamlined process for COVID-19 provider enrollment and reporting.

iii. While our state health department made recommendations on the target/priority groups for H1N1 vaccination, each local health officer made those decisions for his or her local health department's jurisdiction. As a result, actions were not uniformly implemented statewide. Michigan has assembled a group of Local health representatives (Agile Group) to provide input into the COVID-19 planning for the state and local jurisdictions – this group was used for prioritizing testing sites for COVID-19. Multiple stakeholder groups will be utilized throughout the COVID-19 vaccination planning and implementation (see additional playbook sections).

iv. Michigan identified H1N1 vaccine allocation and distribution as challenging. If the type of vaccine is not matched to priority group population. Michigan plans



to use the Agile Group for advice on how to handle this issue to minimize provider confusion and aid in an updated allocation process. All allocations during H1N1 were made through the local health departments. For COVID-19 vaccine, initial allocations will be sent directly to hospitals and hospital systems for vaccination of health care workers identified in Phase I vaccination. Later vaccine allocations will be managed by the Local Health Departments.

v. Based on lessons learned from H1N1, Michigan plans to distribute initial limited supply to healthcare systems as a state function, and to notify the local health departments that may be impacted by this distribution.

b. Seasonal influenza campaigns

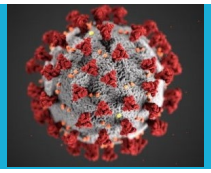
Every seasonal flu season is a pandemic and lessoned learned for managing seasonal influenza prepare us for pandemics.

i. Plans to increase reporting by more non-VFC providers, of flu vaccine doses into MCIR, as a tool to measure improvement in adult flu coverage. There have been increases in reporting from different facility types that serve adults.
ii. Long term care facilities that were not enrolled in MCIR were identified by MCIR regions for onboarding to prepare for 2020-21 flu season reporting and COVID-19 vaccination planning.
iii. An annual flu webinar was launched after H1N1 to review current season recommendations and vaccines that are available for the season. The flu webinar was presented on 9/15/2020 for providers to begin their plan to increase flu vaccination. Over 1,200 healthcare professionals participated in the webinar.
iv. Strategies on curbside and drive-through vaccination services have been promoted and shared with providers through immunization stakeholder listservs.

c. Hepatitis A Outbreak:

The populations most affected by this Hepatitis A outbreak most affected hard to reach populations and thought public health best practices for engaging these populations. There were many lessons learned related to this outbreak which better prepare us for this COVID-19 outreach.

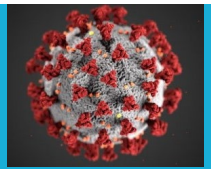
i. Many lessons were learned related to the recent Hepatitis A outbreak.
ii. LHDs created relationships with nontraditional providers such as Long-Term Care, Substance Use Clinics, Homeless Shelters, Food Pantries, Needle Exchange Programs, and Methadone Clinics.



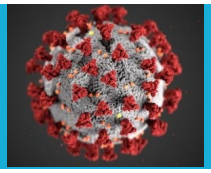
iii. Widescale vaccination of these populations was completed during this outbreak and these established relationships will set the stage for vaccination at these locations during the COVI-19 vaccination program.
iv. An additional lesson learned by local health departments was that the only way to get hard-to-reach populations vaccinated was to build relationships with those communities and go to locations where they congregate.

d. Other responses to identify gaps in preparedness
   i. Collaborate and involve emergency preparedness early in the COVID-19 planning process. The first state internal planning meeting was April 29, 2020 with members from preparedness and immunization teams.
   ii. These meetings have been routine and will continue to identify numbers of people in priority groups and surveys that may be needed to assess ability of partners to store and deliver COVID vaccines.
   iii. Plan to continue to conduct regular meetings to update this team to discuss priority groups for vaccination and plans for distribution.
   iv. Bi-annual assessment of local health department emergency medical countermeasure plans for the receipt, distribution, and dispensing/administration of medical countermeasures to their respective communities.
   v. Whole community needs assessments at local health departments to identify most vulnerable and at-risk populations within their respective jurisdictions.
   vi. Routine exercises (TTX, functional, and full-scale) at state and local levels to address distribution and mass dispensing/administration activities statewide.
   vii. Between 2012-2020, local health departments saw a sizable increase of closed point of dispensing partners, many of which service vulnerable and at-risk populations.
   viii. All LHDs have a Strategic National Stockpile Plan that includes points of dispensing and mass vaccination clinics as part of their jurisdictions Emergency Response Plans. LHDs have been working and exercising these plans since 2003. These plans form the basis of the planning underway for delivery of COVID vaccines.
   ix. Monthly EMS calls in which Immunization participates to communicate to the EMS community.

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.
   a. Michigan plans to use the 2020-21 Seasonal Flu campaign as a full- scale exercise in preparing for COVID vaccine.



i. An interactive flu dashboard that includes flu dose administration and vaccination coverage estimates was developed and will be posted for the public and all immunization partners. The dashboard will be updated weekly and includes vaccination coverage at the state-level and by county and age group. Previous season flu coverage by week is also provided for comparison at state and county levels.
ii. New state flu website was launched to include timely flu updates and information for providers (www.Michigan.gov/Flu).
iii. Drive-thru mass vaccination clinic (Local health departments and pharmacies) will be featured and shared with partners.
iv. Plan for partnerships with colleges and university settings as facilities for large scale mass vaccination clinics.
v. Plan with large commercial pharmacies to conduct outreach mass vax clinics in socially vulnerable areas of the state.
vi. Local Health Department Immunization Coordinator Nurses meeting with all state immunization coordinators was conducted on September 24, 2020 to discuss COVID-19 vaccine preparation and planning.
vii. Vaccine Management Calls (VMC) on a monthly basis with local health department immunization coordinators, IIS regional staff and Immunization field staff and MDHHS program staff to give updates on COVID-19 vaccine planning, storage and handling issues, MCIR tracking. VMC calls will continue with a bi-weekly basis.
viii. Expanding Michigan's Adult Vaccine Program (AVP) to include flu and making flu vaccine more widely available and enrolling many more vaccine providers to the program.
ix. Healthcare Coalition calls held biweekly with Preparedness to give updated COVID-19 immunization information to state healthcare providers.
x. Michigan Advisory Committee on Immunization conducted August 20, 2020 included discussion for increase in flu immunizations and COVID-19 vaccine planning.
xi. Alliance for Immunization in Michigan conducted August 14, 2020 included discussion for increase in flu immunizations and COVID-19 vaccine planning.



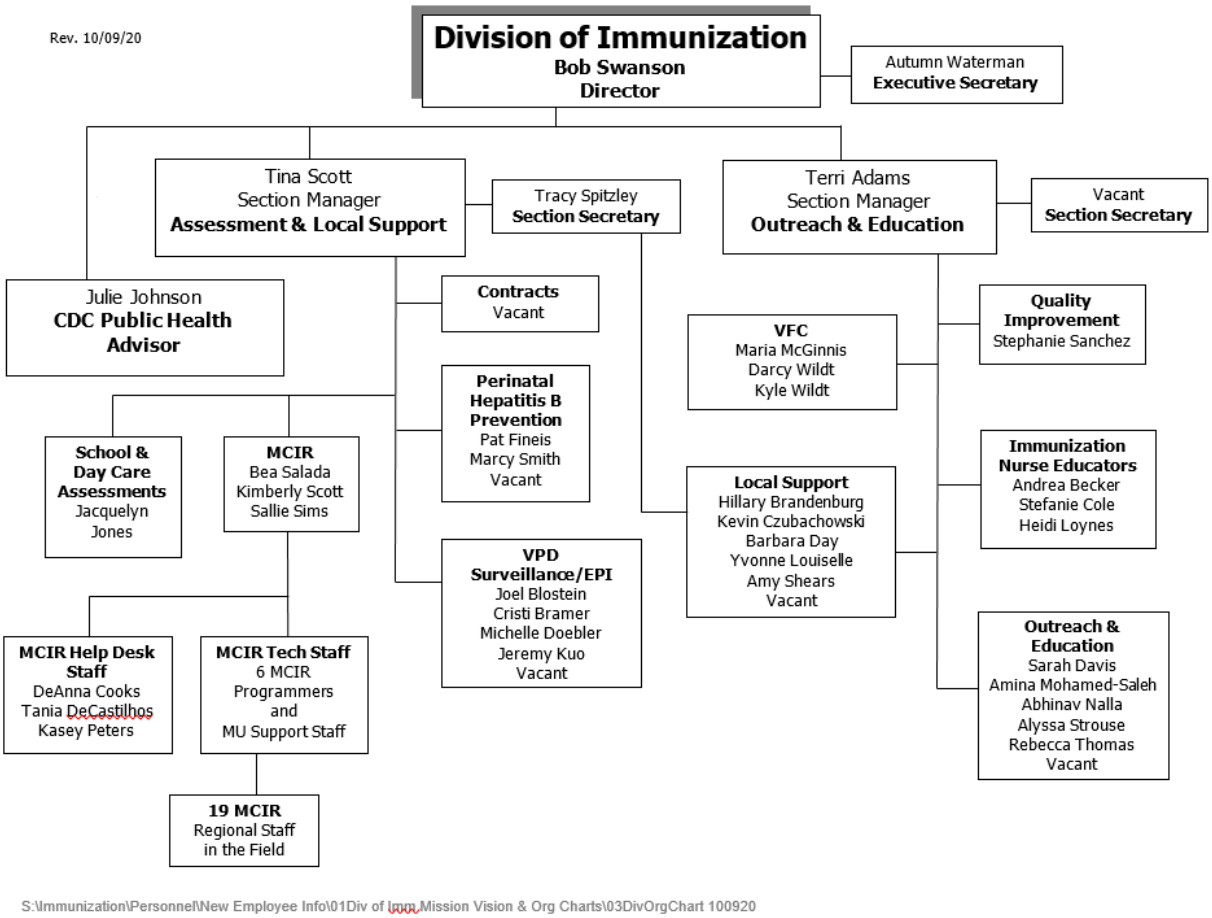
Section 2: COVID-19 Organizational Structure and Partner Involvement

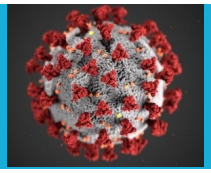
Instructions:

A. *Describe your organizational structure.*

The Division of Immunization is one of 4 Divisions within the Bureau of Infection Disease Prevention but temporarily reporting to the State Epidemiologist within the Bureau of Epidemiology and Population Health. Each of these Bureaus report to the Chief Deputy for Health/State Chief Medical Executive. The Immunization Division works closely with the Communicable Disease Division and partner on outbreak control activities. Another Bureau within the Public Health Agency is the Bureau of Emergency, Trauma, and Preparedness (BETP).

The Division of Immunization has two sections: The Outreach and Education Section and the Assessment and Local Support Section.





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 first group, which has been meeting weekly, involves personnel from across the Department, including the State Chief Medical Executive, State Epidemiologist, Local Health Services, Legal, and Communications. This is a higher-level meeting and mostly provides guidance and direction to the program.

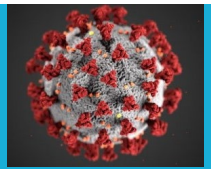
The second group is the Division staff, regional IIS staff and field staff to develop the IIS pandemic module and electronic enrollment process. This group began meeting several months ago to revise the IIS to meet pending requirements, new enrollment demands, new priority groups and create new ordering process to meet VTrckS requirements that were not present with H1N1.

The Division of Immunization is involved in the Department-wide COVID-19 internal calls which occur 3 times per week. These calls provide the opportunity to share work being done across the Department related to COVID-19.

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.*

External Stakeholder Group: This will act as an overarching advisory group to engage and educate a wide selection of partners. This will accomplish not only educating the individuals attending the meetings but also the organizations they represent on the COVID-19 plan. Secondly, it will allow them the opportunity to be heard if they have ideas that could improve the plan. The following groups will be invited to this group, although others may be invited as well:

- MALPH/Local Public Health
- Michigan Health and Hospital Association
- Michigan Primary Care Association
- Michigan Osteopathic Association
- Michigan Academy of Family Physicians
- Michigan State Medical Society
- Michigan American Academy of Pediatrics
- Michigan Pharmacy Association
- Michigan Association of Health Plans
- Michigan Chapter of American College of Physicians
- Long Term Care
- Tribal Health



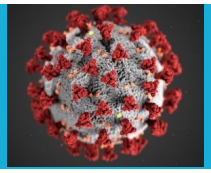
- Michigan Nurses Association
- Medicaid
- CHECC
- Homeless

Several COVID-19 advisory groups have been meeting now for several months. One group is a partnership between Preparedness, Michigan Pharmacy Association, and the Division of Immunization. These workgroup meetings have focused on the COVID-19 vaccination plan and implementation. This group has been meeting at least monthly since April and has been the backbone to Michigan being prepared to vaccinate their population.

Local Health Department: Local Health Departments are key partners to the success of the COVID-19 vaccination program. Each LHD has a well-established SNS plan which has exercised points of dispensing and contains mass vaccination. The immunization program staff has met with all levels of staff from local health departments (LHDs). The Division has met with the LHD immunization nurse coordinators on several occasions to educate on the COVID-19 vaccine program. Nurses have been engaged in the planning of COVID-19 communication and vaccine promotion. Immunization staff have met with local health officers to share information on the COVID-19 vaccination planning. The Division has also presented on 3 statewide COVID-19 specific calls to discuss COVID-19 vaccine planning. The Immunization program has participated in the AGILE workgroup made up of medical directors and others from local public health to discuss COVID-19 vaccination planning. The Immunization program is engaging with a more comprehensive Local Health Department workgroup to make sure they are all knowledgeable about the current planning around COVID-19 vaccinations and to discuss issues that may arise. This will be an opportunity to be sure we are all on the same page so we can present the plan as it exists and solicit input on areas that can be improved. Specifically, we would discuss: Program enrollment, vaccine distribution strategies including allocations, vaccine training plans, changes to MCIR, LHD partnerships with priority groups, vaccination strategies, etc. Included in the meeting should be the following representatives:

- Health Officers
- Medical Directors
- Immunization Nurses
- Emergency Preparedness Coordinators
- Planners/Health Educators

Pharmacy Group: There is an existing Pharmacy Emergency Preparedness Steering Committee (PEPSC) that is run jointly with Michigan Primary Care Association and BETP. The Immunization Program has met on several occasions with the Michigan Pharmacy Association to discuss COVID-19 vaccination planning. We have also had many discussions with community and large chain pharmacies. The plan is to have meetings of all pharmacy groups in Michigan to be sure we are planning for a successful partnership. These meetings will occur after federal decisions are made on their relationships with pharmacies as they relate to LTC. These meetings will be to discuss the different options on how pharmacies can potentially be engaged in the vaccination program. We want to determine the relationships with LTC



and determine the extent that pharmacies can outreach to older adults with underlying medical conditions, as well as vaccinating LTC staff as top priority. It will be important to talk about the national plan and how that will be coordinated in Michigan. Potential partners to include:

- Michigan Pharmacy Association
- Meijer
- CVS/Minute Clinics
- Walgreens
- Rite Aid
- Walmart/SAMS club
- Kroger
- Hometown Pharmacy
- Costco
- Spartan Nash

Michigan Hospital Association: The Immunization Program has met several times with the Michigan Hospital Association including medical directors for Michigan hospitals. Hospitals will be key to our response on vaccinating tier 1 health care workers and have the ability to accommodate large allocations of vaccine if Vaccine A is first to arrive. These meetings have shown a willingness to partner with MDHHS on the vaccination campaign.

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

MPA-State Pharmacy Emergency Preparedness Coordinator

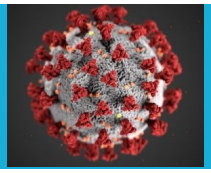
MDHHS Internal COVID-19 Planning group

Pharmacies listed above

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

The Immunization program has a long standing and strong relationship with Local Health Departments on the implementation of the Immunization program as a whole. These strong relationships lay the groundwork for implementation of the COVID vaccination program. The Division of Immunizations worked closely with local public health on the successful implementation of the H1N1 vaccination program. The plan for COVID vaccination is similar to what was accomplished during H1N1.

The Immunization program will continue to communicate and meet with local public health weekly. These meetings will be at all levels including Health Officers, Medical Directors, Emergency Preparedness, and Immunization Nurses. Local Public health departments are closer to their communities and know their communities better than we could at the state level. We



take advantage of those local relationships to be sure we can get the vaccine to the appropriate providers who have the ability to vaccinate all individuals in the community.

The Immunization program has been meeting with the Health Care Coalition Regional groups that supports the entire state. These Health Care Coalitions are critical partners is serving health care systems, hospitals, LTCs and LHDs in times of emergencies. Since April, the Immunization staff have been meeting twice a week with this regional group and will continue to support, educate and coordinate COVID-19 activities.

The Immunization program will continue to interface with all appropriate programs across the Department to be sure all are in support and involved as needed in the immunization efforts. Meetings across the department will continue up to 3 times a week.

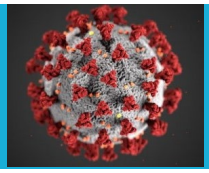
F. *Describe how your jurisdiction will engage and coordinate efforts with leadership from tribal communities, tribal health organizations, and urban Indian organizations.*

The Division of Immunization has already met with the leaders of the Tribal Health Centers twice and will continue to engage them to refine their specific vaccine needs and be sure the needs of this community are met not only by providing vaccine but the educational needs for their community. The Department has a liaison to the Tribal Nations and the Immunization program will continue to communicate through that liaison to be sure communication is coordinated and get to the appropriate people. We will continue to be on the tribal conference calls. We are in the process of completing the CDC spreadsheet to determine the size of the population cared for in each of the tribal health centers and determine their preference in obtaining vaccine from the State allocation or directly from IHS.

Ongoing efforts continue to enroll all tribal health centers into VFC and MI-AVP and the adult flu program to assure public vaccine coverage to the tribal communities. Many tribal health services report not having uninsured populations. Outreach and educational materials focused on risks of influenza in American Indian population were created and shared. Increased outreach to encourage influenza vaccinations continues and urgency with COVID-19 circulating.

G. *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*
  - See above for work with pharmacies.
- *Correctional facilities/vendors*
  - The Division of Immunization will work through the Department of Corrections to reach the state prison populations of Michigan. The assumption at this point is that the Federal Prisons will receive their COVID-19 vaccine allocation directly from CDC. Should this change, the department will establish relationships with



the federal prisons to assure that vaccine is available to all inmates. The State of Michigan has integrated COVID-19 testing into the prison system and will use that infrastructure for the vaccination program in the prisons.

- Local Health Departments have built relationships with local jails especially during the recent Hepatitis A outbreak. Many of the local health departments established vaccination clinics within the local jails. This same outreach will be used to assure the jail populations are vaccinated.

- *Homeless shelters*
  - Statewide messaging to shelters will be done from the MDHHS Housing and Homeless Service program. They have become strong partners to the Immunization program during the recent Hepatitis A outbreak and have been strong partners. Local health departments will be the primary contact to specific homeless shelters. Local health departments will coordinate vaccination clinics at their local shelters.

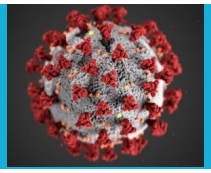
- *Federally Qualified Health Centers*
  - The Division of Immunization works closely with the Michigan Primary Care Association who represents the FQHCs across Michigan. We have recently undertaken an extensive influenza vaccination campaign with the FQHCs to increase the number of vaccines administered. It is the infrastructure build during the flu program that will be used to implement the COVID-19 vaccination program. During the implementation of the flu campaign, we were able to recruit 10 additional health centers into the Michigan Adult Vaccination Program. Ongoing efforts to recruit any remaining FQHCs will continue.

Migrant Populations:

Migrant Communities will be covered by FQHCs. Michigan has a large migrant population that is seasonal, and the FQHCs have a long-standing relationship with this population. The immunization program will work with the MPCA to assure the FQHCs include this population in their COVID-19 vaccination requests as this population moves in and out of our state.

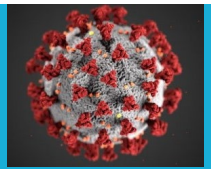
Minority Populations:

Michigan has large areas with primarily black and Hispanic or a blending of the two. Efforts have been especially focused to increase influenza vaccinations in these communities this flu season with the FQHCs. These geographic areas are targeted for mass vaccination clinics with FQHCs and chain pharmacies, increasing vaccinations in clinic with FQHCs and school based health centers, specific communication efforts, faith-based interaction to establish trust in messages and services taken to where to the population lives, plays and prays.



At-Risk Populations:

Education has been focused with all Michigan health care providers to assure those with comorbidities are provided services, vaccinations and follow-up. Access to care is a barrier that must be address and immunization services must be taken to areas where this population lack medical care. The immunization program is offering services with Neighborhood Service Organization, FQHCs, School-Based Health Centers, YMCAs, LHDs and the City of Detroit in an effort to improve access to vaccinations with plans to use these efforts to implement COVID-19 vaccination outreach.



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:*

The initial allocations of COVID-19 vaccine will be directed to 143 hospitals and health systems for use on health care workers. More detailed description below. After initial allocations to hospitals, allocations will be made to each of the 45 health jurisdictions based on several factors including the social vulnerability index and population. LHDs will then use the relationships they have built with the community to allocate out additional amounts of vaccine to the providers in their community who are able to reach the vulnerable populations. LHDs will also receive vaccine to stand up their own targeted vaccine clinics to reach vulnerable populations in the community.

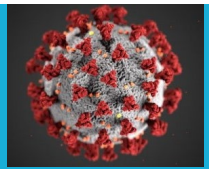
Phase 1: Potentially Limited Doses Available

The Division of Immunization will focus our initial efforts during phase 1 on enrolling providers into the COVID-19 vaccination program that will immunize the critical populations identified. The Division has developed points of contact for groups within the critical populations. Data has been collected on the numbers of individuals in these identified populations. These will include paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or to infectious materials. We will prepare for two doses of vaccine needed, with providing the card from the Kits and utilizing our IIS for USPS mail reminder card and creating IIS text message.

We identified those healthcare settings initially by utilizing our collaborations with the Bureau of EMS, Trauma, and Preparedness (BETP). BETP has developed a list of the hospitals and healthcare systems in Michigan and determined the number of licensed beds in each facility. We are actively collecting information from these groups to determine their reach into the health care community and assessing the number of health care personnel covered by these entities. Initially doses of COVID-19 vaccine will be allocated to these facilities that have the ability to vaccinate large numbers of individuals and reach the priority populations.

Next, we will identify those individuals who may be at high risk of severe complications for COVID-19 illness based on age. These groups include individuals over 65 years of age in Michigan, who have been identified with the U.S Census data and vital records data within the state. Additionally, we determined licensed bed counts and staffing counts for long-term care facilities and points of contact for those facilities.

We will concentrate efforts on recruiting and enrolling providers into the Michigan Care Improvement Registry (MCIR), Michigan's immunization registry, and the COVID-19 vaccination program. The Division of Immunization will focus on training COVID-19 immunizers on storage



and handling procedures, inventory management, and vaccine administration and reporting procedures.

During phase 1, the Division of Immunization will directly distribute COVID-19 vaccine to the facilities identified with our critical populations. After shipments directly to hospitals, allocations from CDC will be distributed to local health departments to prioritize vaccine to providers who have the ability to administer vaccine to other critical populations. The hospital systems are most appropriately set up to manage the 975 minimum dose order should the vaccines be allocated using that minimum order size. Allocations managed by the LHDs will be routed to the providers within their jurisdiction who can vaccinate the prioritized populations. The LHDs will have the ability to hold off-site clinics to reach priority groups and essential workers such as water, light, power and EMS if included as identified by emergency preparedness.

Pharmacies will be able to reach and identify individuals over the age of 65 years who have underlying medical conditions and are at high risk of severe COVID-19 illness. CDC is planning to partner with pharmacies to ship vaccine directly to them. LHDs will also distribute to pharmacies who have not received direct distribution from CDC.

During phase 1, we will focus our communication efforts on healthcare personnel and critical populations identified at high risk of severe COVID-19 illness.

https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5106-91133--,00.html

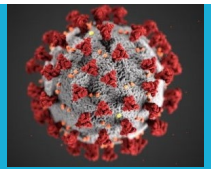
Phase 2: Large Number of Doses Available, Supply Likely to Meet Demand

During phase 2, the Division of Immunization will continue to identify the populations considered essential personnel including grocery and food distribution workers, healthcare workers not immunized during phase 1, high risk populations, and other critical populations. Different categories of essential personnel have been identified and we continue to add to the list with additional critical infrastructure workers.

Phase 2 vaccine distribution will be allocated through the local health jurisdictions. The LHDs will allocate to commercial sector settings such as retail pharmacies, private sector settings including private doctors' offices, and public health sites including Federally Qualified Health Centers, temporary and off- site clinics, and additional locations to ensure equitable vaccine access to the critical and general populations.

Enrollment and training for the MCIR and enrollment in the COVID-19 vaccine program will continue and expand to additional pharmacies, doctors' offices, and public health sites to reach other critical populations.

Communication efforts will begin to expand to reach critical populations and the general public.



Phase 3: Likely Sufficient Supply, Slowing Demand

During phase 3, all enrollment, distribution, and communication efforts will be expanded to include the general population. Routine distribution to any provider enrolled in the COVID-19 vaccine program will occur. Allocation will no longer be distributed through the LHD's, providers will be able to order vaccine through the MCIR system.

Partners currently engaged for vaccination to vulnerable populations:

Local Health Departments:

The Immunization Program will rely heavily on the relationships and the expertise of the local health departments (LHDs) to operate outreach clinics that can reach the most vulnerable populations. LHD experience from recent outbreaks has established strong relationships with community partners and work will be done to reach these populations during this outbreak. LHDs know their communities and have the relationships to reach the vulnerable populations including minority groups.

Lessons learned from the hepatitis A outbreak have established strong relationships with high risk groups such as homeless shelters, substance abuse clinics, STI clinics, and jails, as well as other outreach to vulnerable populations in the community. LHDs should establish outreach flu clinics in these same locations.

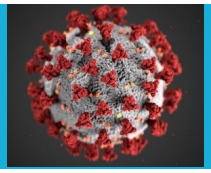
Many strong relationships have already been built by LHDs during this COVID-19 pandemic, including with Long Term Care, (LTC), skilled nursing facilities, assisted living, and other senior centers for surveillance and testing for COVID-19. These relationships will be utilized for vaccination clinic sites. Individuals living in these facilities are at greatest risk for complications to serious COVID-19 complications and should be primary target sites for outreach clinics.

LHDs will reach out to faith-based groups within their communities to establish relationships and hold outreach clinics to reach these groups. Establishing these relationships will assist the LHDs in assuring minority populations have easy access to COVID-19 vaccine.

LHDs are working with employer groups in their jurisdiction to form new partnerships to assure that these employer groups have a mechanism to obtain vaccines for their staff. LHDs will be encouraged to stand up clinics for those employer groups who do not have a current mechanism in place to vaccinate their employees. These businesses include manufacturing, grocery stores, and any other businesses within their community.

Hospitals and Health Systems:

As discussed earlier, health systems and hospitals are well situated to be key players in the vaccination efforts of health care providers in the state. Hospital systems also have a ability to do outreach to vulnerable populations identified in the Phase II vaccination efforts.



Federally Qualified Health Centers (FQHCs):

FQHCs are situated in underserved communities and many have a particular focus on rural areas of the state. That is not to say they also play a role in urban area and serve large numbers of individuals. While outreach to urban areas of the state can be done by the health systems and local health departments, many FQHCs can focus primarily on the rural areas of the state. FQHCs have played a role in testing for COVID-19 and have established themselves in the community to serve those underserved populations. FQHCs not only offer COVID-19 vaccine to all individuals coming to their clinics, but also do direct outreach to communities of need just as they have established with migrant populations in Michigan. Outreach within the community will be the best way to reach these vulnerable populations.

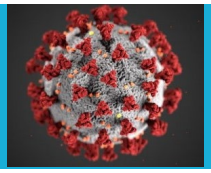
Tribal Health

Many of the tribal health centers will be obtaining their COVID-19 vaccine directly from IHS. For those that will be receiving the vaccine through the state allocation, allocations will be made directly to the Tribal Health Centers from the State allocation rather than obtaining the vaccine from the local health department. The vaccination services at the tribal health centers will be to those seen in their health center but also to provide outreach to vulnerable populations within the tribal community.

Pharmacies:

Pharmacies have established themselves as leaders in the community for adult influenza vaccination efforts. Lessons learned from influenza vaccination will be used to implement the COVID-19 vaccination program. Michigan will partner with pharmacies based on the planning already underway at the National level. We will take advantage of the plan with CDC for direct distribution to the participating pharmacies for support in vaccinating residence in Long-Term Care facilities. MDHHS will work with CDC to determine those pharmacies receiving vaccine directly from CDC's allocation of vaccine so we can determine those LTC centers that will not be covered by the pharmacy agreement. Those pharmacies that are not covered by this arrangement will be identified and shared with LHDs so they can arrange to vaccinate the staff in phase I and the residents during phase II.

Pharmacies are prevalent in most communities and frequented by community members for other services such as prescription refills. By default, they see individuals who may have health conditions that put them at risk of complications to COVID-19 and therefore they have access to them to offer COVID-19 vaccination. Our goal is to engage pharmacies to enhance their outreach in the community to receive COVID-19 vaccines. In discussions with pharmacies, many have the ability to identify and rapidly notify individuals who have high risk conditions. Those pharmacies will notify individuals in the risk groups, such as those over 65 years of age who have comorbidities and direct them back to the pharmacy where they can obtain these needed immunizations. Initially, there will not be enough vaccine to allocate to all pharmacies, therefore selected pharmacies in strategic locations will be used for these outreach efforts.



School Based Health Centers:

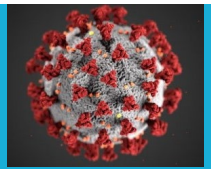
In partnership with the Division of Child and Adolescent Health, School Based Health Centers have been utilized during flu outreach to community members. School Based Health Centers will be used to get COVID-19 vaccine into potentially vulnerable communities throughout the state.

Alana's Foundation in partnership with VNA:

Alana's Foundation works year-round to provide influenza education and awareness with a focus on providing convenient and affordable flu vaccinations for everyone. Alans's Foundation was established by the Yaksich family in memory of their 5-year-old daughter who passed away from influenza. This organizations has conducted very impressive community vaccination events in many areas of the state with a focus on college campuses. These organizations along with the partnership of local health departments will be utilized for the administration of COVID-19 vaccine in multiple venues across the state including colleges and universities.

Established COVID-19 Testing Sites:

The Immunization Program has partnered with COVID-19 testing sites during the flu season to offer flu vaccination at these sites. This same partnership will be utilized to administer COVID-19 vaccine to these strategically placed sites in underserved areas of the state.



Section 4: Critical Populations

Instructions:

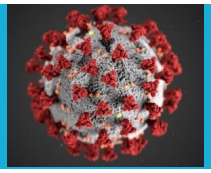
A. *Describe how your jurisdiction plans to: 1) identify, 2) estimate numbers of, and 3) locate (e.g., via mapping) critical populations. Critical population groups may include:*

- *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*

The Division of Immunization utilizes various sources and databases to identify, estimate, and locate critical populations. We work very closely with the Bureau of EMS, Trauma, and Preparedness (BETP) at the Michigan Department of Health and Human Services who have developed multiple resources with assistance from the Michigan Department of Licensing and Regulatory Affairs (LARA), and other departments within MDHHS to identify and estimate the number of individuals working in healthcare, long-term care facilities, federally qualified health centers, and tribal health centers.

Healthcare Personnel: Healthcare personnel will be identified based on the bed counts of the facility and multiplied by a factor of 6 to account for the nursing staff, support staff, and physicians working in a hospital. EM Resource is an application where hospitals and long-term care facilities are required to report their bed counts and will be utilized to estimate the number of healthcare professionals. We have asked those hospitals and health care systems to estimate the number of workers within their system including ancillary and primary care clinics, urgent care, pharmacy and LTC.

Long Term Care: We've identified the long-term care and assisted living facilities that are licensed by LARA in Michigan and will work with this group to identify and locate points of contact for this group. These lists include bed counts by county to better estimate the reach needed in each community. We also rely heavily on local health departments to identify facilities that may not be on the lists we have developed.



Population 65 years and older: We have worked with our Vital Records Program to pull population data of all ages. This data is broken down by county and has been distributed to local health departments for use in focusing on areas of need for vaccination. MDHHS also works with the Aging and Adult Services Programs.

Racial and Ethnic Minority Groups: The Division of Immunization has also used the Vital Records Program to look at racial groups across all local health jurisdictions. This data has been used in the allocation of funding to communities with a larger proportion of minority groups. A similar formula will be used in the allocation of vaccines.

Other Essential Workers: The Michigan Association of Townships and Census data is being utilized to identify EMS and first responder estimates as well as contact information for those groups. We have also obtained EMS data from BETP who licenses and regulates all EMS agencies, personnel, and vehicles.

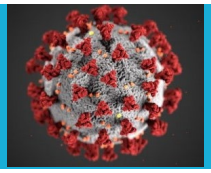
We will also use the Annual Survey of Public Employment and Payroll (ASPEP), which measures the number of federal, state, and local civilian government employees, including law enforcement, and their gross monthly payroll for March of the survey year for state and local governments and for the Federal Government. This survey will help us identify the counts of individuals in those specific occupational areas.

Homeless Populations: Much of this groundwork was laid during the Hepatitis A outbreak in Michigan. Local health departments created strong relationships with homeless shelters, soup kitchens, and food pantries. At the state level we are working closely with the Homeless Services program and integrating our work with theirs. The Immunization program is working with the MDHHS Housing and Homeless Service program.

Correctional Facilities: We are consulting with the Department of Corrections and BETP to identify those individuals who are incarcerated or detained in correctional facilities as well as the employees who work at those facilities.

Tribes: BETP within MDHHS has counts of the numbers of members of the 12 federally recognized Tribes in Michigan. We are currently working with tribes to determine their commitment for the method they will receive vaccines. Attached is the completed spreadsheet which contains a list of tribes that will obtain COVID-19 vaccines from IHS and the list of tribes who will obtain COVID-19 vaccine through the state allocation. The Immunization program is working directly through the tribal liaison within the Department.

Rural Communities: We are working closely with FQHCs across the state. Much work with FQHCs is through the Michigan Primary Care Association which represents FQHCs. This workforce, along with local health departments have access to rural communities. We piloted an influenza vaccination program with FQHCs this year. The concept is to take vaccine into the small areas with limited healthcare access. This plan from their outreach efforts is to be used as a preparedness exercise for the distribution of COVID-19 vaccine to these underserved communities.



We are working with the Centers for Medicare and Medicaid Services in Michigan to estimate and reach those individuals on Medicare and Medicaid in Michigan.

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

As mentioned above we are working with multiple departments and BETP to identify these critical populations. Pandemic planning has already determined the number of workers in the workforce critical to our infrastructure, such as utility workers. New to this pandemic are additional workforce workers such as grocery workers. We have counts of grocery workers by county to assist local health departments in vaccinating these populations. We utilize sources including the United States Census to identify and estimate numbers of grocery workers and other critical infrastructure workforce. We will be working with large chain grocery stores and the pharmacies within those organizations to reach the critical workforce. Additionally, the local health jurisdictions in Michigan will be utilized to distribute and reach individuals within the critical workforce.

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

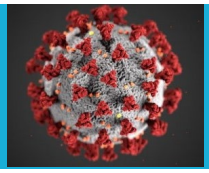
During phase 1-A, we will identify those individuals working in hospitals including paid and unpaid persons serving in healthcare settings that have the potential for direct or indirect exposure to patients and are unable to work from home. We have asked hospitals and health systems to estimate these populations and the capacity they can serve for these populations they may have into the community. We have obtained the number of LTC staff by county for additional outreach. We are working to obtain the number of pharmacy workers throughout the state. We are utilizing data from LARA to estimate additional populations such as urgent care centers.

During phase 1-B we will identify other essential workers, healthcare personnel not immunized during phase 1-A, and those at higher risk of severe COVID-19 illness including people aged 65 years and older. It is at this point where the Immunization program will begin making allocations to local health departments where they will assist with focusing vaccine efforts on the critical populations identified.

Michigan State Police Emergency Management and Homeland Security Division has a Critical Infrastructure Program (CIP). MDHHS will work with this program to help identify and prioritize the critical infrastructure workforce.

Additionally, we will work with the local health jurisdictions to reach those other critical populations identified in the section above. The local health departments will work within their communities to distribute vaccine equitably and vaccinate the populations identified for phase 1-B and 2.

Provider offices will be able to routinely order vaccine during phase 3.

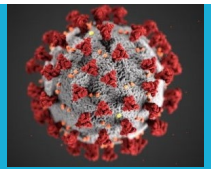


D. *Describe how your jurisdiction will establish points of contact (POCs) and communication methods for organizations, employers, or communities (as appropriate) within the critical population groups.*

The Division of Immunization has worked with our partners identified in part A of this section to establish points of contact within the critical populations. Healthcare personnel contacts have been identified with the assistance of BETP and utilizing the provider contact information in the Michigan Care Improvement Registry.

- The Division of Immunization along with leadership from the Department have set up Stakeholder meetings. Representatives from many of the medical professional groups are part of these meetings including groups such as Michigan State Medical Society, Michigan Osteopathic Association, MALPH/Local Public Health, Michigan Hospital Association, Michigan Primary Care Association, Michigan Osteopathic Association, Michigan Academy of Family Physicians, Michigan American Academy of Pediatrics, Michigan Pharmacy Association, Michigan Association of Health Plans, Michigan Chapter of American College of Physicians, Long Term Care, Tribal Health, Michigan Nurses Association, and Medicaid. Critical populations identified above will be part of this Stakeholder group. These individuals will be critical to engaging their stakeholder groups and disseminating information to those groups.

  After direct distribution to the hospital systems in phase 1-A, distribution of COVID-19 vaccine will be allocated through the local health departments. LHDs will develop points of contact with the provider offices, pharmacies, and other healthcare settings to reach the additional populations.



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.*

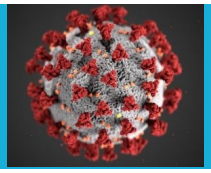
Outreach began in July 2020 to 445 Long Term Care Facilities. The initiative's goals were multiple, and it was conducted before and during the influenza season. The strategies differed based on the characteristics of the facility, as follows:

1. Existing MCIR registered LTC Facilities:
    a. Ensure Provider Site Agreements are current
    b. Ensure site contact information and Site Administrator name is accurate
    c. Offer refresher training to site users
2. Non-registered LTC immunizing Facilities:
    a. Execute MCIR Provider Site Agreements
    b. Assist with MILogin Registration
    c. Assist with MCIR Access Registration
    d. Provide MCIR Basics training
3. Non-registered LTC, non-immunizing Facilities:
    a. Execute MCIR Provider Site Agreements
    b. Assist with MILogin Registration
    c. Assist with MCIR Access Registration
    d. Provide minimal basic training specifically focused on how to find a patient immunization record to check immunization history and forecast information.
    e. Encourage vaccination in their facility

Automated emails (initial in July, follow up in September) were sent to the LTC facility contacts Notice was provided in July to LTC Facility Medical Directors via the MDHHS Health Alert Network.

Phase 1 Provider COVID Registration will be tiered across several weeks and broader than those who will be part of Phase 1 Vaccine Distribution. Registration announcements have been sent to Local Health Departments, Hospitals including Michigan's State Hospitals. This will be followed with outreach to Long Term Care Facilities, and then Pharmacies.

Outreach will begin with a notice being sent via the MDHHS Health Alert Network and through provider associations (example: Michigan State Medical Society, Michigan Pharmacy



Association, Long Term Care Facility organizations, others) to inform that registration will be commencing.

Provider COVID Registration form(s) and instructions will be posted on our website of Michigan.gov/Coronavirus.

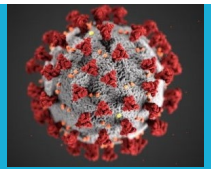
Provider COVID Registration form has been converted to a fillable E-form and will be received centrally in the Lansing office of the Division of Immunizations via email for initial processing. The Division of Immunization is in the process of implementing the registration form into Red Cap for broader distribution.

1. **Unregistered MCIR Providers** will be directed to the appropriate MCIR Regional office for the following:
    i. Execute MCIR Provider Site Agreements (including license verification)
    ii. Assist with MILogin Registration
    iii. Assist with MCIR Access Registration
    iv. Provide MCIR Basics Training
    v. Determination as to method of immunization submission
        1. Direct Data Entry (DDE) on MCIR web application, or
        2. HL7 VXU (and QBP) – providing instruction on how to begin this process.

2. **Existing MCIR Provider with Active Agreement**, staff will validate the status of the provider license.
3. Take the steps necessary to **enroll the Provider in the MCIR Outbreak Module and set up in VTrckS.**
4. Provide additional information as identified on Vaccine Order, Storage and Handling, and other required activity or education/training opportunities.

COVID Provider Registration will be tracked from receipt of registration forms through appropriate conclusion.

Remaining Provider COVID Registration (Phase 2 and Phase 3) - Following the registration of Phase 1 providers, recruitment for remaining providers will be made via the MDHHS Health Alert Network, through provider associations MDHHS Health Alert Network and through provider associations (example: Michigan State Medical Society, Michigan Pharmacy Association, Long Term Care Facility organizations, others) and to existing registered MCIR providers including VFC providers.



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.*

Michigan is the 9th largest state with regard to population with an equally large territory encompassing large urban areas as well as areas that are remote and rural. There are four primary provider types that will be utilized to reach critical population groups: Local Health Departments; Hospitals/Health Care Organizations (including State of Michigan hospital facilities) who in pocket areas of the state are the central hub of the community; Long Term Care Facilities that serve our most vulnerable citizens; and Pharmacies. Pharmacies are uniquely able to identify and conduct outreach to their patients who have chronic medical conditions.

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.*

The Provider COVID-19 Vaccination Registration form will be an E-form that when received will autofill an Excel spreadsheet. The information will then be loaded to a Provider Tracking Access Database/spreadsheet that will then be used for compiling and reporting the required data elements to the CDC. Method for reporting is planned to be an upload of a CSV file. As we migrate over to the use of the Red Cap tool, data will also be downloaded into a CVS file for upload to the CDC SAMS/DataLake.

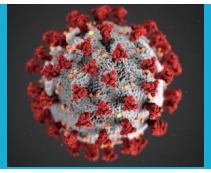
D. *Describe the process your jurisdiction will use to verify that providers are credentialed with active, valid licenses to possess and administer vaccine.*

Division of Immunization staff and MCIR Regional staff will use the Michigan Licensing and Regulatory Affairs (LARA) license verification web application system to verify the provider has an active occupational license in Michigan. This is the same process used for validation of providers enrolling in the MCIR system and in the VFC programs.

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

COVID Providers will be evaluated for level of training needed based on the following:

Path A - Brand new provider to MCIR
Path B - Existing provider user of MCIR
Path C - Existing AVP/VFC MCIR provider user



All materials and video links (YouTube channel) are available on https://www.mcir.org/. Providers who view or complete posted trainings can be tracked.

Before provisioning vaccine to COVID providers and before we finalize a provider to receive the vaccine, the enrollment will be referred to the appropriate local health department. It is expected that each LHD will then reach out to the provider to provide education on the COVID-19 vaccine and validate that they have the capability to appropriately store the COVID-19 vaccine.

Path A - Brand new provider to MCIR (no experience, all training needed)

a. **How to Register in MILogin** (video training, Regional staff assistance)
b. **How to gain MCIR Access** (video training, Regional staff assistance)
c. **Site Administrator Training** (PowerPoint training module with a Certificate of Completion, Regional staff assistance)
d. **MCIR Basics** (Tip Sheets, PowerPoint training module with Certificate of Completion, Regional staff assistance) – Video production of Basics is planned for October 2020.

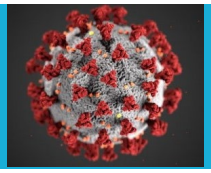
   MCIR Basics training includes the following:

   a. How to Find a Person
   b. How to Add a Person
   c. How to Edit a Person's demographics
   d. How to add or edit a vaccination administered by your site
   e. How to add a Historical Immunization
   f. How to print a Person's Immunization Record
   g. How to Flag a record as a duplicate
   h. How to mark a record as deceased

Training Modules to be completed:

NOTE: Additional information is needed from the CDC on if inventory balancing will be required.

a. MCIR Outbreak Module
b. **How to Report COVID Vaccinations when systems are unavailable** (COVID Vaccine Administration Form)
c. **Vaccine Inventory Management (VIM) Basics** – How to Order; How to document a dose (so it deducts correctly); How to balance; How to report waste; How to report/respond to temperature incursions.
d. **COVID Educational information - ACIP requirements; VAERS; Storage and Handling; etc. will be posted either on https://www.mcir.org/ or on the MDHHS Immunization page for COVID instructions (https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4914---,00.html)**



Path B - Existing provider user of MCIR (no order and inventory experience, refresher training may be needed, MCIR Outbreak Module and COVID order/inventory training needed, COVID Educational Information needed).

Path C - Existing AVP/VFC MCIR provider user (has order and inventory experience, refresher training may be needed, MCIR Outbreak Module training needed, and COVID Educational Information needed.)

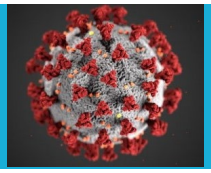
Statewide webinar training is planned to be on a pre-set schedule. Any provider will be able to participate. Trainings will be offered in logical groupings (i.e. not all at once) and on multiple dates and times.

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).*

1. Existence of Signed Redistribution agreements.
2. Ability to maintain the cold chain with use of approved transport coolers and pack-out per CDC storage and handling toolkit.
3. Will require the use of Digital Data Loggers during transport to record temperatures.
4. LHDs to be notified and approve redistributions, vaccine to be transported only within the same LHD jurisdiction, unless approved by MDHHS.
5. MDHHS Immunization Field Representatives will be utilized if at all possible, to transport vaccines to assure proper transport procedures are followed. Required if vaccine is to cross LHD jurisdictions.
6. Instructions on How and What needs to be recorded in MCIR Vaccine Inventory will be provided to both sites.
7. Vaccine redistribution will be tracked within the MCIR system in the transactional inventory process.
8. Supplies from CDC should be provided along with vaccine undergoing re-distribution.

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

Monitor Providers registered with regard to site locations. This will allow additional outreach and recruitment activities to occur if locations are insufficient to meet the anticipated demand based on population density, size of priority group populations (when known), and known disparity regions.

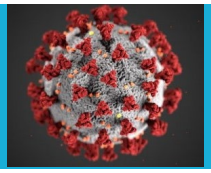


Monitor vaccinations administered to understand current saturation by county based on available information on vaccine distributed and by county characteristics (e.g. race, high risk population, current COVID outbreak area(s), etc.).

NOTE: COVID-19 vaccination administrations will be tracked on a public facing dashboard. This public facing dashboard is being built on the same platform being used for our newly developed flu dashboard. It allows users to view aggregate level data across the state for analysis. See the flu dashboard at www.Michigan.gov/Flu.

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.*

Michigan is fortunate to have robust participation of pharmacies in MCIR. However, the Division of Immunizations is working actively with the Michigan Pharmacy Association to ensure communication to their membership when Provider COVID-19 Registration is open. We will also be forming a pharmacy stakeholder group to educate pharmacies on our plan and to integrate the work they are already doing into the plan.



Section 6: COVID-19 Vaccine Administration Capacity

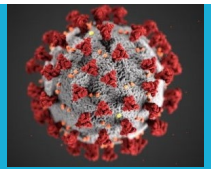
Instructions:

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

- Michigan has a robust immunization information system (MCIR). We will assess the number and types of immunizing providers currently entering immunization data into MCIR. Provider types of note with regard to administering COVID-19 vaccine will include, but are not limited to, family practice Vaccines for Children (VFC) providers, MI Adult Vaccine Program (MI-AVP) providers, pharmacies, and employee/occupational health sites. Seasonal influenza immunization data will be used to assist with determining COVID-19 vaccine administration capacity, as September-December represent the largest capacity for administering seasonal flu doses in addition to other routine vaccines.
- We will continue to work with our Bureau of EMS, Trauma, and Preparedness (BETP) and the Community Health Emergency Coordination Center (CHECC) and will use vaccine outreach clinic and provider data from the statewide Hepatitis A outbreak.
- We will survey local health departments (LHDs) regarding their current immunization clinic and curbside drive-through clinic capacity as well as their projected capacity and plans for each during the winter months.
- COVID-19 vaccine administration capacity and throughput will be influenced by the current Michigan epidemic order regarding capacity limitations in facilities with appropriate risk mitigation measures put in place.
- We will work closely with our VFC/AVP team with regards to immunization providers' storage capacity, i.e., which providers will be able to store and handle COVID-19 vaccine given the vaccine's storage requirements which are unknown at this time.
- Non-traditional vaccine providers and clinic sites will be assessed to determine vaccine administration capacity. This may include COVID-19 testing sites, school-based health centers (some health centers remain open even though the school is doing virtual learning), urgent cares, etc.
- One of the lessons learned during H1N1 was that pharmacies were underutilized in the vaccination efforts. Pharmacies have grown to be strong vaccination partners with a focus on adult vaccinations. Pharmacies have all provided great support for our IIS and submit data routinely to the IIS.
- CDC's PanVax Tool has been used and is actively being used to help us determine COVID-19 vaccine administration capacity.

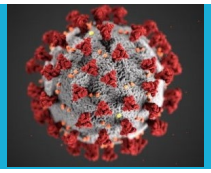
B. *Describe how your jurisdiction will use this information to inform provider recruitment plans.*

- The above-mentioned vaccine provider and immunization data from MCIR will be used to establish a baseline of existing provider types and locations and as well as gaps in vaccination



providers. This information will be used to guide our provider recruitment plans. The VFC/AVP team and MCIR staff will be involved with all provider recruitment discussions.

- Because long-term care (LTC) residents are at high risk for severe outcomes from COVID-19 and LTC facilities are at high risk for COVID-19 outbreaks to occur, recruitment of LTC facilities as immunizing providers in MCIR is already underway. MCIR staff have worked with the Community Health Emergency Coordinating Center (CHECC) and the MI Department of Licensing and Regulatory Affairs (LARA) to obtain lists of licensed LTC facilities to contact and enroll them in MCIR.



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

Instructions:

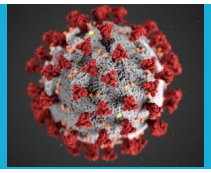
A. *Describe your jurisdiction's plans for allocating/assigning allotments of vaccine throughout the jurisdiction using information from Sections 4, 5, and 6. Include allocation methods for populations of focus in early and limited supply scenarios as well as the variables used to determine allocation.*

a. Michigan has developed methods for allocation that will be based on CDC expectations: populations served by vaccination providers, geographic location for distribution throughout the jurisdiction, provider site storage and handling capacity, and utilize ACIP recommendations as they become available , to inform distribution. When doses are in limited supply, allocations will be prioritized to the critical populations identified in section 4. These planning assumptions for phase 1 allow targeting priority groups of healthcare personnel, LTC staff and residents, critical infrastructure workers, individuals 65 years and over, and those with underlying medical conditions. To ensure appropriate allocations and establish partnerships with those that will vaccinate priority groups especially amidst limited supply, Michigan established a workgroup in April 2020 with representation from the Bureau of Emergency, Trauma and Preparedness (BETP) and the Michigan Pharmacists Association. This group has actively participated in identifying key sectors that must be prioritized and assist in identifying variables for allocation methods.

i. As a priority group for limited supply doses, Michigan has developed a specific plan for hospital and hospital system allocations. Hospital-specific allocation variables will utilize "bed count per hospital" information obtained from BETP. The division has a relationship with the Michigan Health and Hospital Association to ensure enrollment and communication occurs appropriately.

ii. Non-hospital allocations will be allocated to LHDs to prioritize providers who have the ability to administer vaccine to priority groups. To determine the LHD allocations, variables will allow flexibility based on the vaccine which becomes available and key populations needed to be prioritized. Michigan's allocations will utilize a baseline amount (total provided by CDC) and target certain variables which can be weighted as needed and divided among local health department jurisdictions. These weighted percentages that determine jurisdiction amounts can be modified as needed based on ACIP recommendations, priority groups, etc. For example, using the jurisdictional population age 65 years+ as a variable in determining allocations. Variables that are currently utilized for determining allocations per LHD jurisdiction:

1. Baseline population
2. Population 20 years and older
3. Population 50 years and older



4. Population 65 years and older
5. Social Vulnerability Index (ensuring vaccine allocations take into account areas of disparity, populations with access to care issues, etc.)
6. Race
7. Long-term Care Occupancy

b. Hospital allocations will be allocated and ordered by MDHHS state staff. Non-hospital allocations will be determined by MDHHS state staff per LHD jurisdiction using the selected variables. LHDs will then utilize this information to determine the order amount per provider site in their jurisdiction, based on the total allocation assigned. LHDs will be essential in assisting as needed to vaccinate essential workers. MDHHS staff will ensure consistent communication with LHDs of priority provider types based on critical populations identified by ACIP. MDHHS will partner with pharmacies that do not receive direct enrollment at the federal level. We have been in communication with the Michigan Pharmacists Association and have established points of contact for pharmacy groups across the state. Pharmacies will work with long-term care sites for vaccination and they have indicated their ability to play a role in vaccinating age 65+ and those with underlying conditions by having this information readily available. Therefore, they will play a role when population is identified for prioritization.

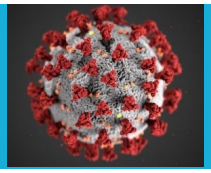
c. As doses become more available in phase 2, allocations will expand, utilizing mass vaccination efforts to ensure HCP, essential workers not covered in phase 1, and general populations are vaccinated. Partners who perform mass vaccination have been established, and LHDs will play a role in these efforts as well.

d. In phase three when vaccine is widely available, routine distribution will occur to enrolled providers as needed. Rather than determine allocations, routine ordering can occur similar to public VFC ordering – more detailed below on ordering.

e. Michigan will also utilize information obtained in the COVID-19 Provider Agreement/Profile to ensure allocations consider the provider type, populations served, storage capacity, etc. We will obtain data using a form that generates into an Excel file, which allows us to filter by these fields for prioritization. The data obtained from the agreements/profile forms will also be shared with Local Health Departments as they will place orders for non-hospital sites (more details on ordering below).

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.*

a. Provider cold chain capability will be extracted into the Excel file generated after they complete their Provider agreement/Profile form. Based on which vaccine becomes available, those storage requirements will dictate distribution – according to aspects such as the temperature requirements and quantity of vaccines per shipment. For example, ensuring an ultra-cold vaccine or vaccine quantity of 975 dose minimum is allocated only to providers that are equipped for such.



b. The state has procured several qualified vaccine transport containers for refrigerated vaccine, as well as digital data logger temperature monitoring devices to support adequate refrigerated transport as needed.

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.*

a. At the time of enrollment, providers will be entered into VTrckS by state staff. When allocations are utilized, state staff will place orders for all providers receiving vaccine according to allocation plan above. Placing the orders will occur via data entry into the IIS (MCIR) which creates the appropriate order files to upload into VTrckS via ExIS. MCIR programmers have developed a COVID ordering tool to assist in placing these several orders at once rather than one-by-one. This tool is based on current functionality for how Michigan currently places public flu prebook orders when allocated doses. Providers will receive notification when an order is placed for them.

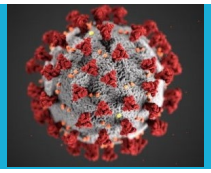
b. When vaccine becomes widely available and allocation is not necessary for the state to enter all orders, providers will place orders directly in the IIS utilizing e-ordering – the current process for ordering public (VFC) vaccine. With this e-ordering process, the order appears for approval first in the LHD IIS queue for order review and approval. After LHD approval, the state staff give the final approval and create the order files for upload to VTrckS.

c. Current inventory will be assessed before orders are placed for providers, which will be obtained directly from the provider's IIS site. Inventory information will be submitted to CDC as required; however, the format of this submission is still pending further details from CDC. The IIS program is aware that depending on the need for how inventory must be submitted to CDC, additional programming may be needed. The current functionality for VFC ordering allows us to capture inventory information from the IIS and upload to VTrckS which may be a similar process used if deemed appropriate.

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

a. For redistribution, agreements must be in place and approved by the LHD. If there is unplanned repositioning needed among providers, the LHD must be informed and approve of this as well to ensure the transfer is appropriate to initiate, is coordinated to ensure cold chain is maintained, and that the IIS inventory for both sites are reflected to reflect movement.

b. Movement of vaccine will be limited to refrigerated vaccine only. Cold chain must be maintained through the entire transfer, ensuring temperatures are monitored and taken during transport and upon arrival. As noted by CDC, cold-chain procedures must be in accordance with manufacturer's instructions and CDC's guidance on COVID-19 vaccine storage and handling. State field staff are available to assist if needed. The state-



procured transport coolers and data loggers can also be requested and utilized as needed to support vaccine transport if needed.

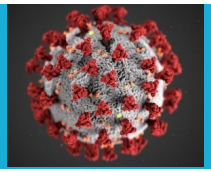
c. Local health departments will be the likely organizations who will redistribute COVID vaccine. LHDs will all sign redistribution forms in preparation of their role making vaccine accessible to clinics.

d. IIS inventory adjustments must be made to reflect any inventory movement. MCIR regional staff will train COVID-19 Vaccine providers during the enrollment process and staff will be available to assist providers if assistance is needed for inventory transactions. Therefore, both the distributing and receiving site must have a MCIR site.

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

a. Inventory and wastage will be monitored using the IIS. For COVID vaccine, a specific "Outbreak Module" is being developed that will support inventory functionality. It will largely be based on the current VFC public inventory module (which allows familiarity to current VFC providers). Inventory will be uploaded automatically into provider's virtual IIS inventory; they will be trained on how to utilize inventory functionality during the enrollment process. Doses will deduct automatically as providers enter administrations appropriately. For any wastage, a transaction must be entered in the IIS to deduct the dose appropriately and allow monitoring at the LHD and statewide level. CDC is still determining process for returns, which will dictate how MDHHS proceeds with creating return labels, submission to VTrckS, etc.

b. As mentioned above, inventory will be submitted to CDC with all vaccine orders as required. Pending the format of this submission will dictate any additional technical programming that may be required.



Section 8: COVID-19 Vaccine Storage and Handling

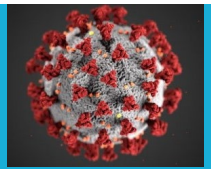
Instructions:

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:*

- *Individual provider locations*

i. Storage and handling training will be required at the individual provider level as part of the enrollment process. Local Health Department (LHD) staff will follow-up with enrolling providers to facilitate this training, and a checklist will be provided from MDHHS so that LHDs utilize a consistent approach for storage and handling training at the provider level. At minimum, the Vaccine Primary and Backup Coordinator must fulfill the training requirements. We are anticipating strong utilization of CDC-created materials for storage and handling education, including COVID-19-specific materials. For example, all providers must complete the CDC COVID-19 Training Module when it becomes available. Depending on the content of the COVID-19 Training Module, a You Call the Shots module may be required for Storage and Handling education. The provider must submit the module training certificate to the LHD. Additionally, enrolling providers must review CDC-provided COVID-19 vaccine-specific storage and handling materials as part of the S&H training checklist (i.e. addendum to the S&H toolkit, product summary sheets, BUD and expiration tracking tools, etc.). They will also be expected to utilize the CDC websites "Vaccination Guidance During a Pandemic" and "Guidance for Planning Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations." We will develop a **COVID-19 Vaccine Provider website** that will list and link to these S&H materials and that these be completed prior to approval by the LHD.

ii. Michigan will hold statewide calls and host webinars to familiarize enrolling providers with expectations, where to locate these training materials, and how to submit to the LHD for approval.



Discussions are also ongoing about temperature documentation submission. Providers will be educated on taking storage temperatures twice daily, including min/max from digital data loggers. MDHHS will provide MDHHS Temperature Logs for daily temperature documentation. However, we are in discussion in regard to whether providers will also be asked to submit temperature logs for review by the Local Health Department (i.e. similar to VFC Providers). We are also discussing whether temperatures should be verified prior to approving an enrollment – i.e. review 7 days of continuous temperature monitoring before enrollment is approved to assure appropriate temperatures are maintained. Additional guidance from CDC may assist in developing this process.

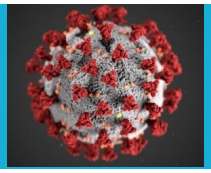
iii. Excursion guidance will be provided to ensure providers are aware of how to act on out-of-range temperatures. MDHHS currently has two documents to support this: MDHHS Guidance on Responding to Temperature Excursions, and MDHHS Emergency Worksheet. These may be revised with COVID excursion contact information when available. Or, if CDC creates a material that supersedes the content in our MDHHS document, that may be used instead and will be available on the COVID-19 Storage & Handling webpage.

iv. When a COVID vaccine becomes available, MDHHS will utilize storage unit capability information obtained in the provider agreements to dictate which providers are capable of receiving and appropriately storing the vaccine (if ultra-cold, if 1,000 dose minimum, etc.). To do so, we will extract the provider agreement/profile data into an Excel file that generates after completion, allowing us to filter by unit type, number of doses able to store, etc.

v. Ultracold temperature information will be detailed during S&H training and on the website to ensure providers are aware of replenishment expectations as needed. MDHHS will ensure ultracold shipments are only delivered to sites that can appropriately store and handle such vaccine. Discussions are ongoing about preparation for dry ice procurement and supply. We will work with the Emergency Preparedness team on this to ensure providers have access to dry ice for replenishment as needed. We are also anticipating additional details on how to monitor these coolers – i.e. do we need ultra-cold digital data loggers, do the coolers have an embedded temp indicator, etc. We also discussed the need to instruct on proper handling of dry ice for provider safety.

vi. The storage unit information obtained at enrollment will be reviewed for appropriateness by the LHD; If appropriate units are not identified in the provider agreement/profile form section B, that location will not be approved for enrollment until rectified. Photos of storage units must also be submitted for approval during the enrollment process. Digital data logger information will be required as well, as continuous monitoring will be necessary. Michigan plans to add a field to the current COVID-19 Provider Agreement/Profile form to capture digital data logger information as part of the enrollment process.

- *Satellite, temporary, or off-site settings*



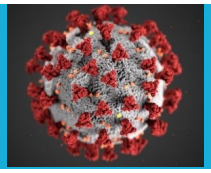
i. Michigan will include materials specific to vaccinating at satellite, temporary or off-site settings. We have already been referring providers to the CDC website dedicated to this, but when COVID vaccine arrives, we will be sure this link is included with training resources (https://www.cdc.gov/vaccines/hcp/admin/mass-clinic-activities/index.html). The information we include in training will reiterate CDC playbook guidance: COVID-19 vaccines may be transported—not shipped—to a satellite, temporary, or off-site COVID-19 vaccination clinic setting **using vaccine transportation procedures outlined in the upcoming COVID-19 addendum to CDC's Vaccine Storage and Handling Toolkit.** Once this addendum to the S&H toolkit is available, it will be linked on our COVID provider website and required to review for any provider intending to vaccinate using these methods. The Local Health Department will assist in oversight.

ii. Cold chain must be maintained at all times for satellite, off-site, and temporary vaccination clinics. LHDs will assist in reiterating this guidance at the provider level. We will review our current transport guidance document to support providers: MDHHS Vaccine Transport Temperature Logs and MDHHS Guidance on Vaccine Transport. These are expected to be posted on the S&H website for provider support. They detail appropriate methods to maintain vaccine viability and provide tools for documentation during any transport; however, they may be updated with COVID vaccine-specific information identified in the S&H addendum as needed.

- *Planned redistribution from depots to individual locations and from larger to smaller locations*

  i. As part of the enrollment process, any providers interested in redistribution MUST have signed redistribution agreements in place in accordance with the playbook. Redistribution should be limited to refrigerated vaccine and must comply with appropriate storage and handling, ensuring the cold chain is maintained at all times during transport and during receipt at the receiving location. Providers must report to their Local Health Department before redistributing vaccine to ensure appropriate measures will be taken for transport. The state field staff can also assist in redistributing vaccine when needed. The state has procured several qualified vaccine transport containers for refrigerated vaccine, as well as digital data logger temperature monitoring devices to support adequate refrigerated transport as needed.

  ii. Inventory adjustments in the IIS MCIR must also reflect any redistribution of vaccine to ensure inventory is updated at all times. We have existing guidance on documenting public vaccine inventory movement, which can support providers in documentation; Additionally, we have IIS regional support staff and LHD staff that can assist providers who need support in inventory adjustments.



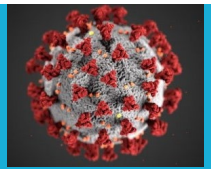
The adjustments must reflect the deduction on the primary provider's IIS site as well as the addition of doses to the receiving provider's IIS site.

iii. Keep in mind ancillary kits when redistributing doses, ensuring the receiving provider receives all necessary components for vaccination.

- *Unplanned repositioning among provider locations*
  i. As expected with redistribution and satellite/off-site/temporary clinics, any movement of vaccine must ensure the cold chain is maintained at all times. If unplanned repositioning must occur among provider locations, they must inform the Local Health Department. This will assist in ensuring the reposition is appropriate and that cold chain measures are in place to transfer doses. The IIS inventory must also have adjustments made to reflect any repositioning.

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

1. As discussed above, vaccine storage and temperature monitoring capabilities will be assessed during review enrollment. LHDs will review storage and monitoring equipment for approval prior to any vaccine shipments being entered for the provider. If unit capabilities are inadequate, the LHD will follow-up with the provider to inform them of requirements for appropriate storage. The storage capabilities will also be used to ensure shipments are directed to providers that can appropriately store and monitor the type of vaccine being ordered for their site. As mentioned above, discussions are ongoing about whether we will request temperature submissions from the provider on a routine basis. Redistribution can only occur in circumstances where the cold chain can be maintained using appropriate transport methods and temperatures monitored throughout. These expectations will be included on the S&H provider website and communicated during the enrollment process. State-procured digital data loggers and transport coolers may be utilized to assist efforts for transferring vaccine if needed.



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 Michigan Care Improvement Registry (MCIR) which is the statewide IIS will be used to collect all COVID vaccine doses administered. MCIR will also be used to facilitate vaccine ordering and accountability. MCIR has a longstanding history of assisting with the management of data related to Immunizations. An Outbreak Module is currently in the final testing phase to implement to manage the COVID vaccination program. Lessons learned from the H1N1 'All Hazards Module' have been used to improve and create an Outbreak Module that will be more robust and have the ability to manage multiple outbreaks at one time should the need arise. Methods data will be entered into the IIS via:

i. HL7 VXU
ii. Direct Data Entry into MCIR web application
iii. Emergency plan - **Vaccine Administration Form** in both
   a. E-form for submittal to email inbox/spreadsheet upload to MCIR, and
   b. paper/fax submittal for Direct Data Entry into MCIR

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

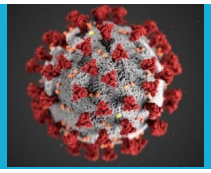
Michigan is on track to be connected to the IZ Gateway in October 2020. Technical Specifications for Provider Enrollment CDC reporting has not yet been reviewed. Because this specification would involve two additional HIE business partners (MDHHS Data Hub and the MiHIN), it is not anticipated that this implementation will be in time to meet COVID Provider Enrollment reporting requirements.

It is anticipated that Michigan will compile the provider data and submit via alternative upload specifications to the SAMS system.

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.*

See section 5 for Provider Training plans, here below in summary:

Most providers are already enrolled in MCIR and have a good working knowledge of MCIR since it is widely utilized. Additional training may be needed for any new providers or training in



areas such as vaccine management for providers who had not previously taken advantage of that functionality. The following activities will support providers:

- Posted or linked on MCIR website(s) - Tip Sheets, PowerPoints, and Video training materials.
- Conduct Statewide webinars on various subjects.
- Tracking Provider milestones will be identified and recorded by appropriate MCIR staff. Tracking will be monitored by Division of Immunization leadership.
- Regional MCIR staff will touch base with providers per training needs/readiness during the Provider COVID Registration process.
- Training will include ensuring providers understanding of how to report vaccinations should systems fail or are temporarily unavailable.

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.*

During H1N1, Michigan, under the Authority of the State Health Officer, required all data to be added to the MCIR regardless of age. Michigan law requires all providers to report all doses administered to children under the age of 20 to the MCIR within 72 hours after administration. Doses administered to adults is strongly encouraged to be submitted to the MCIR. A policy will be needed in Michigan which would require all COVID-19 doses to be added to the MCIR within 24 hours of administration regardless of age.

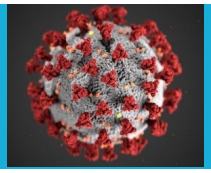
Real-Time documentation from satellite, temporary, or off-site clinic settings will require the provider to resolve with their organization and/or EHR vendor how they will collect information in their EHR system for HL7 VXU submission to the IIS from that site.

Should they not plan on using their own EHR system for documenting the administration and reporting via HL7 VXU, providers will need to work with their organization to procure laptops/hotspots to have on site for doing Direct Data Entry (DDE) into the IIS web application.

Should EHR HL7 VXU or DDE not be possible, a COVID Vaccine Administration Form will be provided for collecting the information. Any process involving a paper or E-form will likely have barriers to being recorded in the IIS in 24 hours.

> Example: In certain rural areas of the state, DDE may be delayed until the staff return to home base for input into the IIS web application.

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.*



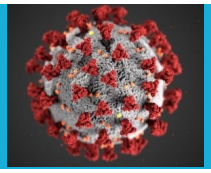
Fully documented in Michigan means either:

1. **Provider is submitting administration via HL7 VXU** (having been onboarded and completed the pre-required data quality review), or
2. **Direct Data Entry on the MCIR web application** (that enforces minimum data requirements), or
3. **COVID-19 Vaccine Administration Form** is completed for DDE into the IIS web application.
    a. From past H1N1 experience, a paper form is least desired for vaccination submission due to reliance on the providers to complete the form correctly before entering the information into the IIS. Follow-up to collect missing information was often unsuccessful.
    b. An E-form, while not having been used before, may assist as field completion "stops" can be put in place. However, completion of the fields does not mean that the data provided is accurate or correct.

COVID-19 Vaccine Administration Monitoring reports will be created and provided to Division of Immunization Leadership regularly.
Monitoring reports will include: Provider Name; Facility Type/Site: Calculation based on Date of Receipt, Date of Administration and date of report to public health.

Provider Sites consistently reporting vaccine administrations over 24 hours late will be contacted to determine reason and to assist when possible with a solution.

F. *Describe how your jurisdiction will generate and use COVID-19 vaccination coverage reports.*
MCIR epidemiologists will use data reported to the MCIR to develop and update a COVID-19 vaccine dashboard, and monthly impact reports. The data reports will be posted online and shared with appropriate stakeholders.



Section 10: COVID-19 Vaccination Second-Dose Reminders

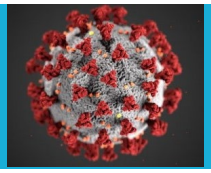
Instructions:

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.*

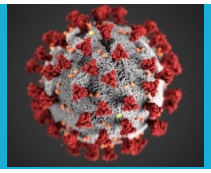
a. **Provider Level Postcard Reminders:** MDHHS plans to use postcard reminders at the provider level to remind patients of their second dose of COVID-19 vaccine. Postcards will be designed and printed by MDHHS and then sent to COVID-19 immunizing provider offices for their internal use. Due to patient confidentiality and protected health information (PHI), these postcards will be very generic about COVID vaccines indicating that they are available, that the series is in two doses and for best protection and effectiveness patient should receive the entire series within recommended timeframe. After the patient receives the first dose of the COVID-19 vaccine, the provider will be responsible for mailing the postcard to the patient to remind them to return to the office for their second dose.

b. **Provider Level Immunization Record Cards:** Immunization record cards will be provided to all COVID-19 immunizing providers in their COVID-19 Vaccine Kits. In order to administer the COVID-19 vaccine, the provider must sign an agreement prior to receiving their COVID-19 vaccine kits. This agreement highlights that the provider must provide the patient with an Immunization Record Card after the vaccine is administered. This record card will identify when the patient should return for their 2nd dose of the COVID-19 vaccine; specifically, it must include the date when the 2nd dose is due, as well as the product that should be used. This Immunization Record Card will be given to the patient, after the vaccine is administered and before the patient leaves the provider office.

c. **Centralized Text Messaging Reminders from the IIS:** MDHHS is currently working with IIS developers and MDHHS legal partners to develop a way to use centralized text messaging reminders from the state's IIS, the Michigan Care Improvement Registry (MCIR), to remind patients of their 2nd dose of COVID-19 vaccine. Specifically, discussions are being held regarding the onboarding of MCIR to Amazon Pinpoint, an interface that is already being used by the department to send text messages to Michigan residents. An algorithm will be programmed into MCIR to generate reminder text messages within 21-28 days of the 1st dose of COVID-19 vaccine, the specific date will depend on the vaccine product. Until the 2nd dose is recorded in MCIR, a follow up reminder text will be sent approximately every 30 days (the exact timing of reminder messages TBD). Policies are currently being established to identify how MCIR should treat patients should they not return for their 2nd dose (i.e. after how many months/what timeframe should the patient no longer receive text message reminders after no 2nd dose is reported in the MCIR). Further, capabilities will be built into MCIR so that the provider can see that a text message was sent to the patient to keep the provider informed of the reminders.



Enhancements to MCIR will include the ability to generate a reminder based on when the 2nd dose of COVID-19 vaccine is due, not based on an "anniversary date" which is how all other vaccine reminders are currently generated in MCIR.



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.*

Michigan will require the provider to resolve with their organization and/or EHR vendor how they will collect information in their EHR system for HL7 VXU submission to the IIS from that site. This includes working with their organization on the procurement of computer devices and supporting equipment (laptops/hotspots, 2D scanners) needed on site. The Immunization program expects that all providers using an electronic health record system will use that system to document COVID vaccine administered and submit that data from the EHR to the MCIR using an electronic data transfer. Over 80% of the data that currently comes to the IIS is submitted using HL7 messaging directly from an EHR.

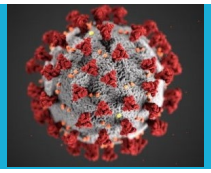
Should they not plan on using their own EHR system for documenting the administration and reporting via HL7 VXU, providers will need to work with their organization on the procurement of computer devices and supporting equipment (laptops/hotspots, 2D scanners) needed on site for doing Direct Data Entry (DDE) into the IIS web application.

Should EHR or DDE not be possible at the clinic site, COVID-19 Vaccine Administration Forms will be provided for collecting the information. Providers will need the capability to enter the information into their EHRs (for HL7 VXU reporting) or via DDE onto the IIS web application. Note: Any process involving a paper or E-form will likely have barriers to being recorded in the IIS in 24 hours.

Example: In certain rural areas of the state, DDE may be delayed until the staff return to home base for input into the EHR or 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.*

Michigan will be able to capture all the Required Standard data elements but does not require the reporting of Vaccine administration site or the Vaccine route of administration. These fields are allowed and stored in the MCIR but there is no current requirement for providers to submit those two fields to the MCIR.



For Optional Data Elements,

1. Recipient race is possible to collect from HL7 VXU messages and system load changes are planned to capture this information. Currently MCIR receives race information when births are loaded to the system received from Vital Records. We currently have race data on individuals born after 2005. MDHHS is working now to change the system to allow for the addition of race and ethnicity data for incoming records.
2. Serology results (Presence of Positive Antibody Result, Y/N) – it is possible to receive this information from the Michigan Disease Surveillance System for positive COVID-19 tests. Transmission and system changes needed to accomplish has not been planned but can be should ACIP vaccination recommendations require this information to be incorporated into a COVID-19 vaccination forecast.

Michigan's IIS is not a HIPAA covered entity and has been careful to not include clinical information into the registry to retain this status. Therefore, the IIS does not collect or store chronic medical condition information, occupation, or membership in other critical population groups. Additionally, the IIS does not have access to chronic medical condition information that is population based.

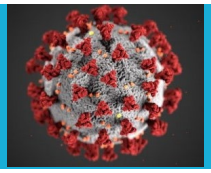
Note: Pharmacies have the capability to contact their patients that will be identified based on condition as needing to receive the COVID-19 vaccine early. Additionally, Emergency Preparedness at the state and Local Health Department level have the contacts needed to reach critical occupational or local population groups.

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.*

MCIR has completed updates to the current version of the server Operating System, has implemented changes to improve the ability to load balance, and can easily expand storage as needed. MCIR is currently well positioned to handle increases in both user traffic and the addition of new vaccine series requirements.

The Immunization Program is currently conducting the final testing of an Outbreak Module which will be used to manage the COVID=19 vaccine. These improvements will allow for the ordering and inventory management related to the COVID-19vaccine including the needed interfaces to the CDC Data Lake. Currently Michigan is determining if improvements can be made to Reminder functionality through the addition of Text Messaging service.

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.*



a. Added hours for HL7 onboarding technical assistance for October through December has been executed contractually.

b. Priorities with regard to MCIR Regional staff contractual work requirements will be adjusted as needed to accommodate prioritization of HL7 onboarding.

c. HL7 VXU Barriers in this onboarding process are usually experienced from the Provider, not from the IIS staff.

    a. Ex: Lack of provider completion of the HL7 Roles and Responsibilities document is barrier to swift onboarding.
    b. Ex: Completion of the MCIR User Agreement can be an issue with Pharmacies, not usually with Providers.

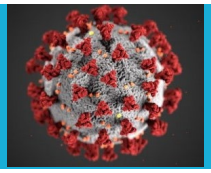
d. Providers need to connect to a Health Information Exchange service in order to submit HL7 VXU and QBP messages to the IIS. HIE's need to submit the message through the Michigan Health Information Network (MiHIN). The Provider and the IIS need to coordinate onboarding activity through the designated HIE and MiHIN. This can produce delays in onboarding due to scheduling of testing and Go Live connectivity.

    The IIS staff? will discuss Continuity of Operations with MiHIN as well as prioritization of onboarding activities for the months of COVID Provider Registration and COVID vaccination period.

e. MCIR VXU and QBP onboarding staffs are examining internal business processes to determine if streamlining can be achieved for the elements within our control.

E. *Describe your jurisdiction's current status and plans to onboard to the IZ Gateway **Connect** and **Share** components.*
Michigan IIS is on track to **Connect** to the IZ Gateway in October 2020.
Michigan IIS is planning on participating in **Share**. IZ Gateway HL7 VXU Implementation Guide received and is being reviewed by the IZ Gateway project team and HIT HIE business partners.

F. *Describe the status of establishing:*
    1. *Data use agreement with the Association of Public Health Laboratories to participate in the IZ Gateway*
    Not needed for **Connect**. Michigan is planning on participating in **Share** and has completed review and edit of the APHL DUA. It was sent to APHL on October 4, 2020.
    2. *Data use agreement with CDC for national coverage analyses*
    Signed in 2019

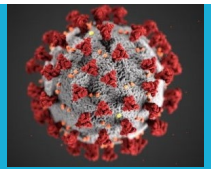


3. *Memorandum of Understanding to share data with other jurisdictions via the IZ Gateway Share component.*
   Signed and in effect.

G. *Describe planned backup solutions for offline use if internet connectivity is lost or not possible.*
Per CDC, data upload alternative will be used for regular reporting.
Should IIS-to-IIS SHARE be in production at the time of COVID vaccinations, a back up plan will be discussed as part of implementation with the impacted states.

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.*

1. Support state mandate to report all COVID vaccinations (if order given).
2. Prioritize the COVID code changes needed in IIS for deployment ASAP
3. Prioritize the COVID Forecast function changes needed in IISASAP.
4. Continue pre-DQA of initial VXU message content acceptability before activating Provider for VXU submission.
5. Monitor for rejected VXU messages per COVID codes and other elements that can/should be fixed by the Provider vendors.
6. Monitor for timeliness of submission by Provider Site with appropriate follow-up activity to support.
7. Continue with regular deduplication activity (nightly internal IIS algorithms, and work with the departments Master Person Index).



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.*

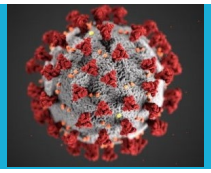
Michigan is developing COVID-19 vaccination communication that will provide guidance for all three phases of the COVID-19 Vaccination Program. The communication plan will identify key audiences, communication channels, and partners during all three phases.

The Michigan Department of Health and Human Services (MDHHS) has a communication division who will help guide any messages to ensure that all communication is developed with consideration for health equity, using culturally responsive language that is bias-free. The communication division will play a role in all phases of the communication plan and will work with our media partners.

MDHHS also will work closely with the Community Health Emergency Coordination Center (CHECC) to coordinate consistent COVID-19 communication messages throughout the State. The CHECC along with our State Emergency Operation Center (SEOC) ensures that information is shared broadly throughout the State through a variety of conference calls, emails, and blast messages. The CHECC helps ensure that during times of an emergency that all partners within the State receive accurate and timely information, and messages. Currently, the Division of Immunization at MDHHS has two managers and one nurse educator working directly with the CHECC on COVID-19 vaccine updates. They attend key department and State calls to report on the COVID-19 vaccination program.

Communication will reflect vaccine arrival and allocations. If there is limited supply, allocations will be prioritized to critical populations identified in section 4. The planning assumptions for phase one target priority groups of healthcare personnel, Long Term Care (LTC) staff and residents, critical essential workers (EMS, first responders), individuals 65 years of age and older, along with individuals who have underlying medical conditions. Depending on which vaccine is available and the allocation amount received will determine who will receive vaccine first, and who the targeted communication will focus on first. As more vaccine allocation arrives and we move into phase two and three our communication audience, channels, and partners will adjust.

MDHHS, to ensure timely messaging, will have a small internal team to finalize communication messages. This team will be a sub-group of an already established communication workgroup and strategy team within the Division of Immunization. The Division of Immunization Communication Workgroup is a team of educators, program leads, nurse educators, and



managers that work to create posters, educational pieces, social media messages, and articles regarding immunizations. The Immunization Communication Workgroup will be reviewing the educational needs for COVID-19 vaccine and working closely with nurse educators to develop appropriate COVID-19 vaccine materials, along with clinical provider materials and webinars if needed. CDC materials will be reviewed as it is released. From this Immunization Communication Workgroup, a smaller team will be formed that will include managers, educators, a lead from the CHECC, a lead from the MDHHS communication department and a lead from the MDHHS ADA compliance team. Communication messages will flow through this internal team to increase the pace that messaging can go out. This internal communication team will work with the I Vaccinate campaign on messaging as well as our media partner Brogan. Currently, these 2 partners work closely on immunization messages with the State and will be a continued partner to ensure broad communication about the COVID-19 Vaccination program. MDHHS will work with a variety of partners to help promote the importance of COVID-19 vaccination and build confidence in the COVID-19 vaccination program.

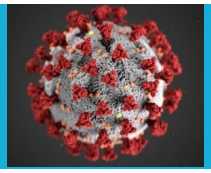
Currently MDHHS has a webpage (Michigan.gov/COVIDVaccine) dedicated to Vaccines During COVID-19. This website houses materials to help stress the importance of staying up-to-date with immunizations during the pandemic. As COVID-19 vaccine information is released from CDC or created by MDHHS it will be shared on this webpage to make it easy for the end user to find important COVID-19 education and messages. The Immunization program will create a dashboard on this website that will contain many metrics related to vaccine uptake and vaccine distribution. The metrics the Division will post on this website are as follows:

- Number of Providers, by practice type, that are enrolled in the COVID vaccination program
- Number of doses of COVID vaccine distributed in Michigan
- Percent of the population vaccinated by age group
- Number of doses of COVID vaccine administered, by age group
- Number of individuals who have received their second dose of COVID vaccine

i. Phase one

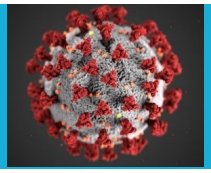
During phase one, once vaccine allocation is determined, COVID-19 vaccine messaging will emphasize key audiences. The audience that will be focused on first for messaging will be critical health care workers (HCW), critical essential workers (first responders), and LTC. To ensure messages reach these priority groups, MDHHS will communicate via email and partner calls with health systems, local health departments (LHD)s, and key partners. We will focus on communicating about COVID vaccine development, distribution of vaccines to health systems, and COVID-19 vaccine clinics. Health Systems will determine key critical health care workers and push out targeted communication.

- During phase one, communication channels will be limited to emails, text messages, and flyers due to the targeted audience.
    - Through the help of the CHECC, a website, a hotline, email, and a Chatbot (Chat with Robin) will be utilized to answer questions and concerns from



HCWs, vaccination providers, and the public. Using these methods, MDHHS will be able to monitor and track communication, which will help monitor reception of COVID-19 vaccine and gear education and messaging towards current concerns.

- Through the MDHHS internal communication team, outreach will begin with our MDHHS partners at LARA (Licensing and Regulatory Affairs). LARA can communicate in a timely manner broad messages regarding COVID-19 vaccine clinics, safety, and resources to licensed HCWs in Michigan. A general message will be sent to prepare HCWs (critical HCWs) about COVID-19 arrival via LARA's listserv and outreach methods.
    - Michigan Health and Hospital Association (MHA): to get messages out to all health systems within the State.
    - Michigan State Medical Society (MSMS): to get messages out to the internists and family practitioners.
    - Medical unions and affiliate agencies that represent groups at large such as the Michigan Nursing Association (MNA).
    - Michigan Association for Local Public Health (MALPH): a partner with MDHHS that will help to support communication messaging to the LHDs.
    - Michigan Advisory Committee on Immunization (MACI): an advisory board for the MDHHS Division of Immunization comprised of public and private sector organizations. This group will be utilized to help promote and further COVID vaccine communication to build confidence in the COVID-19 vaccination program in both sectors of the State.
    - Health Care Coalitions (HCC) via the CHECC: will promote vaccination to our first responders. Currently, the HCC has a weekly call with the emergency operations centers (EOC) in each region. During that call COVID-19 vaccine promotion, distribution, clinics, safety, and efficacy will be discussed to further promote vaccination.
    - Aging & Adult Services Agency: To reach out to our LTC and high risk 65 plus population.
    - Michigan Pharmacy Association (MPA): communication will begin with the pharmacy association as they will be partners in administering COVID-19 vaccine. Pharmacists have ways to communicate broadly with their consumers and can send out messages at large when vaccine allocation allows.
    - MDHHS will work with other State departments such as the Disability Health Program Coordination for the State of Michigan. Messages, flyers, and posters will be reviewed for ADA compliance, culturally responsive language, and bias-free language.
    - To further our partnerships, we will work with our Parent Information Network (PIN) group to help build on professional organization partnerships to facilitate COVID-19 vaccine outreach.

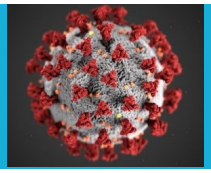


- Again, COVID-19 vaccine allocation will determine critical health care worker/health system distribution. If vaccine received allows, communication will go out to ensure further HCWs, first responders and high-risk LTC residents, including VA, receive vaccine.
    - Our messaging will further branch out to include a broader health care system response.

ii. Phase 2

During phase two, as vaccine allocation increases, we will broaden our phase one priority groups and continue emphasis on additional HCWs and the high-risk population, including those 65 years and older, and those living in LTC/adult homes. The audience that will be focused on for messaging will be all HCWs, health systems, family practice providers, along with internist and geriatric providers. The local health departments will also be part of the audience for vaccine allocations, LTC facilities, adult homes, and office of aging. We will focus on communicating about COVID vaccine development, distribution of vaccines, COVID-19 vaccine clinics, and vaccine safety.

- During phase two, we will open more communication channels. There will be continued use of emails, text messages, flyers, and will open further to begin use of TV ads, radio spots, bulletin boards, and social media.
- MDHHS will continue to build on partnerships from phase one and create new ones:
    - Health plans: will work with health plans to do reminders for their subscribers, this may be done through email or text messages.
    - Will outreach to faith-based groups to educate, promote, and facilitate questions regarding COVID-19 vaccination. Outreach will include work with religious leaders (catholic dioceses, Amish, etc.).
    - To reach the high-risk population, including those 65 years and older in a timely manner and broadly, MDHHS will reach out to partners within phase one such as the Office for Aging and physician professional agencies.
    - Tribal: Reach out to MDHHS tribal partners to ensure appropriate messaging is meeting this target group.
    - Michigan Pharmacy Association (MPA): pharmacist communicate via broad messages. Partner with MPA to get broad COVID-19 vaccine messages out through the pharmacy reminder systems.
    - The CHECC: through the help of the CHECC, a website, a hotline, email, and a Chatbot (Chat with Robin) will be utilized to answer questions and concerns from the public.
    - I Vaccinate: MDHHS will work with the I Vaccinate campaign, a parent run vaccination information group that manages a website and does outreach to help promote vaccine confidence through families.
    - AIM: MDHHS will work with the Alliance on Immunization in Michigan (AIM), a coalition promoting vaccines. We will work with AIM to provide education for



providers through their provider education site and work to build vaccine confidence through their public information site.
- PIN: To further our partnerships, we will continue our work with our Parent Information Network (PIN) group to help build on professional organization partnerships to facilitate COVID-19 vaccine outreach.
- MDHHS will work with other State departments such as the ADA Coordinator of State of Michigan.
- Will build on all partnerships from phase one so we can ensure that an effective message is still being shared, especially through professional organizations.

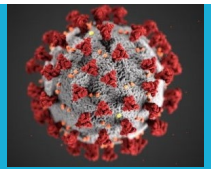
The additional communication channels during phase two can be utilized to promote COVID-19 vaccination and help prepare for a broader message in phase three.

iii. Phase 3

During phase 3 COVID-19 vaccine supply should be plentiful and MDHHS will continue to build off the communication messages from phase one and two. An emphasis will be put on the general population.

The audience will be the general population, all Michiganders. The messaging will be focused on everyone, all providers, all health systems, places of employment, and schools. The local health departments will partner to help with COVID-19 vaccination, questions, and vaccine management. We will focus on communicating about COVID vaccine availability, safety, and efficacy.

- During phase three, communication channels used will be the continued use of emails, text messages, flyers, TV ads, radio spots, billboards, and social media and will be utilized to promote COVID-19 vaccination and to build vaccine confidence.
- MDHHS will continue to build on all partnerships from phase one and two, and create new ones:
  - Health plans: will work with health plans to bring about messaging through mailings, email, and text messages.
  - Department of Education: Will put an emphasis on the young adult students as well as build a foundation for education regarding COVID vaccination for the elementary and secondary school-aged children.
  - Colleges and Universities: MDHHS will work with colleges and universities in Michigan to promote and encourage vaccination among young adults in higher risk settings, such as dormitories and community housing. MDHHS will work with on-campus health clinics to provide vaccine as well as communication partners on each campus to provide vaccine information.
  - Outreach to the faith-based groups to educate, promote, and facilitate questions regarding COVID-19 vaccination. Outreach will include work with religious leaders (catholic dioceses, Amish, etc.).



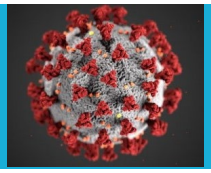
- Tribal: Reach out to MDHHS tribal partners to ensure appropriate messaging is meeting this target group.
- I Vaccinate: MDHHS will work with the I Vaccinate campaign, a parent run vaccination information website, to help promote vaccine confidence through families.
- AIM: MDHHS will work with the Alliance on Immunization in Michigan (AIM), a coalition promoting vaccines. We will work with AIM to provide education for providers through their provider education site and work to build vaccine confidence through their public information site.
- PIN: To further our partnerships, we will continue our work with our Parent Information Network (PIN) group to help build on professional organization partnerships to facilitate COVID-19 vaccine outreach.
- MDHHS will work with other State departments such as the ADA Coordinator for the State of Michigan.
- Migrants, homeless, etc?

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.*

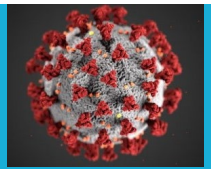
Crisis and emergency risk communication (CERC) messaging will need to be established before, during, and after COVID 19 vaccine is available. During all three phases, risk communication will be established. Communication will help communities understand the importance of vaccination as well as the benefits and risk. MDHHS will utilize the CHECC to develop the COVID-19 website, hotline, and CHATBOT. Communication will be handled by an internal communication team with a clinical focus. This team will create information that will be shared to help with answering public questions in a timely manner. Information shared will stress the importance of vaccination, risk of disease, and benefit of vaccination, by resources such as the CDC VIS and any additional CDC guidance documents. All information shared on the hotline, website, and CHATBOT will be monitored for updates and feedback to help promote continued education on COVID-19 vaccination program concerns to ensure that vaccine confidence is built.

Communication will be sent via partner listservs, radio spots, social media (Twitter, Facebook, etc.), TV spots, and billboards. We will partner with the CHECC, MDHHS Communication Division, I Vaccinate, and PIN, to ensure communication is regular, culturally sensitive, and bias free. Working with these partners will keep dialogue going with media and other partners and help maintain trust and credibility of the COVID-19 vaccination program.

MDHHS Division of Immunizations also has access to the Michigan Health Alert Network (MIHAN). If a high alert communication message needs to get out fast to public health, healthcare and public



safety personnel, the internal communication team along with the CHECC can utilize the MIHAN to get this time sensitive, high alert communication out.



Section 13: Regulatory Considerations for COVID-19 Vaccination

Instructions:

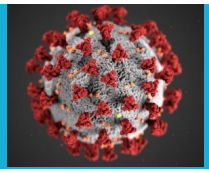
A. *Describe how your jurisdiction will ensure enrolled COVID-19 vaccination providers are aware of, know where to locate, and understand the information in any Emergency Use Authorization (EUA) fact sheets for providers and vaccine recipients or vaccine information statements (VISs), as applicable.*

The COVID Provider Enrollment form discusses the need to use either the VIS or the EUA fact sheet depending on the situation. Providers are required to read that document and agree to the terms of the document to participate in the COVID Vaccination Program. The Michigan Immunization Program posts all Vaccine Information Statements on our website available for download. The division will post the relevant COVID VIS or EUA fact sheet on our website. The Division will also educate on the use of the VIS or EUA fact sheet at the time they are enrolled in the program at the local level during the overall education done by the local health departments. As the Nurse Educators develop the education materials related to the COVID-19 vaccination program, information will be included to discuss the need to provide the appropriate VIS or EUA fact sheets.

Clarification is needed from the CDC on what languages will be available from CDC of the VIS or EUA statements.

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.*

As stated above, all enrolled providers in the COVID-19 vaccination program will need to sign the COVID-19 vaccine enrollment form and agree to provide the appropriate VIS or EUA fact sheet. Materials will be developed and distributed to providers who have enrolled in the COVID program to educate them on the use of these forms. The division nurse educators will put educational materials in their presentations to discuss the use of the forms and the distribution of the forms to all individuals being vaccinated.



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).*

Surveillance for adverse events related to COVID-19 vaccination will be conducted through reports to the national VAERS. MDHHS will provide information about the adverse event report submission process to all health care providers who enroll in the COVID-19 vaccination program as part of the enrollment literature. A state website devoted to COVID-19 disease and COVID-19 vaccination will prominently feature information about vaccine adverse event reporting. Education about adverse events and procedures for adverse events reporting will be discussed during partner calls and our immunization nurse education sessions related to COVID-19 vaccination.

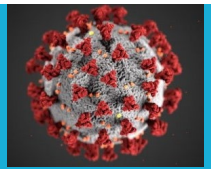
Providers will be informed that, as per the federal COVID-19 vaccination program, COVID-19 vaccination providers are required to report any adverse events they, or a vaccine recipient, subjectively deem "clinically significant" following a dose of COVID-19 vaccine.

The report submission process will be through the online reporting function on the VAERS website. MDHHS and LHD personnel will be available to assist in the report submission process if requested or needed.

In addition, because it is recognized that adverse event-related health care visits may be made to health care providers who are not specifically enrolled as COVID-19 vaccine providers, MDHHS will broadly disseminate instructions on adverse event reporting to all health care provider entities, including hospital and health care systems, emergency departments, urgent care centers, telehealth entities, and through medical professional organizations. Methods for disseminating this information will include mailings and messaging to professional organizations as well as Health Alert Network messaging in the Michigan HAN system.

A direct link to the VAERS online report form is accessible on the Michigan Care Improvement Registry (MCIR), the state's immunization information system. VAERS reporting related to COVID-19 vaccine, as well as for all other vaccines, will be promoted on the MCIR system.

MDHHS will periodically re-iterate the requirement for adverse event reporting and the process to providers throughout the course of the COVID-19 vaccination program. Concise

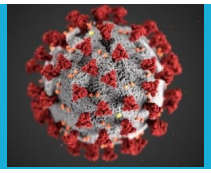


information about the VAERS reporting process will be included in other MDHHS communications that concern the use of and instructions for COVID-19 vaccine(s).

Vaccine recipients will also be provided information at the time of vaccination about the importance of and the process for completing and submitting an adverse event report. We anticipate one critical medium for providing this patient information would be a Vaccine Information Statement (VIS) or a equivalent patient information fact sheet, if for example the vaccine is made available and distributed under an Emergency Use Authorization. Emphasis will be placed on attempting whenever possible to complete a report in conjunction with the vaccinating provider to ensure essential information (which includes date and time of COVID-19 vaccination, date and time of adverse event onset, age at vaccination, vaccine type and brand name, manufacturer, lot number, route of administration, the dose number in series if applicable, a description of the event, treatment, and outcome, and result or outcome of the adverse event).

The Michigan Immunization program is also hopeful there will be information about the reporting of any adverse events on the immunization record card that will be provided at the time of administration. This immunization card was developed by the CDC and will be distributed and accompany all vaccine shipments. Since Michigan has not yet seen this immunization record card, we are assuming there will be information about adverse event reporting including a link to the VAERS website.

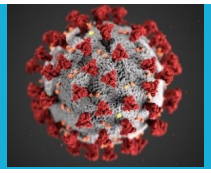
Michigan's Vaccine Safety Coordinator (VSC) will participate in receiving jurisdiction-specific COVID-19 vaccine summary VAERS report data sent from CDC, for informational purposes. If requested by CDC/FDA, the Michigan VSC will assist in follow-up of a VAERS report involving COVID-19 vaccine.



Section 15: COVID-19 Vaccination Program Monitoring

Instructions:

- *Describe your jurisdiction's methods and procedures for monitoring progress in COVID-19 Vaccination Program implementation, including:*
  - *Provider enrollment*
    i. Michigan plans to use a fillable electronic form for providers to complete. The completed form will be sent to a designated email address where it will be retrieved and auto-loaded to a spreadsheet/Access database. Required reporting elements will be retrieved from this tracking spreadsheet/database. Work is being done to create an enrollment form in Red Cap that will be used for enrollment. This data will be uploaded to the SAMS portal every Monday and Thursday using the outlined CSV file format.
    ii. It is anticipated that Michigan submit via alternative upload specifications should it be necessary.
  - *Access to COVID-19 vaccination services by population in all phases of implementation*
    i. We will monitor vaccination uptake and ordering using data reported to the MCIR at the provider-level. We will aggregate the data by providers that see target populations in the given implementation phase. These data will be placed on the COVID dashboard that is being developed.
  - *IIS or other designated system performance*
    i. IIS vendor support will monitor IIS system performance using RELIC.
    ii. IIS availability is checked by Support Services staff every weekday morning around 7 a.m.
    iii. IIS HL7 transmission reports are produced monthly to review for post transmission HIT HIE partner system disruption issues.
  - *Data reporting to CDC*
    i. Based on CDC guidance and reporting requirements, we will submit daily reports of all doses administered and provider enrollment data twice weekly
  - *Provider-level data reporting (included in response below)*
  - *Vaccine ordering and distribution (included in response below)*
  - *1- and 2-dose COVID-19 vaccination coverage*
    Using data from the state IIS, the Michigan Care Improvement Registry (MCIR), MCIR epidemiologists will consistently monitor the progress of COVID-19 vaccine ordering by providers. In addition, MCIR epidemiologists will query data submitted by vaccine providers to estimate 1- and 2-dose COVID-19 vaccination coverage. COVID-19 vaccine administration and coverage reports will be developed and distributed to Local Health Department partners and external stakeholders.
- *Describe your jurisdiction's methods and procedures for monitoring resources, including:*
  - *Budget*

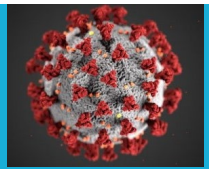


i. The Division Director will work with the contracts manager and the budget liaison to be sure all contracts and budget expenditures are occurring as expected. This will include monitoring all contract related to COVID.

- *Staffing*
  i. Additional staff are being hired within the Division to assist with the surge of work related to COVID. These staff will be working to recruit and enroll additional providers into the COVID program and will monitor vaccine usage across the state. These individuals will also assure that all provider COVID vaccine orders are successfully uploaded and processed.
- *Supplies*
  i. The Division of Immunization will work with BETP and the SEOC on any supply shortfalls that may occur during this vaccination campaign.
  ii. Supplies include but are not limited to: dry ice, gloves, needles, syringes, digital data loggers, transport coolers, face masks, refrigerators, sharps containers, band-aids and freezers.

- *Describe your jurisdiction's methods and procedures for monitoring communication, including:*
  - *Message delivery*
    i. The Immunization Nurse Educators in collaboration with the Communications department will monitor all messages that go out related to the COVID-19 vaccination campaign. Work is currently being done to message on the importance of receiving the COVID-19 vaccine once it is available.
    ii. MDHHS communications will be monitoring messages posted to social media for inappropriate responses or misinformation. Communications has a standard protocol for addressing these situations.
    iii. Immunizations and Communications is working with IVaccinate to post information on COVID-19 vaccinations and will utilize bloggers to support positive messages.
  - *Reception of communication messages and materials among target audiences throughout jurisdiction*
    i. MDHHS Communications works with Brogan and Martin-Waymire, which are advertising and marketing groups to produce and oversee reception of messages and materials of COVID campaign.

- *Describe your jurisdiction's methods and procedures for monitoring local-level situational awareness (i.e., strategies, activities, progress, etc.).*
  - The Division of Immunization will review situational reports submitted by local health departments during the COVID vaccination efforts. The Division will also monitor the number of doses distributed, administered and on hand by each of the local health departments



- The MCIR Epidemiologists can at any given time pull from MCIR the number of COVID-19-doses remaining in inventory that have been distributed but not administered.
- MCIR Regional Coordinators have the ability to pull reports to determine reporting of doses within 24 hours of administration requirement. Follow-up with non-compliant providers will occur.

- *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 Division of Immunization has developed a public-facing influenza vaccine dashboard, that provides users with location of public vaccine providers as well as with data regarding vaccine doses administered and vaccination coverage. This dashboard is posted on Michigan's newly updated influenza website (Michigan.gov/Flu). Using the influenza vaccine dashboard as a template, we will develop another COVID-19 specific dashboard that can provide users with similar metrics and tools. The exact location of this dashboard has yet to be determined.

Appendix

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