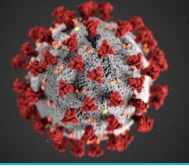


# COVID-19 Vaccination Plan

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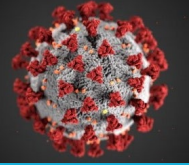
OKLAHOMA STATE  
DEPARTMENT OF HEALTH

Dr Fauzia Khan  
Immunization Service



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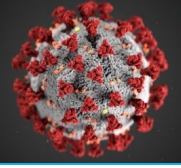
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## Record of Changes

Date of original version: September 25, 2020

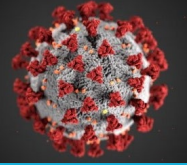
Date Reviewed	Change Number	Date of Change	Description of Change	Name of Author
09/11/2020		9/20/2020	Draft Plan Prior to Playbook, CDC template	Fauzia Khan
9/23/2020	7	9/23/2020	Draft	Gino DeMarco
9/24/2020	1,2,3	9/24/2020	Initial Entry	Mendy Spohn
09/25/2020	5, 6, 9, 10, 11, 13 & 14	09/25/2020	Initial Entry	Fauzia Khan
10/1/2020	7,8	10/1/2020	Revisions to 7; Draft of 8	Gino DeMarco
10/4/2020	3,15	10/4/2020	Revisions	Mendy Spohn
10/9/2020	12	10/10/2020	Initial Entry, Revisions	Fauzia Khan for Communications
10/11/2020	All	10/11/2020	Revisions	Buffy Heater
10/11/2020	All	10/11/20	Revisions	Fauzia Khan
10/12/20	All	10/12/20	Revisions	Buffy Heater
10/12/2020	All		Formatting, appendices, TOC update	Sarah Waters
10/14/20	All	10/14/20	Revisions	Buffy Heater



## Instructions for Jurisdictions

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

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



## Section 1: COVID-9 Vaccination Preparedness Planning

### **Instructions:**

- A.** Describe your early COVID-19 vaccination program planning activities, including lessons learned and improvements made from the 2009 H1N1 vaccination campaign, seasonal influenza campaigns, and other responses to identify gaps in preparedness.

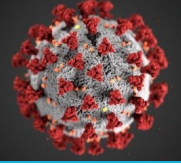
The Oklahoma State Department of Health (OSDH) began initial planning discussions on August 25, 2020 with an internal team representing the immunization division, emergency response and state partner leadership. A weekly meeting schedule was set to keep everyone informed of Operation Warp Speed (OWS) guidance. Meeting cadence increased as the playbook and other detailed guidance became available; eventually, a twice-weekly schedule was established while workgroups connected daily updating plan details and program management functions. The Immunization Service has lead the technical components and provider enrollment process, while other divisions within OSDH use their advanced stakeholder relationships and logistical skills to advance the plan. The Oklahoma National Guard and specialists from other state agencies add their leadership expertise to the entire pandemic response including vaccine planning. This broad leadership representation will be key as we operationalize the plan.

The planning team is comprised of several OSDH divisions, including local health department leadership with community level H1N1 experience. Both rural and urban health departments are represented. Beyond OSDH, other core planning team members represent the follow sectors: Governor's Office and Cabinet, Oklahoma National Guard, Office of Emergency Management, Indian Health Service, Chickasaw Nation, Oklahoma Hospital Association, Oklahoma and Tulsa City-County Health Departments, and other state agencies. A list of statewide vaccine planning stakeholder entities is provided in the appendix.

Each planning member has access to the After Action Report from the H1N1 pandemic response. Those who experienced or have knowledge of the 2009 operations are vocal and have key roles in 2020 COVID-19 Vaccine Plan development. Important lessons learned from H1N1 include the following:

A) Vaccine allotment and distribution to tribes missed the mark in 2009. There are 38 federally recognized tribes and no reservations in Oklahoma. Tribal operations and tribal healthcare are critical to all sectors in Oklahoma, especially Public Health. Therefore, the OSDH tribal liaison, IHS leadership and other tribal leaders are at the table as we make decisions for all Oklahomans. Additionally, plan drafts will be shared with the OSDH Tribal Advisory Board, Southern Plains Tribal Advisory Board, Oklahoma City Area IHS and tribal leaders to gain input and feedback throughout the planning and implementation process;

B) In the initial weeks of the H1N1 vaccine push, very limited portions arrived in Oklahoma and came directly to OSDH for dissemination. During the early days of Phase I, low vaccine supply in expected; therefore, the planning team is using past experience to develop messaging that will help explain the rationale behind difficult decisions concerning first priority populations to receive the vaccine; and



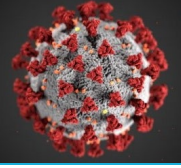
C) The public did not consistently return for the second dose of H1N1 vaccine as expected complicating efficient inventory management systems. Therefore, saving vaccine for the second dose of COVID-19 is not recommended. This is reinforced by the reality that ultra-cold chain storage and handling of some of the COVID-19 vaccine presents many challenges to storing vaccine for a prolonged period of time. Resupply and ordering of COVID-19 vaccine will be complex and must be monitored continuously to ensure appropriate tracking and administration of second doses.

Influenza vaccine campaigns and preparedness activities over the past fifteen years in Oklahoma communities have included mass immunization clinics and other medical counter measures exercises. While the COVID-19 vaccine will initially be in short supply and logistically challenging, if mass vaccination is indicated, throughputs and capabilities are known and practiced throughout Oklahoma Point of Distribution (POD) locations. Example, on September 25, 2020, a small local county health department was able to vaccinate 270 people per hour in a scaled down POD (two lanes, six stations, and 10 vaccinators). The swab testing PODs for this current pandemic response offers additional insight into location capacity and manpower considerations. Limitations for COVID-19 vaccine clinics will include ultra-cold chain monitoring/capabilities and paperless technology/connectivity for patient information and vaccine tracking.

*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.*

During the planning phase, continual reviews of the COVID-19 vaccine plans, the process and the projected operational needs take place twice weekly through in person meetings, shared document sites and virtual interactions. A schedule of facilitated workshop discussions with chief stakeholders was established to familiarize local county health departments, tribes, hospitals, providers, federally qualified health centers and long term care facilities with plan considerations and components. Each workshop allowed the stakeholders to view current planning considerations and offer input/concerns/ideas which offers a profound effect on overall success of this vaccination program's ability to reach critical populations, ultimately maximizing impact. CDC trainings and meetings information was also shared so participants could attend sessions based on their availability and interest.

A workshop exercise was conducted on October 8, 2020 with the following objectives: to ensure state and agency leadership are familiar with operational assumptions and potential controversial decisions they will face, to identify critical areas where risk communication and messaging is of crucial importance to success or failure of this plan, and to indicate where gaps exist in the plan. All Local Health Department (LHD) directors from across Oklahoma were in attendance, including Oklahoma City and Tulsa. Others in attendance were: Cabinet Secretaries, Interim Commissioner of Health and OSDH Senior Leaders, IHS leadership, Hospital Association Director, Communication Specialists and National Guard.



Outcomes of the workshop included:

- Emphasis was giving to LTCF staff being our first focus for priority populations. It was understood vaccine for this population would come from the state allocation. Some discussion occurred about fluidity of priority groups in reference to elimination of waste, uptake rates of vaccine among this population, and final vaccine types, logistical considerations, and indications.
- Communication messages regarding vaccine safety trials and the meaning of Emergency Use Authorization (EUA) will be produced to initiate a public awareness campaign. Once the plan is submitted, the Joint Information Center (JIC) will begin disseminating and educating the public about the COVID-19 Vaccine Program and to begin preparing targeted messages for unique circumstances.
- A survey of specific priority groups and the broader state was discussed to assess attitudes relating to the COVID-19 Vaccine and to gain Intel on development and delivery of messages to encourage vaccination. Example: Tulsa conducted similar research and found respondents trust their private doctors more than public health; and sent a survey to Tulsa health care coalition partners to gauge their interest in taking the vaccine upon its availability.

Before November, a communications tabletop workshop exercise will occur. All public health communications staff and contractors will be present and other public information specialists from stakeholders will be invited. The purpose of the exercise will be to key in on JIC roles and responsibilities, critical message development and consumer considerations.

## Section 2: COVID-19 Organizational Structure and Partner Involvement

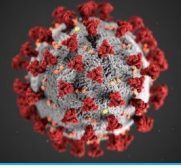
### *Instructions:*

#### *A. Describe your organizational structure.*

In Oklahoma, the Commissioner of Health reports directly to the Governor and his cabinet secretary. The Commissioner is the leader of a centralized public health agency which covers 75 of the 77 counties in Oklahoma. The Commissioner is responsible for ensuring Oklahoma has a plan for receiving and administering COVID-19 vaccine in collaboration with tribal partners, independent/urban public health departments, federal entities and private providers across the state.

While the OSDH Immunization Division will be vital to this vaccine effort, it was recognized early that a larger operations committee will be needed to manage the complex functions necessary for successful storage, monitoring, tracking and administration of COVID-19 vaccine. The following functional areas were identified and leaders were assigned responsibility for the activities under each area:

- 1. Population ID, Count and Tracking** – identifying the various populations into which Oklahomans will be segmented for vaccination purposes, maintaining a count of persons in each population, and tracking vaccination-related information for each population.



2. **Prioritization and Health Policy** – determining the relative priority for each population and the phase in which they will be vaccinated; making ongoing determinations of health policy related to the project.
3. **Supply Chain/Logistics** – physically obtaining and moving vaccines and ancillary items under the prescribed constraints from their source to providers responsible for vaccination.
4. **Provider Enrollment/Relations** – conduct provider outreach; enroll, train and maintain relations with vaccine providers.
5. **Stakeholder Management/Relations** – conduct community outreach; enlist, train and maintain relations with non-provider stakeholders including tribes, community/governmental health organizations and long-term care facilities.
6. **Public Relations/Communication** – determine public communications vision and direction; communicate with the public and media groups; create and maintain public-facing website.
7. **Governor’s Office Liaison** – interact with Governor’s office to provide executive direction to and communication with the project team; handle political considerations.
8. **CDC/Federal Liaison** – interact with CDC (and other federal agencies if required) to ensure compliance and appropriate information flow.
9. **Information Technology** – manage project systems, technical issues and IT-related considerations.
10. **Operations and Briefing** – monitor and control day-to-day project cadence; conduct briefings as necessary; coordinate and expedite tasks as required to maximize success. Future Plans Cell.
11. **Finance and Administration** – monitor and coordinate financial information and decisions; interact with OSDH on budget and administrative requirements.
12. **Legal** - provide guidance for all sections of the plan, but specifically messaging, interagency agreements, and regulatory considerations.

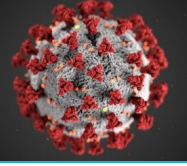
An organizational structure chart is included in the appendix.

- 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 public health leaders in Oklahoma recognize the need for broad sector involvement in planning and execution. A Core Planning Team was established in early September. Members include a local health department director, Oklahoma City and Tulsa health department planners, OSDH leadership, Oklahoma National Guard, communication consultants, IHS leadership, Immunization Division experts, hospital association, and members from the Governor’s Cabinet.

The majority of the Core Team have been critical members of the COVID-19 response in Oklahoma and have established a strong working relationship. Many members have over 20 years’ experience in public health, while others have high level experience in logistics and operationalizing large missions. Members of the larger planning team include redundancy which enables backup in case of illness or other situations preventing members from working.





- 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.*

Prior to the establishment of the core planning team, a large group was established in August, meeting on a weekly basis, to provide a broad group of statewide stakeholders' current information provided by the OWS federal team, planning assumptions, updates to planning activities and situational awareness for their organizations. This larger planning group includes core planning team members, who provide updates, and members from the following organizations or groups: Oklahoma City-County Health Department (OCCHD), Tulsa Health Department (THD), IHS, Office Of Emergency Management, Public Health Emergency Response Planners, Regional Directors for Local Health Districts, Oklahoma Hospital Association, Oklahoma Office of Primary Care, Universities, Private Providers, Department of Mental Health, Tourism Department, Non-Profit organizations, Office of Minority Health, Faith Based Organizations, experts in working disability law and services, health equity coalitions and the Oklahoma National Guard. Additionally, weekly briefings to the Interim Commissioner of Health and members of the OSDH leadership team began occurring in September. The Commissioner of Health reports directly to the Governor as his appointee and in such capacity the Commissioner provides information and updates regarding the state's vaccine planning efforts.

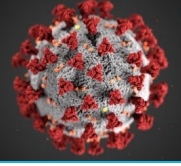
External to OSDH, THD and OCCHD have a broad network of community partners with whom both entities collaborate and communicate with on a regular basis. Those partners consists of agencies across a wide variety of sectors, serving diverse populations including those sociably vulnerable and/or underrepresented groups. Each will continue to work with external partners to ensure information flow in both directions, consult with subject matter experts (SMEs), and receive input from stakeholders. THD plans to host their 2020 stakeholders meeting virtually to disseminate information regarding COVID-19 vaccination planning and allow partners to have the most currently available information and situational awareness.

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

In addition to the two planning groups (large group and core group) described in previous sections, the Oklahoma State Department of Health formed a COVID-19 Vaccine Distribution Advisory Council to provide recommendations and approve a COVID-19 distribution framework for the State of Oklahoma. Members of the Advisory Council were selected for their medical expertise with an emphasis on diversity related to geography, race and ethnicity, and practice setting.

Membership on the COVID-19 Vaccine Distribution Advisory Council includes:

- Douglas Drevets, MD - Infectious Disease, OU Medicine; Oklahoma City, Oklahoma
- Charles Grim, DDS, MHSA - Secretary, Chickasaw Nation Department of Health; Ada, Oklahoma
- Judith James, MD, PhD - Vice President of Clinical Affairs; Member & Chair Arthritis & Clinical Immunology; Lou Kerr Chair in Biomedical Research; Oklahoma Medical Research Foundation; Oklahoma City, Oklahoma



- Gitanjali Pai, MD, AAHIVS - Infectious Disease; Memorial Hospital and Physicians' Clinic; Stillwell, Oklahoma
- Chandini Sharma, MD - Geriatric Medicine; Geriatric Center of Tulsa; Tulsa, Oklahoma
- Richard Brent Smith, MD - Family Medicine; Lawton, Oklahoma
- Mousumi Som, DO - Internal Medicine; Oklahoma State University; Tulsa, Oklahoma

The core team members and their roles/expertise is shared as Appendix A.

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

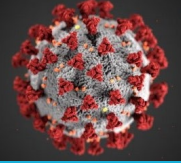
The Oklahoma COVID-19 Vaccination Program Team will work in concert to ensure the functions necessary to enroll and engage a provider network, to oversee vaccine orders, shipments and tracking of doses. Weekly meetings will continue throughout the phases of the vaccine program. A situation room will be set up at the OSDH facility to accommodate the members of the core team in daily operations of this mission. The situation room will allow for virtual and in person interactions to ensure all relevant parties can weigh in on decisions necessary for successful distribution, ordering, tracking, storage and messaging needed for this program.

Continual communication will occur between the Immunization Division and providers to ensure all requirements or potential complications are addressed. The Vaccination Program Team will ensure state officials stay briefed on vaccine program metrics of success including vaccine uptake, supplies, throughput and tracking. Local public health officials participate in coordination calls twice weekly related to all COVID-19 related response priorities. Local health departments will continue to keep stakeholders and the general public informed.

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

Over 388,000 Oklahomans receive medical care from Indian Health Service facilities through federal healthcare facilities and/or through independent tribal nation health systems. This planning team recognizes the need for complete interconnectedness between state and tribal public health systems. As core members of the Oklahoma COVID-19 Vaccine Planning Committee, RADM Travis Watts, Area Director for the Oklahoma City Area Indian Health Service, and Dr. Daniel Molina, Chief of Research and Public Health for the Chickasaw Nation Department of Health, have an active role and provide suggestions for the entire plan, not just the parts pertaining to tribal considerations.

American Indian citizens account for approximately 10% of the population in Oklahoma and are served by a robust and expansive health system including federal (IHS), urban and tribally run clinics and hospitals. This planning team recognizes the need for coordination and synergy between state and tribal public health systems. As core members of the Oklahoma COVID-19 Vaccine Planning Committee, RADM Travis Watts, Area Director for the Oklahoma City Area Indian Health Service, and Dr. Daniel Molina, Chief of Research and Public Health for the Chickasaw Nation Department of Health, have an active role and provide suggestions for the entire plan, not just the parts pertaining to tribal considerations.

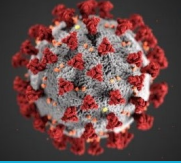


In addition to tribal and IHS representation on the Vaccine Planning Committee, the Oklahoma State Department of Health (OSDH) implemented and formalized a 'rapid consultation' and feedback process for all Oklahoma tribal and tribal serving stakeholders. Bi-weekly "all tribes" virtual meetings were held to provide updates on the state planning process, seek feedback and guidance from tribal health experts and align state planning efforts with tribal and IHS entities. Initial outreach was made to tribal and IHS facilities with in-patient capacity for COVID-19 treatment to seek workforce data to assure tribal facilities were considered and included for this priority population.

As the plan developed, the planning team presented assumptions and components to statewide tribal advisory groups and leaders of larger tribal systems. Questions, feedback and internal operational planning for specific tribes was considered and incorporated into the overall Oklahoma plan. For example, the Chickasaw Nation has established a mass testing/mass vaccination operation at four of their clinic locations in south central Oklahoma that has the capacity for 1,200 vaccinations per day. They will soon have a facility ready to expand this capacity to approximately 4,500 vaccinations per day. They have graciously offered these facilities for the entire population. This is just one example of how partnerships will be incorporated into this plan.

**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* – Walgreens and Walmart teams met with the core team to share their willingness and collaboration to support the State plan during all phases.
- *Correctional facilities/vendors* - OSDH leadership works closely with the Oklahoma Department of Corrections (DOC) through the Multi-Agency Coordination Center (MACC) which includes Governor briefings three times per week. Local and state public health officials work directly with the Nurse Manager in the Medical Services Unit of DOC on daily logistics for positive case investigation and COVID testing for all DOC facilities. Coordination between local jails and public health happens at the local health department (LHD) level including departments under the purview of Tulsa Health Department (THD) and Oklahoma City County Health Department (OCCHD) as well as OSDH. They currently work together on infection control, testing capacity and positive case investigations/recommendations. Vaccine will be added to these frequent discussions at both the DOC and local jail levels.
- *Homeless shelters* – see below
- *Community-based organizations* – see below
- *Federally Qualified Health Centers (FQHC)* - Working through the Primary Care Association, the Immunization Division has scheduled virtual meetings with FQHCs from across the state to ensure they are properly enrolled and updated about their role in the Oklahoma COVID Vaccination Plan.
- *Oklahoma Hospital Association* – Virtual meetings are scheduled with hospitals to ensure the provider agreements are understood and completed. Plan details and priority group considerations are the current main focus of these discussions.



The Office of Minority Health & Health Equity (OMHHE) Advancing Health Equity and Strengthening Minority Health Program includes various strategies to advance health equity, eliminate health disparities, increase cultural competency and strengthen Oklahoma’s health system infrastructure.

The OSDH has focused on underserved and diverse communities by partnering with specific organizations and associations. Through these partnerships, the agency has developed tailored messaging and reached out to targeted audiences. The Office of Minority Health and Health Equity and other diverse OSDH staff have contributed time and effort by translating materials and providing interviews on multiple TV and radio stations statewide. These interviews have helped with common sense guideline outreach and opened lines of communication amongst various multi-cultural communities.

The first strategy to advance health equity is to ensure that non-English speaking clients receive equitable services. This program will utilize the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as a framework to “provide effective, equitable, understand, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred language, health literacy and other communication needs”.

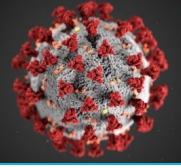
OMHHE will continue to work with agency leadership to implement policy and practices that promote professional development and increase the capacity of the public health workforce for those employees providing language assistance. Strategies include continuing education and proficiency testing. The OSDH will develop and provide training for agency interpreters across the state.

In addition to reducing language barriers across public health systems, the OMHHE provides staff support to increase health equity and cultural competency throughout the public health system. The OMHHE staff supports capacity building and stakeholder engagement for state and local health improvement efforts. The staff collaborates and consults with program staff and community engagement teams to identify data driven strategies to improve health. An additional emphasis will be placed on disparate populations with the greatest need. Capacity building efforts include but are not limited to identifying and convening stakeholders, developing communication strategies, identifying community resources and assessing needs and researching evidence-based strategies.

Faith-based communities:

Oklahoma has its own unique combination of faith-based organizations (FBO) that has evolved as a result of history, geography, cultural diversity, median age, and migration patterns, etc. The FBOs are born of a history of providing services and support. They provide access to their communities and are vital to the entry of outsiders to the many cultures that make up our state – because they are trusted. The OMHHE currently works in collaboration with the Community & Faith Engagement arm of the Infant Mortality Alliance (IMA). This collaboration meets quarterly and focuses on enhancing family and community systems that can have broad impacts on minority families and communities.

The OMHHE will continue to leverage collaboration and build relationships with faith-based organizations, leaders and congregants. Identifying those faith-based organizations with a capacity and desire to partner involves inquiry and discover. Experience has shown that many things are possible when systems partners



work together with faith-based groups with integrity and mutual respect. Strategies to engage this population include:

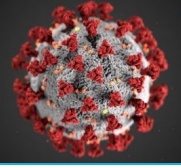
- Utilizing personal outreach to initiate and maintain relationships with faith-based organizations within the targeted community
- Recruiting individuals who are known and respected in the faith-based community to assist with conducting outreach efforts
- Connecting with faith-based groups to encourage supportive and facilitative roles. For example, provide space for vaccine sites, open their site to planning activities, host community forums, assist with outreach and referrals of congregants and community members to needed services, encourage their congregants and followers to get involved in vaccine activities, and lend their names and voice to advocacy efforts.
- Connect with independent storefront community-serving ministries of lesser-known faith-based groups. The organizational capacity of these groups may seem small, but their reach into underserved communities can be quite significant.

Community based organizations:

The Opportunities Industrialization Center of Oklahoma County, Inc. (OIC) is a private, nonprofit organization. This community organization meets once a month and dedicated to inspiring and motivating adult learners through academic and career education. The OIC serves as a board member and assist with guidance and connecting to improve literacy rates in Oklahoma - OIC is a non-profit whose mission is to provide individualized services, education, and skills training to those who are unemployed, underemployed and in need of education and training skills for gainful employment. Programs offered include: computer training, conversational English, Citizenship work, health literacy, high school diploma prep classes and TANF literacy. In 2019, OIC expanded to offer courses at no or low cost and provided to citizens residing throughout Oklahoma, Cleveland, Logan and Canadian counties.

Supporters for Families with Sickle Cell Disease (SFSCD), a comprehensive community-based organization which services individuals and families living with sickle cell and thalassemia disease and trait in Oklahoma. Supporter's is the center of contact and community service provision for the estimated 40,000 Oklahomans with sickle cell trait and approximate 1,500 Oklahoma families living with sickle cell and thalassemia disease in Oklahoma. The OIC meets bi-weekly with this group. There is a current MOU in place with the SFSCD and OSDH OIC providing information about its services to patients diagnosed with sickle cell disease and information to local public health departments. This group serves as a stakeholder with OSDH efforts to develop an overarching State Health Equity Plan. A portion of the plan will include a chapter with SCD recommendations on establishment and improvement of Oklahoma's system to assist individuals and families encountering SCD or trait diagnoses.

The OIC continues community engagement efforts with the SFSCD. Prior to COVID-19, the OIC leveraged collaboration and participated in the 2020 Black Health Counts, Health Equity Forum where the OIC provided the community with information and education on health disparities and healthy equity. In November 2019, OIC issued the keynote address for the 15<sup>th</sup> Annual Sickle Cell Awareness Gala to include information on health and health equity. The OIC participated with the community efforts in



August 2020 providing school supplies and PPE at the “Spreading Hope Back to School Bash for Children and Youth with Special Needs” The SFSCD has reached out to the OMHHE with questions around COVID-19 and vaccines. There are plans to engage this population to assist with education strategies and culturally sensitive messaging around vaccines. Additionally, leverage collaborative efforts with the SFSCD, community champions and political leaders. There is a desire to engage this community at the beginning of the vaccine efforts, host webinars and virtual town halls to include storytelling to build a bridge between public health, healthcare and the community.

The OMHHE successfully convened collaborative members across various professions, communities, and industries in strengthening our collective capacity to develop Oklahoma’s first State Health Equity Plan. This multi-sector team convened for the first time in June 2019 and again in September and December. Due to the guidance and realities surrounding COVID-19, the April 2020 State Health Equity stakeholder meeting was cancelled and plans for future in-person meetings were placed on hold. The group continues to engage and collaborate via electronic means. A list of OMHHE stakeholder organizations is provided in the appendix.

## 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:

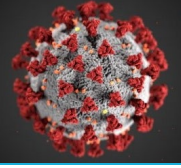
Overarching tenets for Oklahoma’s COVID-19 Vaccination Program:

- 1) Save lives and maximize benefits of vaccine to overall pandemic response mitigation.
- 2) Treat all people with equal regard and mitigate health inequities.
- 3) Minimize or eliminate vaccine waste and ancillary supply loss.
- 4) Maintain constant awareness of vaccine inventory and administration reporting.

### **Phase 1: Potentially Limited Doses Available**

The Commissioner of Health, supported by the COVID Vaccine Program team, will make overall decisions regarding all aspects of the program including vaccine allocations and supply deployment. Each phase of the operation will require specific messaging and communication to the public and to vaccine providers. One key focus for the communications team during phase 1 will be transparency surrounding how the priority groups were decided, the rationale used to determine the first target populations for vaccine, and the fluidity of among groups within phase 1 where vaccine distribution will be highly dependent upon the type, indication, and logistics associated with the specific vaccine provided to the state.

Vaccine supply is expected to be very low in Oklahoma at the beginning of phase 1. In order to maximize the benefit to Oklahoma’s pandemic response while mitigating inequities and disparities, Oklahoma’s allocation framework was informed by the core planning team and thoughtful review from an independent advisory committee to the Commissioner of Health. The advisory committee was comprised



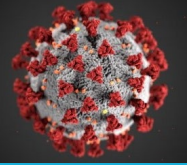
of medical professionals representing the following sectors: infectious disease, biomedical research specific to immunology, tribal health systems, dentistry, family practice, and internal medicine. Two of the members were from outside the metro areas.

The Oklahoma COVID Vaccine team acknowledges there are many unknowns regarding COVID vaccine including but not limited to the type, amount, indication, and logistical considerations of the vaccine. As such, the plan is being built on hypothetical scenarios and planning assumptions, based on information and guidance that is known today. This plan is intended to be flexible and fluid and allows for future changes as more information becomes known to the state. The state anticipates the possibility for significant revisions to the plan upon receiving confirmed, finalized information regarding the initial federal vaccine distribution to Oklahoma.

For example, ultra-cold (-80C) vaccine may be the first available from manufacturers and may be shipped in 1000 dose lots. Current CDC guidance indicates large, closed-pod, mass-vaccination sites with ultra-cold storage capabilities may be necessary as vaccine storage containers may only be opened twice daily, requiring very large volumes of doses to be administered in a very short period of time (e.g. less than 6 hours), and prohibiting the ability for vaccine to be transported to multiple sites. The prepositioning of stock would likely be necessary at central locations across the state that have adequate ultra-cold storage capacity and physical space and staff to accommodate mass-vaccination throughput. In this example, the appropriate initial distribution channel may be large, metropolitan health systems currently serving COVID patients where it is possible for 1000 doses to be administered to the phase 1 priority groups within a 6 hour period. Such a distribution channel would likely require planning for communication to the phase 1 priority groups indicating the scheduling system for their receipt of vaccine, priority group individuals arriving at the mass vaccination site, and development of throughput and post-vaccine monitoring processes. As additional ultra-cold vaccine become available, other large health systems may be utilized as closed-pod, mass-vaccination sites.

In contrast, another example could assume the initial availability of cold (-20C) vaccine available from manufacturers and shipped in 20 dose lots. Such cold vaccine could be maintained in commercial refrigeration units, which are more widely available than ultra-cold units. Smaller vaccine storage containers with 20 dose increments, coupled with the ability for health care facilities to utilize available freezer space, could allow for vaccine transportation, storage and administration at facilities who serve/staff phase 1 priority populations in smaller volumes. In this example, the appropriate initial distribution channel could include a wide variety of health system facilities (e.g. long term, nursing, assisted living facilities, etc) who serve/staff phase 1 priority groups. Vaccination could occur among groups of 20 individuals (per the vaccine storage container capacity) and operate in a closed-pod setting. Like the example above, planning for communication to and scheduling of the phase 1 priority groups would need to occur, however more flexible, smaller scale vaccination events would be feasible given the different logistical considerations of the cold (-20C) vaccine type.

Healthcare staff working in Long Term Care and Assisted Living Facilities will be the first priority. Vaccine supply for these staff will be initially provided by the state allocation, especially during instances of very limited supply. Later in Phase I and subject to implementation of federal Pharmacy Partners Plan, the



majority of Oklahoma's Medicare Certified LTC/ALFs will come from federal allotments directly provided by national pharmacy agreements. The COVID Vaccine Team will work with the facilities not certified by Medicare to determine the best way to distribute/administer vaccine to their employees. These staff will be vaccinated through closed pods and strike teams via direct shipments to LHDs (the term LHD includes also THD, OCCHD). The COVID Vaccine Team will work with LTC/ALFs to determine the best manner to address potential transportation challenges to/from vaccination sites among staff.

As phase 1 progresses, shipments will be directed to local health departments (LHD) or to hospital providers in the cities where hospitals treat COVID-19 inpatients. The LHD will coordinate the location and details for a closed POD. Vaccine handling, patient information tracking, recording vaccine administration into OSIS/VAMS, and setting up details for the second dose closed POD will be the responsibility of the LHD strike team. The LHD personnel have long standing relationships with the hospitals in their areas and will be able to collaboratively problem solve issues with guidance from the Immunization Division and COVID Vaccine Operations Team.

During phase 1, Oklahoma will provide COVID-19 vaccination services in closed point-of-dispensing (POD) setting that allows for maximum number of people to be vaccinated while maintaining social distancing and other infection control procedures. Closed PODs will be conducted by private and public providers during this phase. This is to ensure vaccine remaining after patients in the intended POD are vaccinated is transferred to another location or to another critical population identified in phase 1 to eliminate the chance for waste of the vaccine.

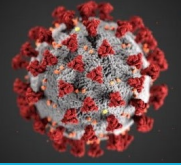
While vaccine is limited, the Immunization Service will ensure all pandemic vaccine providers enrolled in the program are educated and trained on vaccine handling, storage and administration. Additional attention will be given to pandemic providers serving Phase I critical populations to ensure not only their enrollment, but understanding and capacity to manage the new COVID vaccine as it is initially made available. The Immunization Service will be responsible for ensuring all providers understand the reporting requirements and how to record, track and report patient information into OSIS or VAMS. A GIS map has been developed to recognize the geographic representation across the state in order to identify areas underrepresented by enrolled vaccine providers. This map includes overlays of socioeconomic data, transportation and language barriers and provider details.

As vaccine supplies increase, the Immunization Service will increase the number of orders to be filled by hospitals across the state in order to reach healthcare workers. As phase 1 develops and more priority groups are included in the allocation, Federally Qualified Health Centers (FQHC) and tribal health systems will be key to the distribution plan. Long term care staff and residents will be a focus due to their risk of transmitting infection to others in a residential facility serving our most fragile population. The LHDs will begin hosting vaccine clinics for populations age 65 and above at risk of severe morbidity and mortality.

During phase 1, Oklahoma will identify gaps in the plan and logistics. Continuous improvements and steps toward efficiency will be taken as we learn more about cold chain requirements, vaccine inventory tracking and patient record reporting.

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





As supply grows, the COVID Vaccine Team will continue to identify and enroll pandemic providers critical to the established phase 2 priority groups. Orders will be generated by the providers, approved by the Immunization Division, communicated to CDC and shipped by OWS. Critical population categories will expand. As orders are shipped or strike teams deployed, the Vaccination Program Team will ensure equitable distribution and attention is paid successful administration of the vaccine to Oklahoma's most vulnerable populations. The communication professionals in the JIC will monitor uptake and social media responses to this implementation plan in order to address any concerns about attitudes toward vaccination or to provide real time updates on vaccine access points.

As vaccine supplies grow the populations eligible under phase 2 priority groups will increase as well. Mass immunization clinics will be utilized by the LHD and some tribes to enable quick administration and greater access for the public. Some public/private partnerships will evolve as mass immunization is instituted. Private providers may be used as volunteers or engaged as co-hosts for mass flu vaccine clinics across Oklahoma.

For fifteen years, Oklahoma has practiced mass vaccination plans across the state. Currently, each of the 11 districts (including Tulsa and Oklahoma City) have locations and operational plans to vaccinate people quickly. COVID-19 vaccine will be different in some ways (e.g. suggested wait time after vaccination to assess any reactions) and the same in many others. COVID-19 Vaccine will require attention to crowd grouping and sanitation of vaccine area to control further spread of the disease.

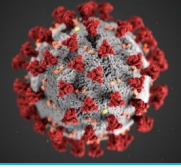
Curbside and drive in vaccine clinics will likely be used by providers to allow for quick vaccination and control of spread.

### ***Phase 3: Likely Sufficient Supply, Slowing Demand***

In phase 3, vaccine supplies should be sufficient and priority populations from phases 1 and 2 should have had the opportunity to receive the vaccine. More will be known about the vaccine effectiveness and potential side effects. Vaccine will be available across the entire state during this phase. The Vaccination Program Team will monitor vaccine uptake and second dose coverage across all populations. Further expansion of priority populations will happen. The state acknowledges that while critical population groups have been identified across all three phases of COVID-19 vaccine availability, uptake will be dependent upon personal choice of individuals and their employers. As time passes, phases are experienced, and data are collected, more will become known regarding the rate of uptake among the population.

Vaccine storage concerns could be a concern during this phase. If OWS logistics go as planned, the state should only receive vaccine as they need it, but surpluses of vaccine will likely happen in some areas due to slowing demand for the vaccine. The Vaccination Program Team will ensure proper storage and monitoring. Vaccine will be transferred to other locations where uptake may be better. The JIC will continue to focus messaging toward vaccine safety and importance.

A vaccine planning graphic illustrating the phased approach and major considerations is provided in the appendix.



## Section 4: Critical Populations

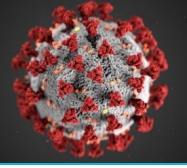
### Instructions:

- 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 OSDH anticipates that populations including people from racial and ethnic minority groups, tribal communities, people with underlying medical conditions and/or disabilities, and those who are under- or uninsured will likely be present among all priority populations. Oklahoma Tribes and Tribal citizens are included in the State's Vaccine Distribution Framework to provide vaccination services as part of its jurisdiction to receive vaccine and ensure they have access to vaccination services. The vaccine available and uptake among these groups will be monitored as a subset of all critical populations. As quantification of priority populations is performed, subsets of each group will be identified. Vaccine availability and uptake will be monitored as data sources may be available to ensure subset groups are offered vaccine to the degree desired to meet the overarching tenet #2 as above. Additional vaccine communications strategies may be enacted to include targeted outreach to the subset groups and the appropriate local community resources and organizations and other partners best suited to spread the message in coordination with the state's COVID-19 vaccine JIC.

Identify:

The OSDH will rely upon the expertise and guidance of the CDC as the state's liaison to COVID-19 vaccine planning. Much information and guidance has already been shared with the state by the CDC indicating populations' range estimates of risk of exposure. The OSDH understands the CDC, partnering with various national organizations from the scientific and academia sector (e.g. NASEM, JHU, ACIP, WHO, etc.) has employed a process of obtaining and reviewing scientific sources from literature, reports, and recommendations. This review has resulted in the critical populations list provided above.



Upon release of the CDC playbook in September, the OSDH assessed existing data sources for each of the critical populations identified. Both state and national datasets were sought. State level data sources were assessed for the granularity possible (e.g. county or zip code level data). At minimum, county level data were identified for all critical population groups. The approach used by the state to identify appropriate data included use of established, dependable, long-standing national or state sources of information.

#### Estimate:

As the OSDH seeks and utilizes existing state and national data sources to quantify the total potential universe of critical populations offered vaccine at a county and statewide level, the results of the initial draft information gathering were shared among core and large working groups. These statewide and county level estimates were used by the groups to develop an initial draft of the potential critical population priorities among the phases. As described above, the vaccine advisory committee was utilized as the group to make final recommendations to the Commissioner of Health regarding final population priority levels. The vaccine advisory committee utilized the same initial statewide and county level estimates used to quantify the total potential universe of critical populations offered vaccine to help inform their recommendation development.

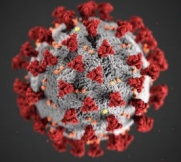
The rate of uptake of vaccine was and is being explored. Initial ad hoc surveys were conducted among public health staff, some hospitals, and a few long-term care facilities resulting in take up rate ranges of approximately up to 40%. At the vaccine planning tabletop exercise conducted the first week of October, a stakeholder shared that a recent, independent ad hoc survey indicated overall take up rates between 30-50% had been estimated for the state's population. The stakeholder group had discussion at the tabletop that anecdotal expressions of local, regional, and individual opinions on vaccine use among healthcare workers varied greatly with examples ranging from 0% take up to 20% take up expressed by staff who acknowledged that many unknowns about the vaccine appeared to cause uncertainty. The need for a statewide survey across all critical population sectors was discussed, the timing of which should coincide closely with the vaccine availability so as to gauge most accurate opinions on uptake based on vaccine information known at that time. Plans are being discussed among the core-planning group to develop such a series of surveys.

#### Locate:

The OSDH has used the estimated total potential universe of critical populations offered vaccine at the state and county level to populate an ArcGIS mapping tool. This tool has been in use throughout the COVID-19 response in a variety of ways to demonstrate the disease burden across the state. The tool is being used for vaccine planning to locate and visually represent the masses of critical populations to be offered vaccine in each phase. The OSDH is actively adding a variety of data layers to the ArcGIS map software, which provides the ability to sort information and allows areas of greater or lesser concentration of group populations by county.

#### Oklahoma COVID-19 Vaccine Distribution Framework:

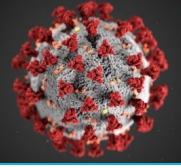
##### **PHASE #1**



1. Nursing home, assisted living, and long-term care facility staff.
  - a. Description: Workers in residential health care settings who either work in situations where risk of transmission is high or are at an elevated risk of transmitting the infection to patients at high risk of mortality and severe morbidity.
  - b. Estimated universe of people offered vaccine statewide: 12,000
2. Public health staff conducting frontline COVID-19 pandemic mitigation and control activities (*including but not limited to nurses, public and private lab personnel, and others with direct contact with the public*).
  - a. Description: Workers in public health care settings who either work in situations where risk of transmission is high, who themselves are unable to avoid exposure to the virus, and who play a critical role in ensuring that those with or suspected of COVID-19 are able to be served by the public health system.
  - b. Estimated universe of people offered vaccine statewide: 500
3. Health care workers providing direct inpatient COVID care.
  - a. Description: Workers in acute/emergency health care settings who either work in situations where risk of transmission is high or are at an elevated risk of transmitting the infection to patients at high risk of mortality and severe morbidity.
  - b. Estimated universe of people offered vaccine statewide: 84,000
4. Nursing home, assisted living, and long-term care facility residents.
  - a. Description: Individuals living in residential health care settings that increase their risk of infection and resultant morbidity and mortality.
  - b. Estimated universe of people offered vaccine statewide: 19,000

## PHASE #2

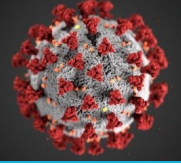
1. First responders, paid and unpaid (*including but not limited to, EMTs, paramedics, fire departments, law enforcement, homeland security and emergency managers*).
  - a. Description: Workers who provide emergency services in situations where exposure to infected individuals is unavoidable when rendering necessary immediate care to the public.
  - b. Estimated universe of people offered vaccine statewide: 10,000
2. Adults age 65 and older.
  - a. Description: Older adults, with prioritization placed upon those with multiple comorbid conditions including but not limited to hypertension, obesity, cardiovascular disease, diabetes mellitus, chronic lung disease, chronic liver disease, who are at high risk of mortality and severe morbidity resulting from COVID-19 infection.
  - b. Estimated universe of people offered vaccine statewide: 635,000
3. Health care workers:



- a. Providing care primarily for adults 65 and older (*including but not limited to home health workers*);
  - b. Providing care involving the direct treatment or screening for cases of COVID-19 in outpatient settings (*including but not limited to providers in urgent care and primary care settings*); and
  - c. Providing care in other high-risk outpatient settings (*including but not limited to health care workers performing aerosolized procedures or the close examination of the nasopharynx such as dentists, respiratory therapists and speech-language pathologists*).
    - i. [For all subsets above] Description: Workers in chronic health care settings who either work in situations where risk of transmission is high or are at an elevated risk of transmitting the infection to patients at high risk of mortality and severe morbidity.
    - ii. [For all subsets above] Estimated universe of people offered vaccine statewide: 67,000
4. Staff and residents in congregate locations and worksites (*including but not limited to homeless shelters, group homes, prisons/jails, and manufacturing facilities with limited social distancing capacity*).
- a. Description: Workers and persons living in congregate settings who are at high risk of exposure to and transmission of COVID-19 infection.
  - b. Estimated universe of people offered vaccine statewide: 49,000
5. Public health staff supporting frontline efforts and state and tribal government leaders (*including but not limited to public health clerks, administration and leadership as well as senior state and tribal government officials and staff*).
- a. Description: Workers whose work is vital to the function of society and the economy, who work without adequate protection while in close proximity with coworkers and members of the public, and who are at high risk of exposure to and transmission of COVID-19 infection.
  - b. Estimated universe of people offered vaccine statewide: 2,000

## PHASE #3

1. Teachers, students, residents and administrative staff in educational settings (*including but not limited to pre-K-12 schools, child care facilities, early childhood facilities, colleges, universities and other post-secondary institutions*) as may be eligible for the vaccine (e.g. appropriate ages to receive the vaccine).
  - a. Description: Workers and students, for which exposure is very difficult to control due to the nature of their institutions, and who serve an important societal role ensuring educational needs are met, with prioritization placed upon those with multiple comorbid conditions including but not limited to hypertension, obesity, cardiovascular disease, diabetes mellitus, chronic lung disease, chronic liver disease, who are at high risk of morbidity and mortality resulting from COVID-19 infection.



- b. Estimated universe of people offered vaccine statewide: 1,022,000
2. Critical infrastructure personnel ("essential business/industry" personnel) as specified in the Governor's 3rd Executive Order.
  - a. Description: Workers who are at high risk of exposure to, transmission of, and morbidity and mortality resulting from COVID-19 infection.
  - b. Estimated universe of people offered vaccine statewide: 1,500,000

## PHASE #4

1. All remaining Oklahoma residents.
  - a. Description: All Oklahoma residents who are at high risk of exposure to, transmission of, and morbidity and mortality resulting from COVID-19 infection.
  - b. Estimated universe of people offered vaccine statewide: 556,500

## NOTES:

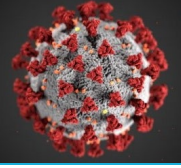
- The above distribution framework may be modified pursuant to logistical considerations and the changing rate of COVID-19 infections among populations. Direct federal distribution of the vaccine is expected to occur for certain populations and may further modify the distribution schedule.
  - Where necessary, prioritization within population categories may be made based on comorbidities, age, exposure level and access to PPE.
  - Tribally operated programs, facilities, etc. will be included in all phases and critical populations.
- A. *Describe how your jurisdiction will define and estimate numbers of persons in the critical infrastructure workforce, which will vary by jurisdiction. By county, counts of workers in each sector are determined.*

## State Sourced

Building upon the data sources mentioned above, the OSDH will further enhance and add specificity to the local health system data for phase 1 on their critical workers at a facility level. The state aims to leverage existing partnerships to gather enrolled pandemic provider facility specific counts of healthcare workers. These partnerships include but are not limited to the Oklahoma Hospital Association (OHA) for healthcare provider estimates across the state, the state EMS agency for estimates of EMS providers across the state, and LTC organizations and leadership for patient populations and staff estimates across the state.

## Locally Sourced

Local county health departments (LHDs, which include also THD and OCCHD), working collaboratively with their community facilities and partners, will be asked gather population and facility specific counts of priority groups throughout each phase and provide this to OSDH. A similar approach was taken during the



H1N1 pandemic. OSDH will use this information to assist with the distribution plan (discussed later in the plan) of the various critical priority populations within the state.

- B. *Describe how your jurisdiction will determine additional subset groups of critical populations if there is insufficient vaccine supply. Urban vs rural, monitoring percentage of populations for race/ethnicity groups, uptake estimates and actuals for each critical population, etc.*

Initially, the availability of a vaccine will be limited due to manufacturing and logistical (e.g. ultra-cold storage, packing container size (1000 doses), inability to break apart containers, limited vaccine viability timeframe after thaw/reconstitution, etc.) constraints. The distribution of vaccine will follow the critical population priority set forth by the advisory committee recommendations and approval by the Commissioner. Additional subset groups of critical populations may be developed based upon comorbidities, age, exposure level and access to PPE. Additional modifications to the distribution plan and among priority populations may be made pursuant to logistical considerations and the changing rate of COVID-19 infections among populations. The OSDH Commissioner of Health will receive recommendations from the core planning group and, if needed, the vaccine advisory committee to review and approve the subset groups of critical populations and associated allocation strategy and prioritization. The strategy will be influenced by CDC guidelines, disease burden, and vaccine type and supply.

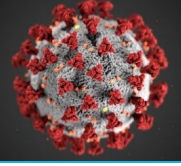
The phased approach for vaccine distribution among critical priority populations will be utilized. The methodology for the allocation of the vaccine will build upon guidance developed as part of COVID-19 vaccine planning. This methodology will be adjusted based on experiences during the first wave of the COVID-19 response, data on the virus, its impact on populations, the availability, indication for, and performance of each vaccine, and the needs of the critical workforce.

- C. *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.*

Use of all stakeholders involved in aspects of COVID-19 planning efforts, including but not limited to pandemic provider enrollees, push provider agreements, statewide partner organizations and associations, large and core planning group members, LHDs, tribal leaders, the media and general public, and others will ensure the continued use of this COVID-19 planning network after initial vaccine distribution. Use of the JIC and implementation of the COVID-19 vaccine communication plan will establish POCs and methods to distribute and promote new information timely and effectively. The communication plan outlines the ability for continuous modifications to methods as a communication venue for status updates.

## 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.*

Oklahoma began creating a potential pandemic provider list in January 2020 as a required activity under Core grant. Providers were recruited through the Oklahoma Health Advisory Network (OK-HAN), which reached approximately 5,000 healthcare providers throughout Oklahoma. Vaccines for Children providers were reached through the Immunization Field Consultants (IFCs). Over 515 pandemic providers including LHDs, RHCs, FQHCs, hospitals and others enrolled with Immunization Service before CDC released its provider enrollment forms.

[https://www.ok.gov/health/Prevention\\_and\\_Preparedness/Immunizations/Pandemic\\_Vaccine\\_Provider\\_Enrollment/Pandemic\\_Vaccine\\_Providers/index.html](https://www.ok.gov/health/Prevention_and_Preparedness/Immunizations/Pandemic_Vaccine_Provider_Enrollment/Pandemic_Vaccine_Providers/index.html)

Immunization Service's immediate efforts are focused on identifying and recruiting providers that will provide services to phase 1 critical population, including LTC and assisted living facilities staff, public health and healthcare personnel, first responders, and people with increased risk for severe illness related to COVID-19, including those 65 years and older.

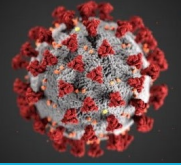
The Vaccine Coordinator and Immunization Nurse are leading the provider enrollment effort and have reached out to 70 LHDs. The LHDs (including also THD and OCCHD) will be part of vaccine administration to all populations in phase 1. For equitable distribution of the vaccine, FQHCs leadership will be reached via zoom call in the coming days. Provider enrollment information will be shared with the CEOs of large and mid-sized hospitals via webinar/screen sharing during meetings on October 22-23, 2020. Local pharmacies will be enrolled for community administration when vaccine becomes available in large quantities in Phase 2 and 3. If ACIP recommends the vaccine for children under 18 years, immunization team will reach out to the 760 VFC providers that are already enrolled in the OSIS. Vaccine availability and access will be monitored via GIS map which will also be used to enroll providers in vaccine deserts.

Pandemic provider information is entered into CDC CSV file and uploaded through Immunization Data Lake (IZDL) portal. Providers are also being enrolled into OSIS and VTrcks, and verification of credentialing will occur during the enrollment process.

- 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.*

Using guidance from the playbook and working with several stakeholders, Oklahoma has identified critical population groups and providers serving these groups are being enrolled.





At this time, our understanding is that the LTCF's staff will be the responsibility of the State and the residents will be vaccinated by pharmacies through direct allocation from the Federal Government.

For phase 1, we will be using local County Health Departments to administer state allocated vaccine to LTC and public health staff through closed PODs and will work with partners to coordinate vaccine to tribally ran LTC and public health programs. Later, we will reach out to large hospitals to administer vaccine to their Health Care workers providing direct in patient care to COVID patients. Depending on vaccine availability and uptake, vaccine will be available from one group to the next. Information collected from the provider enrollment forms will be used to narrow the providers that will receive vaccines for the populations they serve, as later phases require providers to be enrolled as pandemic providers prior to their ability to be recipients of direct shipment of vaccine.

- 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 previously 515 state system enrolled pandemic vaccine providers' data were collected via Qualtrics and saved in excel workbook.

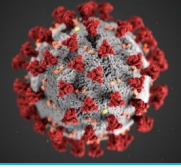
Provider Information from CDC enrollment forms is stored in an Excel workbook. Information is then copied into CSV file and uploaded via SAMS - authenticated mechanism.

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

Pandemic Providers are being enrolled into OSIS and VTrcks to capture required information, including shipping address. Licensure will be verified as part of this process. Nontraditional providers, unable to utilize OSIS, will complete pandemic provider enrollment through the help of Immunizations Service staff. These staff will complete the credentialing process for providers. Non-traditional providers will be required to utilize the federal VAMS platform.

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

Training materials will be created and shared on a Pandemic Provider landing page available on the OSDH website. These materials will include information on vaccine storage and handling, administration instructions, FAQs, and VAERs information. Educational resources will be added to the landing page as additional information becomes available. In addition to the webinars and online videos, the Immunization Field Consultants (IFCs), Local Emergency Response Coordinators (LERCs) & COVID 19 Vaccine specialists will be trained as trainers and responsible to provide in person training and/or to facilitate online training to providers. The database on the providers will be used to track training topics and information.



- 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).*

Redistribution forms are being signed by all providers. Providers' administration capacity will be measured through the CDC enrollment forms. Depending on the storage and handling instructions on the type of vaccine arriving in Oklahoma, strike teams and PODs will be used to minimize handling of the vaccine. COVID-19 vaccine availability, and vaccine uptake will be tracked using the GIS/ARC map, and adjustments and transfers will be initiated based on this data.

OSIIS inventory system will be utilized to facilitate transfers of COVID-19 as needed.

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

Immunization Service will utilize the Oklahoma population GIS/ARC map to determine population estimates throughout the state. Efforts are being made to identify and enroll pandemic providers in counties and zip codes with socially vulnerable populations. Federally qualified health centers are an important partner to administer COVID 19 vaccine to minority population. If the tribes decide to receive state allocation, tribal providers and others providers serving tribes will be enrolled as pandemic providers. Both the COVID-19 vaccine availability, and vaccine uptake will be tracked using the GIS/ARC map, and adjustments and transfers will be initiated based on this data.

- 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.*

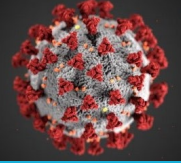
As part of outreach efforts to enroll pandemic providers, pharmacies and pharmacists were approached through board of pharmacy. There are over 200 pharmacies enrolled in the Oklahoma State Immunization Information System (OSIIS). Efforts are underway to enroll pharmacies for bidirectional data exchange with OSIIS.

## **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.*

Oklahoma is collecting vaccine storage and administration capacity as part of the Pandemic Provider enrollment process. Oklahoma is working with several partners to ensure channels are in place for



distribution to phase 1 targeted populations. Once additional doses are available to meet public demand, we will utilize the GIS/ARC map and Pandemic Provider storage and administration capacities to distribute vaccine equitably throughout Oklahoma. During Phase 3, we will continue to monitor pandemic vaccine availability and uptake throughout the state, and target regions with lower than average COVID-19 vaccine coverage rates.

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

The information gathered from the pandemic provider survey, will be used to plot each pandemic provider on a GIS/ARC map. This map will show the location of all pandemic providers, as well as their vaccine inventory and administration numbers. The capacities of these providers will be evaluated and compared to the regional population estimates. Any gaps in COVID-19 vaccine access will be identified, and additional pandemic vaccine providers will be recruited in those areas.

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

**Instructions:** Oklahoma's allocation, ordering, distribution and inventory management will vary considerably based upon the project phase for vaccine administration:

Phase 1 will begin as tightly controlled by OSDH in order to validate this plan and ensure operational readiness of the stakeholders. As the vaccinated percentage of critical populations increases and operational competency is established, OSDH will relax some controls and decentralize some administration.

Phase 2 will see more and more decentralization with OSDH moving from active control to monitoring and approving provider actions.

By Phase 3 OSDH's role will primarily be monitoring, supervision and quality assurance.

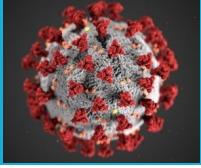
**Instructions:**

- 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.*

Section 4 shows the populations and their relative priority in vaccine allocation. The Logistics team is developing a Vaccine Distribution Plan (VDP) that lists a Distribution Priority Code (DPC) for each population. DPCs consist of a number that may be accompanied by a letter.

- Numbers are absolute priorities, with lower numbers being higher priority. Number 1 is the highest priority, 2 is the next highest priority, and so on. Assuming logistical and vaccine supply constraints are adequately addressed by OWS, the OSDH intends to complete offering vaccine to all populations at one number before moving to the next (i.e., all priority 1 before any priority 2).

# OSDH COVID-19 VACCINATION PLAN



- Letters are relative priorities within a single priority number, used to show how vaccine allotments received will be allocated to multiple populations. Three populations assigned 2A, 2B and 2C all have priority two, which means they would not receive any allocation until after all priority 1 populations are complete (having been offered vaccine) and they would all be complete (having been offered vaccine) before any priority 3 populations receive any vaccine. Associated with each letter would also be a percentage, with A being the highest and B being equal to or less than A, and the total of all letters being 100%. If 2A was 40%, 2B 40% and 2C 20%, then once all priority 1 vaccines were distributed, the next receipts would be allocated 40%/40%/20% respectively to priorities 2A, 2B and 2C until they were 100% complete. Once all A vaccines are complete for a particular priority, additional vaccine receipts would be allocated to each letter's prorate share of the remaining total.

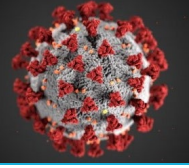
The VDP takes the county-level information in this plan and adds estimated uptake information by facility to estimate how each vaccine lot received will be consumed by various populations. It uses the PDC to assign each facility to an expected "dose lot," which is the sequentially numbered vaccine lot received from CDC. This detailed plan allows OSDH Logistics to plan exactly where each dose goes before it is received, which should improve efficiency once vaccine shipments start. A sample VDP specific to Phase 1, and the relationship with this Vaccination Plan is shown below:

Phase	Population	County	Count
1A	HCW - LTC/Asst Liv	01	863
		02	64
		03	1,201
		...	
		77	57
1B	OSDH Frontline Staff	01	4
		02	27
		03	121

County populations are broken down to facility level, uptake is estimated and dose lots are assigned according to DPC

Phase	DPC	County	Count	Facility	Count	Est Uptake	Doses	Dose Lot(s)
1A	1	01	863	Sunshine House	173	25%	43	1
				Tallgrass-Norman	206	35%	72	1,2
				St. Edwards	69	33%	23	2
				Bright Horizons	415	33%	137	2,3
8	02	64	Talequah Manor	64	45%	29	16	
4			03	1,201	Lincoln Center	95	25%	24
5A				Integrus Memory	320	25%	80	11,12
5B				St. Edwards Memory	88	50%	44	12
9		77	57	Woodward House	57	40%	23	19

# OSDH COVID-19 VACCINATION PLAN



OSDH will supplement the VDP with a Dose Administration Plan (DAP) that lists the physical administration site for each dose lot. Initially in Phase 1, OSDH plans to administer each dose lot in a single closed POD or other controlled environment to maximize throughput and minimize potential vaccine waste. The DAP lists each Dose Lot, the location where it will be administered, the facility personnel who will be immunized and a backup facility in case uptake is less than estimated from the scheduled facility population. A sample DAP is shown above.

OSDH will use the VDP and DAP to allocate and distribute vaccine until supply is sufficient to offer vaccination to all identified special populations and vaccination of the general public begins (i.e., through Tier 3).

The OSDH Logistics team will use these plans to alert vaccine sites and facility staff in advance of vaccine receipt, validate receipt of ancillary supplies and perform other process expediting as necessary.

Dose Lot(s)	Location	Facility Staff	Count	Backup Staff
1	Sunshine House	Sunshine House	43	Prestonwood
		Tallgrass-Norman	57	
2	Bright Horizons	Tallgrass-Norman	15	Integrus Memory
		St. Edwards	23	
		Bright Horizons	62	
3	Bright Horizons	Bright Horizons	75	Integrus Memory
		Prestonwood	25	

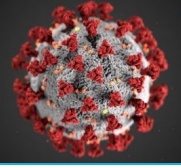
If the number of facility staff that show up at a location is less than expected and all of the doses will not be used, OSDH will contact the backup facility staff to get the proper number of replacements so all doses will be used within the desired timeframe, to avoid waste. If a vaccine administration site has doses they are unable to use after exhausting the backup list, OSDH will pick up the “Recovered Vaccines” and transfer them to backup storage (see below) or another administration site.

OSDH intends to establish a web-based “Dashboard” to assist in managing the process and communicating with providers. The dashboard is expected to show information such as populations and priorities, enrolled providers, LTC facilities and resident/staff counts, anticipated shipment counts/dates, etc.

- 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.*

OSDH is collecting refrigerated, frozen and ultra-cold storage capacity information from vaccination providers through a series of surveys as well as the CDC Provider Enrollment form. OSDH will use employees and/or National Guard to verify this information as necessary and may include physical inspection if warranted.

OSDH has also partnered with the Oklahoma Medical Research Foundation (OMRF), an Oklahoma-City-based state-of-the-art medical research facility with certified frozen and ultra-cold vaccine/biologic storage, to provide backup storage should it be necessary. OMRF has the facilities, staff and expertise necessary to ensure proper storage and handling of inventory with minimal issues. The OMRF facility will



also be used, if necessary, to create transfer shipments or store Recovered Vaccines until they can be distributed.

Additional partner facilities are being actively identified by the COVID planning core group team, and assessments of their ultra-cold storage capacity and availability are being amassed.

OSDH will incorporate provider storage capacity into the DAP described above (for Phases 1 and 2) and will ensure that, once direct shipments begin in Phase 2, approved orders are only going to providers with the appropriate storage capacity.

Cold chain storage capacity will be shown on the Dashboard/GIS map.

OSDH assumes all federal shipments will include continuous temperature tracking devices (TTDs) for the original shipping container. OSDH will purchase and use TTDs for Transfer Shipments.

As vaccine administration progresses into Phase II, OSDH will ensure that orders being shipped directly to providers do not exceed the provider's cold storage capability or that a plan is in place for using the backup storage necessary to allow the provider to consume the entire order in an appropriate timeframe.

*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.*

Early in Phase 1, OSDH will be the only entity placing orders for vaccine, will receive all vaccines from federal sources and will administer vaccines through county health departments according to the prioritization and methods described above.

As OSDH control is relaxed and individual providers begin placing orders, OSDH will review and approve those based upon the VDP and DAP. Once general distribution begins, OSDH will monitor provider information in OSIS daily and contact providers to resolve discrepancies or issues. OSDH will also reconcile the information exchange between OSIS and VTrckS daily.

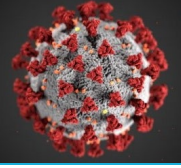
*D. Describe how your jurisdiction will coordinate any unplanned repositioning (i.e., transfer) of vaccine.*

The strategy for Recovered Vaccines is described in Section 7.A above.

OSDH will also establish a QC hotline for providers to broadcast an alert that they have vaccines that need to be recovered. OSDH's QC group will ensure the vaccine doses are retrieved and redistributed. This process is described in more detail in Section 8.

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

OSDH will use the QC group to perform this monitoring as an extension to the hotline and Recovered Vaccine processes described above and in Section 8. QC staff will monitor inventory levels and usage in VTrckS daily and, should a provider mark any vaccine as wasted or unusable, will consult with the provider to determine cause and any mitigation required for the future.



## Section 8: COVID-19 Vaccine Storage and Handling

### **Instructions:**

- A. Describe how your jurisdiction plans to ensure adherence to COVID-19 vaccine storage and handling requirements, including cold and ultra-cold chain requirements, at all levels:
1. Individual provider locations
  2. Satellite, temporary, or off-site settings
  3. Planned redistribution from depots to individual locations and from larger to smaller locations
  4. Unplanned repositioning among provider locations

OSDH assumes all vaccines received from governmental or private sources will arrive:

- In packaging that will maintain the appropriate cold or ultra-cold temperature for some minimal number of days after OSDH's receipt, and
- With a temperature monitoring device (TMD) that continually tracks the temperature and whether a temperature excursion has occurred in the past, and
- With an intact cold chain according to the TMD.

Since all Phase I shipments will be received by OSDH, its responsibilities in that phase consist primarily of:

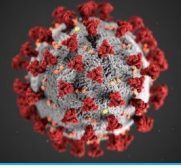
*Establishing an appropriate central location to temporarily store vaccines awaiting distribution to their final facility.* OSDH will create a primary receiving facility (PRF) in Oklahoma City at a warehouse with the necessary cold and/or ultra-cold storage to receive up to 100,000 vaccine doses at one time. OSDH is in the process of contracting for such a warehouse, and expects it to be in place by Oct. 21, 2020.

*Transporting vaccine to administration sites according to the DAP and recharging the transportation container with dry ice.* OSDH will centrally receive all vaccines and will transport them to the appropriate administration sites listed in the DAP. Once administration is complete, OSDH will return the shipping container as instructed by CDC. OSDH intends to contract for dry ice with multiple suppliers by Oct. 21, 2020.

*Establishing a quality control (QC) monitoring process to verify adherence to cold-chain requirements.* See detailed discussion in 8.B below.

*Collecting, storing and redistributing vaccine doses from providers who are unable to deplete their supply within the projected temperature window.* OSDH assumes that, despite detailed planning, there will be sites who are unable to deplete their allotted vaccine for a variety of reasons. Providers will report their oversupply using the hotline (see description below) and QC will coordinate with the Logistics team to have the vaccine retrieved and either stored or redistributed to another provider.

As vaccine supply grows and Oklahoma moves into Phase II, OSDH intends to allow direct vaccine deliveries to providers from federal sources and QC activities will increase exponentially as the



number of providers increase. It is also likely that hotline calls and redistribution could increase as supply spreads across more providers.

By Phase III, OSDH's focus will primarily be QC to ensure cold chain integrity, with a minor amount of effort involved in the other areas listed above.

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

OSDH believes that a formal QC process is the best method for ensuring appropriate storage and cold chain control. OSDH will create a QC group responsible for executing this process, with responsibilities for (1) sampling and inspecting enrolled provider cold storage ; (2) reviewing transfer documentation for each change of vaccine possession; (3) providing a multi-pronged communications hotline (telephone, website, text) where providers can report unused vaccine that needs to be retrieved and redistributed.

## **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.*

COVID-19 vaccine administrations will be collected through a combination of Oklahoma State Immunization Information System (OSIIS), and the Vaccine Administration Management System (VAMS). Providers will be able to enter COVID vaccine administrations manually (through web interface) or through HL7 messaging in OSIIS. Providers who do not have an Electronic Health Record (EHR) and do not currently enter vaccine data into OSIIS will be able to use VAMS to document COVID administrations and the data shared back to the OSIIS system through the IZ Gateway.

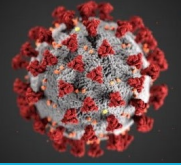
- B. Describe how your jurisdiction will submit COVID-19 vaccine administration data via the Immunization (IZ) Gateway.*

The current plan is to pull COVID administrations from OSIIS and VAMS and then send through the IZ Gateway to the CDC using HL7 messaging. Envision (OSIIS software vendor) is currently working with Oklahoma Immunization Staff to determine the best way to submit the data through the IZ Gateway.

A graphic depicting the state and federal vaccine information systems and their interoperability is provided in the appendix.

- 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.*





Providers will be trained on Enhanced OSIS and VAMS through in-person training, live and recorded webinars starting late October 2020. The training will include data elements required for COVID vaccine administrations and timeline for data submission.

- 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.*

All Pandemic providers, traditional and non-traditional, will be enrolled into Enhanced OSIS, which will give them the ability to document COVID vaccinations manually or through HL7 messaging. VAMS will also be utilized to help non-traditional providers (ex. nursing homes, long-term care facilities, satellite, temporary or off-site clinic settings) who do not currently have an EHR to document COVID vaccinations.

- 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.*

Data quality for COVID administrations will be monitored on a weekly basis through the various data quality reports available in Enhanced OSIS to assess completeness, timeliness, and accuracy of the data. Deduplication will occur on a daily basis to ensure unique records. Reports will be performed in SAS/Enhanced OSIS looking at provider submission numbers. Results of the above reports will then be relayed back to providers in order to improve data quality and ensure data submission is completed according to the required time interval.

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

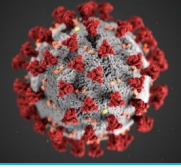
COVID vaccine reports will be generated through Enhanced OSIS and SAS software will be used to look at vaccine coverage, inventory, and administrations. These reports will be used to monitor vaccine inventory, administrations, vaccine coverage for high priority and high-risk groups to help ensure maximum COVID vaccine coverage of the Oklahoma population.

## **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.*

Providers will be trained to remind patients at the time of the 1<sup>st</sup> COVID-19 vaccine that a second dose is required and time interval. Each client will receive a shot record card after administration with information on the type of vaccine and due date for second vaccine. A reminder/recall report is being developed by Envision to allow for reminder/recall of COVID vaccine recipients. VAMS will also have recall and appointment capabilities that providers can utilize.



A statewide recall can be completed on a monthly basis utilizing OSIS and Docutech at OSDH.

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

### **Instructions:**

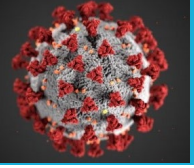
- A. Describe your jurisdiction's solution for documenting vaccine administration in temporary or high-volume vaccination settings (e.g., CDC mobile app, IIS or module that interfaces with the IIS, or other jurisdiction-based solution). Include planned contingencies for network outages or other access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

Providers will utilize VAMS, their EHR, or OSIS to document vaccine administration in temporary or high-volume vaccination settings. If the EHR is utilized, they will be required to be set up to send HL7 messages of the vaccine administration to OSIS. If network outages or other access issues arise we can utilize excel spread sheet/paper documentation with data entry occurring as soon as the outage or access issues are fixed. We may also be able to utilize roster uploads in VAMS.

- 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.*

Only age is required by our current system but OSIS can collect age/race/ethnicity/Employment Information. OSIS does not collect chronic medical conditions or membership in critical population groups. OSIS can capture the below list although we are discussing with other states and the vendor as how to collect Vaccination Complete.

# OSDH COVID-19 VACCINATION PLAN



Required Data Element*	Standard or Mass Vaccination
<i>Data elements required for IIS to report</i>	<i>Standard = IIS core data element Mass Vaccination = May require IIS enhancement</i>
Administrated at location: facility name/ID	Standard
Administered at location: type	Standard
Administration address (including county)	Standard
Administration date	Standard
CVX (Product)	Standard
Dose number	Standard
IIS Recipient ID	Standard
IIS vaccination event ID	Standard
Lot Number: Unit of Use	Standard
Lot Number: Unit of Sale	Standard
MVX (Manufacturer)	Standard
Recipient address*	Standard
Recipient date of birth	Standard
Recipient name*	Standard
Recipient sex	Standard
Sending organization	Standard
Vaccine administering provider suffix	Standard
Vaccine administering site (on the body)	Standard
Vaccine expiration date	Standard
Vaccine route of administration	Standard
Vaccination complete	Mass Vax

\*Identifiable Information

- 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.

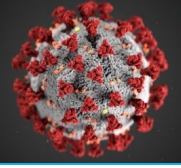
OSIIS is currently being migrated to a new software vendor, Envision. Once migration is completed providers and OSDH personnel will have access to enhanced capabilities that were previously unavailable. Go-live with the new system (Enhanced OSIIS) is planned for the first week of November 2020.

- 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.

Currently over 500 facilities have signed up to be pandemic providers in Oklahoma which includes traditional and non-traditional providers. Those facilities will be sorted by vaccine administration capability and organized into priority groups. Providers that are considered high priority will be enrolled into OSIIS first and then each successive priority group will be enrolled.

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

Currently Oklahoma has signed the Interjurisdictional MOU with AIRA allowing us to share data across jurisdictions and our legal team is currently assessing the APHL DUA. Once the DUA is signed, Oklahoma will be able to connect to the IZ Gateway.



**F. Describe the status of establishing:**

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

The Oklahoma legal team is currently assessing the APHL DUA.

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

Oklahoma has not received the CDC DUA but we are currently assessing the required elements sent by the CDC.

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

Oklahoma has signed the Interjurisdictional MOU with AIRA allowing us to share data across jurisdictions

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

Excel spread sheet or paper documentation will be used with data entry being completed as soon as internet connectivity is available or possible. If an EHR is utilized then prioritizing receiving HL7 messages from those clinics will be priority.

**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.**

Data quality for COVID administrations will be monitored on a weekly basis through the data quality reports available in Enhanced OSIS to assess completeness, timeliness, and accuracy of the data. Deduplication will occur on a daily bases to ensure unique records and reports will be performed in SAS and Enhanced OSIS looking at provider submission numbers. Results of the above reports will then be relayed back to providers in order to improve data quality.

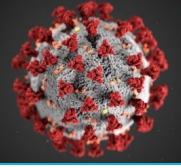
## Section 12: COVID-19 Vaccination Program Communication

**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.*

Oklahoma COVID-19 Vaccine Communications Strategy: Phase 1

In order to prepare for successful awareness of the COVID-19 vaccine and its distribution process, the agency is proposing a comprehensive communications strategy that will focus on addressing the first phase of vaccine distribution through the end of 2020. It's important to note that, while this plan focuses on this short-term phase, some of the overall proposed strategies will prevail throughout the vaccine's



expected distribution to the wider population in 2021. CDC communications tool kit is awaited at this time and will be used to draft messages and social media posts.

## GOAL

To create awareness and build trust for the COVID-19 vaccine and its importance for combatting the COVID-19 pandemic, as well as its effectiveness in preventing the disease for those who decide to receive it.

## Objectives

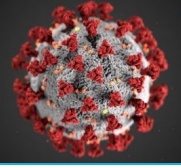
1. Create awareness of the first phase of distribution of the vaccine to phase 1 populations.
2. Develop an awareness and activation campaign that will provide Oklahomans within the Phase 1 priority list the information they need to make a decision about getting Vaccinated
3. Arm providers and partners across the state with key information that will allow them to inform and guide Oklahomans as they prepare to receive the vaccine

## Key Messages by Attitude Segment

- **Pre-Consideration:** Addressing those that are not considering getting vaccinated.
  - **Put people first, always.**
    1. Protect the front line first.
    2. Focus on phases, not tiers. While individuals within phase 1 will get priority for receiving the vaccine, we want to ensure that all Oklahomans understand that the focus on the phases is based on availability of the vaccine and vulnerability of the populations outlined within this phase. This isn't about valuing some people over others.
  - **Let's create a world without COVID-19.**
    1. Empower the citizens.
    2. Connects the vaccine to the world we all want.
- **Consideration:** Encouraging those actively considering getting vaccinated to act.
  - **Control COVID-19 in Your Community. Get Vaccinated Today.**
    1. Use autonomy & personal freedom to our advantage
  - **A Vaccine Puts You in Control**
    1. Use autonomy & personal freedom to our advantage
    2. Emphasize that a vaccine will create the Oklahoma we all want to enjoy
- **Action:** Providing logistical details of where to get vaccinated.
- **Maintenance:** Ensuring Oklahomans get their second dose.

## Dos & Don'ts

- Do



- Balance rational language (data, numbers, etc) with emotive language (healthy, free, control, etc.)
- Use a variety of spokespeople to help alleviate messenger bias (ideally spokespeople who citizens identify they trust through polling)
- Always include a place where people can find out the details
- Don't
  - Rely on images of needles / vaccine that scare people
  - Vague instructions
  - Data without context (causes more questions than insights)
  - You Must\_\_\_ (stay away from mandate language)
  - Normalize the pandemic or use clichés
  - Make anything other than COVID-19 the enemy (media, opposition, etc.)
  - Opposition messaging

Tone of Voice: How our messengers sound matters as much as what they are saying.

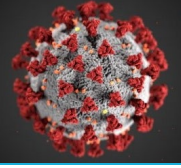
1. Informative but not academic
  1. Give numbers only when helpful
  2. Use data to support the narrative—not as a narrative substitute
2. Clear but not blunt
  1. Get to the point
3. Helpful but not condescending
4. Relevant but not narrow
5. Human but not casual

#### Key Spokespeople

- Gov. Stitt
- Dr. Lance Frye, Commissioner of Health, OSDH
- Dr. Bruce Dart, Tulsa Health Department
- Patrick McGough, Oklahoma City Health Department
- Local Regional Area Directors
- Vaccine and health care providers
- Partners / Ambassadors
  - OU / OSU
  - Tribal leadership
- Mayors of key cities across the state where first phase doses will likely arrive
- Vaccine advisory group
  - Oklahoma Medical Research Foundation (OMRF)
  - Infectious disease doc

#### Target Audiences (Phase 1)

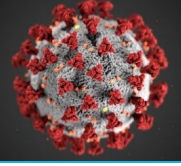
1. Individuals within the priority groups outlined in phase 1



1. Staff at Long Term Care Health/emergency workers
2. Frontline workers providing direct COVID-19 care
3. Residents and staff at managed care facilities
4. Minority individuals within phase 1 priority groups
2. County/local health departments
  1. County health departments
  2. Tulsa Health Department
  3. Oklahoma City County Health Department
3. Vaccine providers and partners
  1. Hospitals and other health organizations
  2. Managed care facilities
4. State leadership/partners
  1. State legislature
  2. Governor
  3. Federal delegation
  4. Tribal leadership

## Stakeholder Outreach

1. Grassroots
  1. Audiences:
    1. Vaccine providers across the state
    2. Phase 1 priority groups, including minority groups within this population
  2. Tactics:
    1. Virtual town halls introducing the vaccine featuring state experts who will be available to answer questions
    2. Internal communication efforts from facilities or organizations where individuals work or live about the vaccine
    3. Printed materials outlining vaccine process, benefits and safety (as available) for providers to give individuals receiving the vaccine
    4. Messaging and materials to reach minority groups in the appropriate language and meeting accessibility requirements
    5. PPE/mask distribution drive with branding/logo of vaccine campaign along with informational materials for vaccine that individuals could share with friends and family
    6. Given the large portion of phase 1 recipients being health care workers, emphasis on the science and confidence in the vaccine trial process will be critical
2. Leadership
  1. Audiences:
    1. Legislators
    2. State leadership
    3. Tribal leadership



## 2. Tactics:

- 1.Virtual (or in person, as needed) meetings with each audience group to outline the latest plans regarding vaccine distribution and other details prior to vaccine arrival.
- 2.Daily or weekly updates to each audience outlining progress being made in vaccine distribution, key statistics and other pertinent information
- 3.Talking points and other useful information for legislators to use as they communicate with constituents asking about the vaccine
- 4.Messaging for Governor's office, other state leadership, to communicate progress about the vaccine during ongoing COVID-19 briefing.

## Supporting Strategies

### 1. Messaging and branding

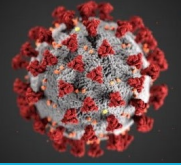
1. Development of key messaging matrix
2. Development of a logo and brand -- for use throughout all phases of vaccine distribution
3. Design
  - 1.Simplify type and color pallet
  - 2.Create clear message hierarchy
  - 3.Always have legibility
  - 4.Premade charts/graphs
  - 5.Don't show needles
  - 6.Use healthy non-mask imagery for promotion of vaccination
  - 7.If two shots use dualism in designs
4. Naming Options
  - 1.Our Best Shot

### 2. Work Together to Be Together

#### Media relations

1. Press conference on or close to Nov. 1 as first doses arrive in the state (or as an update if vaccine not ready/arrived)
  - 1.Media advisory
  - 2.News Release on phase 1 plan
2. Messaging materials
  - 1.Frequently asked questions
  - 2.Talking points
  - 3.Response matrix for social media
3. Statements regarding how Oklahoma is preparing for arrival and distribution of vaccine as questions start coming in from media
  - 1.So far we've seen questions from national media about overall plan, dry ice management and vaccine from Pfizer
  - 2.Manage messaging from the national perspective, following CDC's lead and monitor messaging coming from the White House





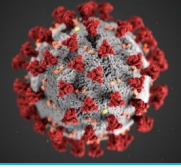
3. Develop template materials for sharing updates with media
4. Weekly briefing from OSDH featuring updates about the vaccine, trends and key takeaways. Note: This would be a topic within the standing weekly briefing to media contacts
3. Digital
  1. Develop a landing page dedicated to vaccine information to serve as a central hub of information
  2. Build vaccine-specific response guide for community management
  3. Use statistics and hard facts to back the narrative
  4. Employ social listening to track public perception of the vaccine rollout in Oklahoma and identify questions to be resolved, opportunities for engagement, and threats to address proactively
  5. Utilize shares or amplification of content from trusted sources like area doctors, the White House or the Governor when messaging aligns
  6. Create social media and email toolkits than can be used by grassroots partners to efficiently spread awareness and accurate information during vaccine rollout
4. Primary Research
  1. Survey of rural and other areas' attitudes toward the COVID-19 vaccine
    1. To be conducted this fall ahead of wider distribution in early 2021
  2. Questions about messaging resonance
  3. Questions about intent to get vaccinated for COVID-19
  4. Questions about attitudes toward vaccines in general
  5. Questions about trusted messengers

Oklahoma State Communications team will be working closely with the Oklahoma and Tulsa Health Departments, tribal PIOs, hospital associations to ensure messaging consistency, clarity and accuracy of information being shared from the CDC and the federal government through OSDH to the rest of the state. This is particularly important during phase 1 as anticipated distribution of the vaccine will be limited to a centralized entity (OSDH) directly to providers, due to limited availability of the vaccine. Providers in the Tulsa and Oklahoma City metro areas will likely receive available doses in this initial phase, so focus on consistency and bringing these departments in as partners from the beginning will prove successful in addressing the needs of local residents in our target audiences.

**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.*

The following are perceived risks associated with vaccine distribution and lack of awareness of the process for the remainder of 2020.

1. Perception that the vaccine production has been rushed



2. Perception that vaccine distribution at this point is politically motivated (think: 2020 presidential election)
3. Vaccine has been developed under an emergency process of approval (EUA)
4. Concern surrounding the limited supply of vaccine
5. Concern surrounding the groups that will receive the vaccine as a priority -- i.e. “why are only these folks receiving the vaccine and why is it not available to others who are at risk?”
6. Misalignment on timeline per CDC and vaccine providers/developers versus what the President is saying publicly
7. Confusion about vaccine process, especially between different brands of vaccines -- two doses needed and why it’s important to get both doses vs. others that may only require one dose
8. General skepticism about the need or effectiveness of vaccines

## Risk/Crisis/ Emergency Communication

Crisis and emergency risk communication (CERC) is the application of evidence-based principles to effectively communicate during emergencies. These principles are used by the JIC to provide information that helps people, stakeholders, and entire communities make the best possible decisions for themselves and their loved ones. CERC recognizes that during emergencies, we work under impossible time constraints and must accept the imperfect nature of our choices. CERC principles include:

- Be First
- Be Right
- Be Credible
- Express Empathy
- Show Respect

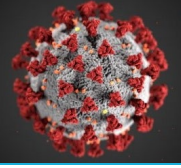
The JIC will disseminate messaging before, during, and after COVID-19 vaccine is available to help communities understand the importance of vaccination as well as the benefits and risks. Communicating what is currently known, regularly updating this information, and continuing dialogue with media and other partners throughout the vaccine distribution and administration process is essential to establish and maintain trust and credibility.

OSDH partners with key stakeholders who will offer additional support and resources to the COVID-19 vaccine program. During Phase 1, it will be critical for all stakeholders to be informed of the situation as it evolves to improve preparedness and coordination. Depending on urgency and subject, communication with stakeholders may be done over the phone, email or through routine or ad hoc reports.

## 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. 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.



Oklahoma State will train and share an informational presentation for enrolled COVID-19 vaccination providers which will include information about Emergency Use Authorization (EUA) and link to locate the EUA fact sheets online.

EUA and vaccine information statements (VISs) fact sheets (as applicable) for providers and vaccine recipients will be shared online and as hard copy.

All vaccine providers, public or private, are required by the National Vaccine Childhood Injury ((NCVIA 42 U.S.C. § 300aa-26) to give the appropriate VIS to the patient (or parent or legal representative) prior to every dose of specific vaccines. We will reinforce the need to share the EUA and VISs (as applicable) and the ways to share the VIS as below:

- Paper copies of the VIS can be printed and given to patients prior to vaccination.
- Permanent, laminated office copies may be given to patients to read prior to vaccination.
- Patients may view VISs on a computer monitor or other video display.
- Patients may read the VIS on their phone or other digital device by downloading the pdf file from CDC's website.
- Patients may be given a copy of a VIS during a prior visit, or told how to access it through the internet, so they can read it in advance. These patients must still be offered a copy to read during the immunization visit, as a reminder.

*Patients must still be offered a copy of the VIS to take away following the vaccination. The patient may decline.*

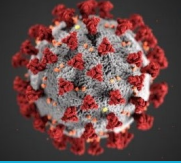
## Section 14: COVID-19 Vaccine Safety Monitoring

### **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).*

During Phase 1 of COVID-19 vaccine distribution, information on the importance of the Vaccine Safety Assessment for Essential Workers (V-SAFE) as a tool for ongoing safety surveillance will be shared with providers as a part of initial trainings. These trainings may be conducted in-person, or virtually, and will also cover storage and handling information, the Vaccine Information Statement, and the vaccine manufacturer's package insert. V-SAFE, will provide enhanced safety monitoring for COVID-19 vaccine for essential workers in early phase vaccination.

During all phases of COVID-19 vaccine distribution, providers will be advised to report to VAERS any adverse event that occurs after the administration of the vaccine. Information on VAERS will be shared during the training with the vaccine providers. They will receive VAERS brochures, in both English and Spanish, to distribute to those patients who receive COVID-19 vaccine in an effort to promote self-reporting of adverse events.



Oklahoma State Department of Health will continue with the 211 COVID-19 response Hotline, which was created on March 6, 2020. It has continued to be utilized by the public for general COVID-19 questions, as well as testing availability. The 2-1-1 helpline greeting is available in English and Spanish with the main menu instructing callers to “Press 8” for COVID-19. The COVID-19 Hotline will be updated to prompt specifically to monitor and respond to questions from those who receive COVID-19 vaccine. The Hotline is staffed by registered nurses, and both hours of operation and staffing may be adjusted to meet the demands of the public.

Immunization Service will create a COVID-19 vaccine “landing page” on its website to provide vaccine safety information, including VAERS, as well as other resources such as Frequently Asked Questions, and links to additional educational materials. It will also include the GIS/ARC map, which will direct the public to providers with COVID-19 vaccine once the vaccine becomes more widely available. This will be a primary point of communication sharing related to COVID-19 vaccine with the public, and this website will be included on COVID-19 vaccine guidance.

## Section 15: COVID-19 Vaccination Program Monitoring

### **Instructions:**

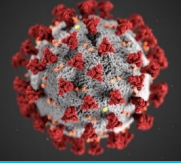
**A.** Describe your jurisdiction’s methods and procedures for monitoring progress in COVID-19 Vaccination Program implementation, including:

- Provider enrollment
- Access to COVID-19 vaccination services by population in all phases of implementation
- IIS or other designated system performance
- Data reporting to CDC
- Provider-level data reporting
- Vaccine ordering and distribution
- 1- and 2-dose COVID-19 vaccination coverage

The OSDH Immunization Service oversees enrollment, systems, reporting and monitoring of the COVID-19 vaccine rollout. The organization of the department ensures staffing roles and responsibilities are clear and designated to have knowledgeable people working in each area. The director of the Immunization Service has relationships with the CDC project liaison for ongoing, routine progress reports and technical assistance. Likewise, the director consults regularly and frequently with the Deputy Commissioner on programmatic and operational aspects of the program’s rollout and monitoring. The Deputy Commissioner in turn provides periodic and ad hoc updates to the Interim Commissioner, which are suitable for briefings to elected state officials as needed.

**B.** Describe your jurisdiction’s methods and procedures for monitoring resources, including:

- Budget
- Staffing



- *Supplies*

The OSDH finance and budget department will be monitoring the budget and providing regular reports to the planning team and CDC.

Immunization Service will use temporary and contract staff to fill in immediate needs. The COVID 19 Vaccine specialists will be supervised by the county health department staff.

The state will be checking with all providers if they received ancillary supplies and will supplement from our own warehouse. PPE will also be shared and monitored along with the vaccine.

**C.** *Describe your jurisdiction's methods and procedures for monitoring communication, including:*

- *Message delivery*
- *Reception of communication messages and materials among target audiences throughout jurisdiction*

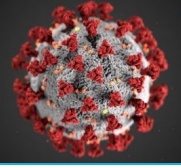
The OSDH, through use of the state email system, utilizes confirmation of successful message delivery through a variety of ways. The first, a recipient's reply to a message indicates success. The second, a read-receipt can be requested from the recipient. Third, the state email system generates a "message unsuccessful" alert when an inactive or incorrect email address is an intended recipient. In this instance, the sender checks the email address and verifies/corrects - or performs a warm reach out via phone call to secure the proper contact information. Distribution lists are maintained for all target audiences, and as updates/corrections are received, the master lists are updated.

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

The County Health Departments associated with OSDH have been providing situational awareness reporting for all COVID-19 response efforts through Teams Channels and spreadsheets. This includes daily testing numbers, school case monitoring, long term care testing project and Department of Corrections outbreaks and much more. The requirements concerning vaccine tracking, White House recommendations, reporting and recall of patients will allow for easier quantitative oversight, but to capture daily happenings related to vaccine, a spreadsheet tracking mechanism will be used. Tulsa and Oklahoma City health departments will be given access to those spreadsheets.

Two days per week, the regional administrative directors from all nine OSDH health districts gather on a morning briefing call at 0730 to receive briefings from the state, to provide local-level situational awareness on all things COVID and to organize response activities across the state.

Local health departments, including OCCHD and THD, have a number of modalities for use in urgent and emergency situations when communication is critical. Communication platforms may include but not limited to phones, office and mobile (to include SMS), 800 MHz radios, email, Situation Reports, web conferencing, call downs, and WebEOC. Any and all modes of communication can be used to gain real time updates and situational awareness from the field.



The COVID-19 Vaccine Planning Core Team will meet several times per week as operations begin, and they will continue to do so until operational tempo normalizes. The weekly vaccine planning meetings with the larger group of stakeholders will continue to proceed until they are not needed.

- E. Describe the COVID-19 Vaccination Program metrics (e.g., vaccination provider enrollment, doses distributed, doses administered, vaccination coverage), if any, that will be posted on your jurisdiction's public-facing website, including the exact web location of placement.*

Oklahoma will use a GIS map for planning of COVID 19 vaccine distribution and administration. Some components of the map will be shared with the public such as COVID Vaccine providers and locations and availability of clinics. Attention and consideration is being given to the level of information being made publicly available, as security of the vaccine at the recipient facility must be ensured.

## Appendix

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

Appendix A: Oklahoma COVID-19 Vaccine Plan Project Management Structure

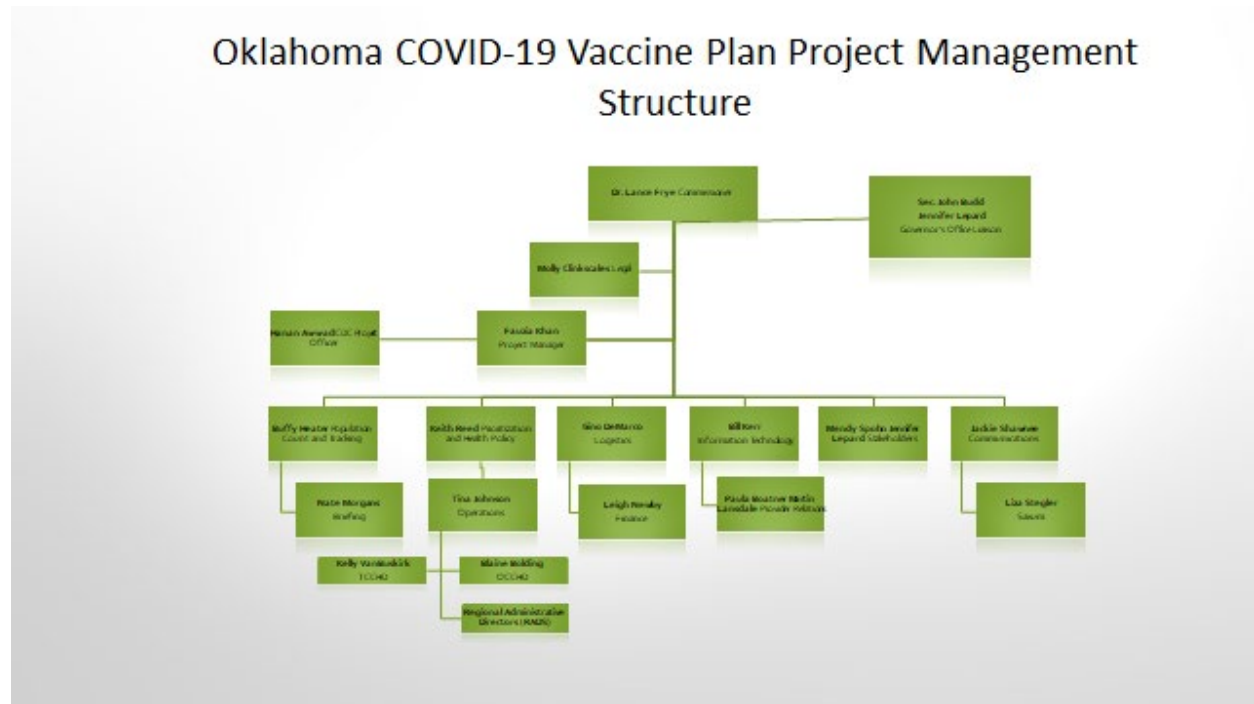
Appendix B: Oklahoma OMHHE Stakeholders

Appendix C: Stakeholders

Appendix D: OK Operation Warp Speed Immunization Software Integration Process

Appendix E: Vaccine Planning Graphic

## Appendix A: OK COVID-19 Vaccine Plan Project Management Structure



## Appendix B: Oklahoma Office of Minority Health and Health Equity Planning Stakeholders

OHCA Regional Strategy Forum; Dean of Student Affairs, Langston Univ; Oklahoma Legislature, Interim Study; Minister - Church of Christ, Guthrie, Ok; Regions VI, VII, VII Preparing for a Lifetime; Office of Primary Care; Office of Maternal and Child Health; Lend-A-Hand; Parent-Child Center; OBI; Conference for AA & Hispanics; Atty. Legal Aid Services; OKC Black Chamber; OKC Fire Dept; Variety Care; NAACP; OBI - Be The Match; Tulsa HD; Oklahoma City County Health Dept; Personal Health Services; Medical Facilities; The Education Employment Ministry (TEEM); Oklahoma Affordable Housing Coalition; University of Central Oklahoma, MSW; Academic Advisor, UCO; CPRSS; Home Care Assistance; Complete Care Home Health; OKC Black Chamber of Commerce

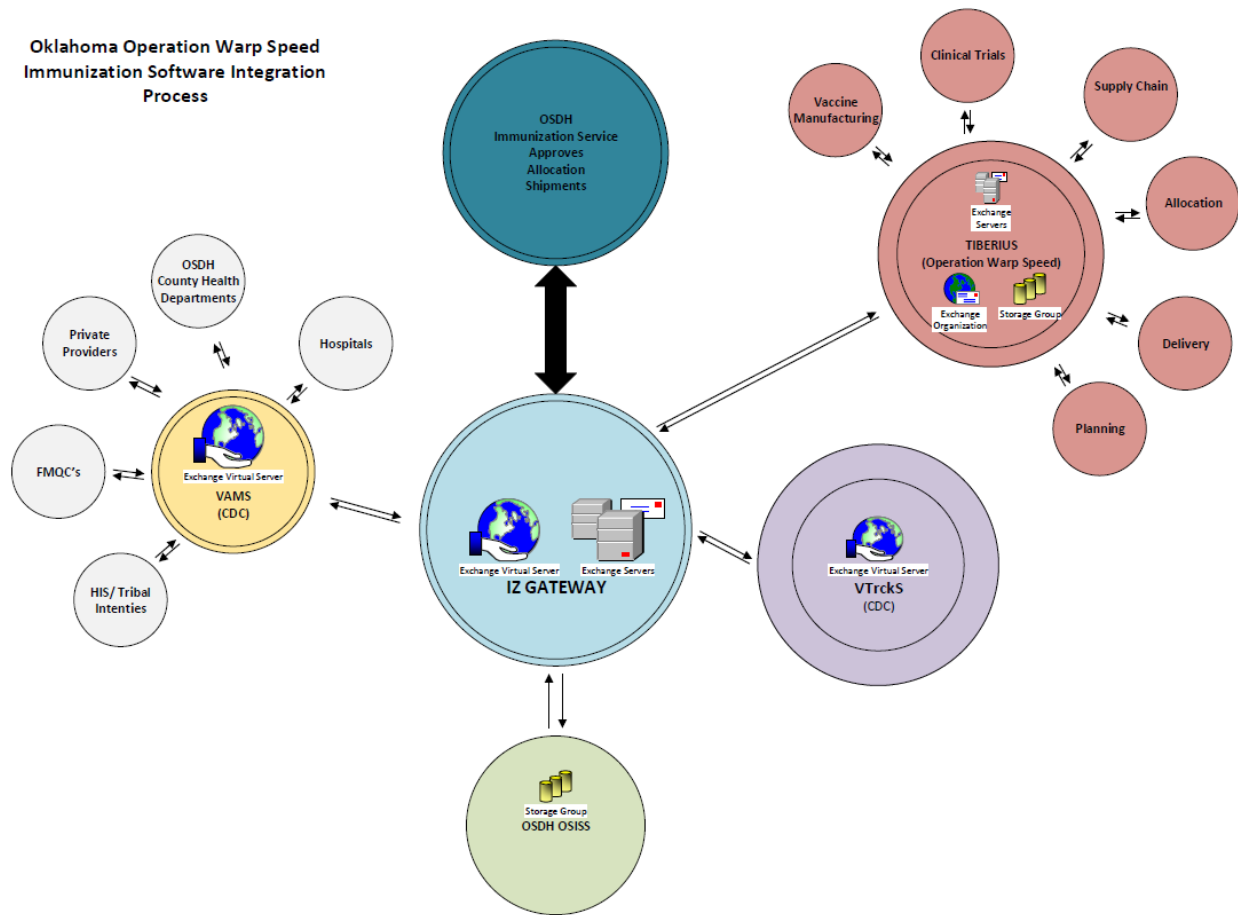


## Appendix C: Statewide Vaccine Planning Stakeholders

American Association of Retired Persons (AARP) Oklahoma
Care Providers of Oklahoma
Center for Disease Control (CDC)
Department of Corrections (DOC)
Federal Qualified Health Centers (FQHC)
Governor's Office
Indian Health Service (IHS)
Oklahoma City-County Health Department (OCCHD)
Oklahoma Commerce
Oklahoma Funeral Directors Association
Oklahoma Health Care Authority (OHCA)
Oklahoma Hospital Association (OHA)
Oklahoma Medical Research Foundation (OMRF)
Oklahoma National Guard
Oklahoma Osteopathic Association (OOA)
Oklahoma Pharmacists Association
Oklahoma State Department of Education (OSDE)
Oklahoma State Medical Association (OSMA)
Oklahoma State Regents for Higher Education (OSRHE) (esp dorm housing and medical)
Oklahoma Tourism
Pharmacies
Tribes
Tulsa Health Department (THD)
US Dept. of Health & Human Services (HHS)

# Appendix D: OK Operation Warp Speed Immunization Software Integration Process

Oklahoma Operation Warp Speed Immunization Software Integration Process



# Appendix E: Vaccine Planning Graphic

