

Indiana Guard Reserve Training Academy

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Memo #1

COVID Vaccine Distribution Training: Background

Planning for Distribution of COVID Vaccine in the event of IGR deployment to assist.

Distribution: From States To The Public

According to the planning guidance provided by HHS and the CDC for the 2009 H1N1 pandemic, each state, in coordination with local health departments, can recruit vaccine providers and sites to be pandemic vaccine providers. Providers willing to administer the vaccine enroll with state health departments and agree to requirements for receiving, storing, administering, and tracking vaccine administration. Depending on the governance structure of the state, enrolled providers will place orders for the pandemic vaccine with either the state or local health department's immunization program. The CDC provides each state a daily allocation of vaccine based on population, and states can prioritize and fill orders by the state or local immunization program against those allotments. Orders are then sent to the CDC, and vaccines will be shipped directly to the provider through a centralized vaccine distributor. For some critical workforce groups, states may consider coordinating separate vaccine clinics with employers. For example, hospitals or health systems may vaccinate their own workforce.

States may also choose to administer all or some of the vaccine through state-run vaccination sites. If so, they may use emergency mass dispensing as a model for distribution, for which extensive plans have been developed for other threats, such as anthrax. States can use a variety of methods to dispense the medication; they may elect to distribute vaccines directly to residents through state-administered PODs, or they may choose to pass the vaccine (and dispensing responsibility) through to local agencies and private sector partners. Strategies for vaccine dispensing generally fall into two models: "pull" and "push."

- **Pull models** allow the public to retrieve vaccines from PODs (e.g., drive-through clinics, clinics established at schools, and other areas).
- **Push models** require state and local officials to push the vaccine out to entities who are responsible for delivering the vaccine to specific populations.

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These methods can also be used in combination. Given the disproportionate burden of COVID-19 on communities of color, the elderly, and individuals in congregate care settings, "push models" into communities that may face barriers to vaccine access will be important to support equitable distribution for those most at-risk of harmful effects from the virus. When selecting a strategy,

states should consider operational capacity, the amount of vaccine available, available staff, and facility requirements for their jurisdictions. States should also coordinate with local partners, health care facilities, businesses, and other stakeholders to distribute the vaccine from the SNS to affected areas.

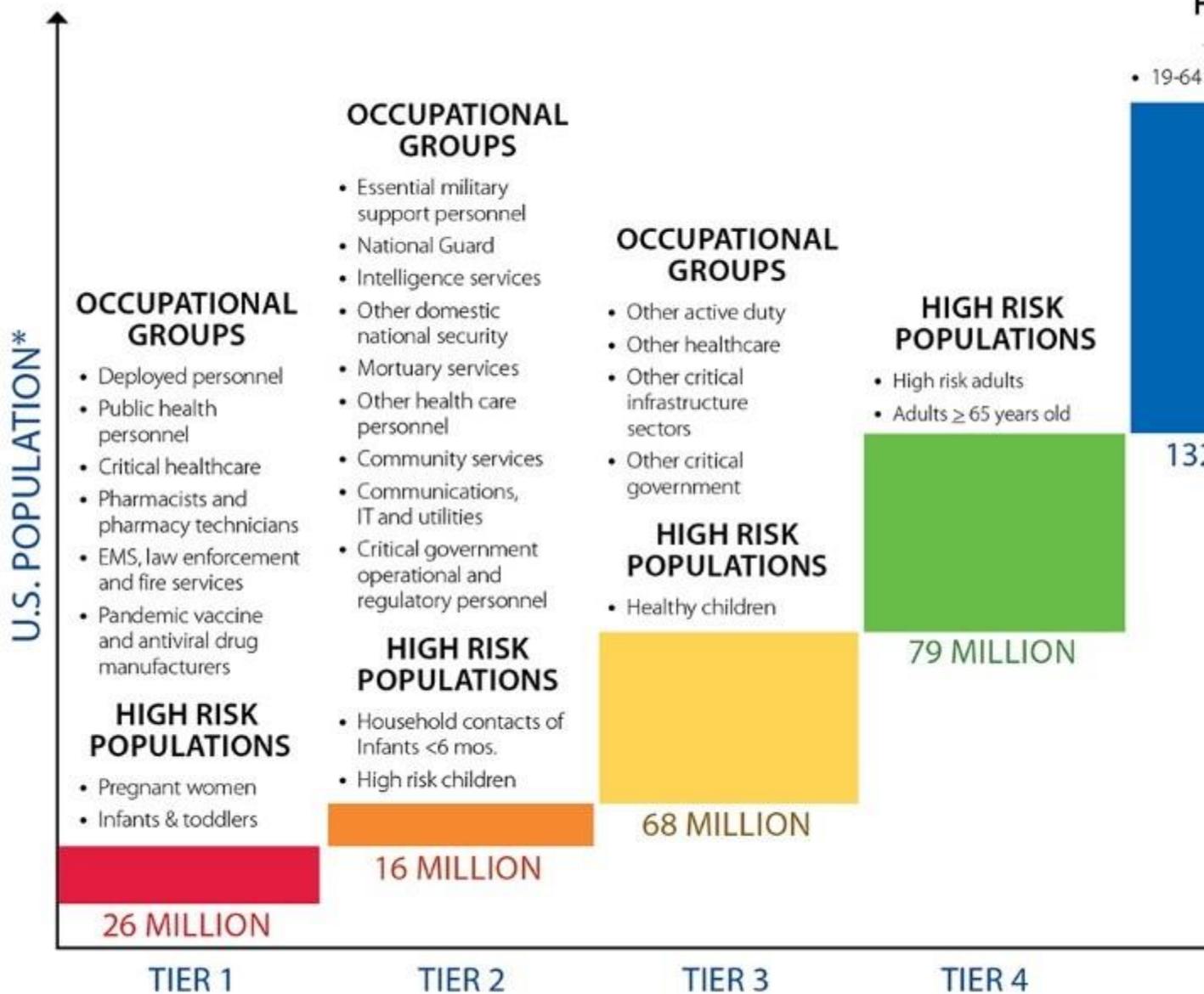
Prioritization Of Critical Populations

Initially, the availability of a vaccine is likely to be limited, due to manufacturing constraints. State leaders will need to make difficult decisions concerning vaccine allocation and prioritization. To most effectively and equitably allocate vaccines, state leaders should develop prioritization schedules based on CDC guidelines, disease burden, and vaccine supply.

According to HHS, a tiered approach for vaccine distribution will be utilized. The methodology for the allocation of the vaccine will build upon guidance developed as part of pandemic flu planning. The method will be adjusted based on “experience during the first wave of the COVID-19 response, data on the virus and its impact on populations and the performance of each vaccine, and the needs of the essential workforce.” CDC’s established General Principles and Interim Guidance on Pandemic Vaccination provides the general framework for how a limited vaccine should be targeted, using the following objectives:

1. Maintenance of homeland and national security,
2. Provision of health care and community support services,
3. Maintenance of critical infrastructure, and
4. Protection of the general population.

For a severe pandemic, CDC uses these priorities to establish five “tiers” of vaccination prioritization:



As previously mentioned, HHS will be adjusting this guidance to account for COVID-19-specific considerations. Generally, states are encouraged to follow national guidance to ensure fairness and uniformity across the U.S. and minimize confusion; however, within the parameters of the guidance, states will have the authority to distribute the vaccine to meet the specific needs of their populations. The unequal impact from the pandemic, as well as relative availability of vaccines, will cause rates of absenteeism to fluctuate between states, and the continuity of essential products and services will likely vary. Therefore, groups identified for earlier vaccination may differ between states. Additionally, state leaders, in coordination with local health authorities, will also play a role in determining when to begin offering vaccines to persons outside the initial target groups, a decision made based on local situations.

Previous Planning Efforts And Lessons Learned

States and the federal government have engaged in planning for mass distribution of pharmaceuticals before the advent of COVID-19. Every year, the seasonal influenza (flu) vaccine is manufactured and distributed for public consumption, with a national uptake rate of 45.3 percent of adults and 62.2 percent of children for the 2018-2019 season. In 2009-2010, the H1N1 influenza virus required the development and distribution of vaccines at a national scale, and state experiences during that epidemic may provide useful guidance for developing their COVID-19 vaccine strategy. Similarly, governors may consider borrowing concepts from plans developed for the distribution of *Bacillus Anthracis* (Anthrax) countermeasures.

H1N1 Influenza

In 2009, the H1N1 influenza uncovered operational and policy challenges across the federal government with regard to the distribution of vaccines. Similar to COVID-19, H1N1 was novel, with the majority of the U.S. population lacking immunity to the virus, and an understanding of its virulence was unknown. The H1N1 vaccine was initially available in the United States in October 2009, almost four months after the World Health Organization's (WHO) pandemic declaration, but did not become more broadly available until late December 2009. By this time, the peak of H1N1 influenza activity had passed, and many individuals were no longer as interested in getting vaccinated. The credibility of all levels of government was diminished when the amount of vaccine available to the public in October 2009 did not meet expectations set by federal officials. Vaccine distribution was delegated to state and local jurisdictions, which were provided flexibility in deciding the best methods for distribution. For this vaccine, the federal government extended its contract with the centralized distributor responsible for public-sector purchased adult and pediatric vaccines, as well as those distributed through the Vaccines for Children Program. The distributor (McKesson) required a 100-dose minimum order and many states were forced to break down and repackage the vaccine to efficiently serve smaller vaccination sites, such as nursing homes, rural doctors' offices, and schools. H1N1 also underscored the importance for state leaders to have well-defined, initial target groups for vaccination, and that this prioritization is communicated to both the public and public health authorities.

Bacillus Anthracis (Anthrax)

State preparedness efforts for anthrax attacks may provide additional frameworks that governors can consider leveraging in their COVID-19 vaccine planning. The mass prophylaxis protocols for anthrax provide models of government-led vaccination targeted at rapidly protecting large segments of the population. States have planned to receive countermeasures directly and then dispensed to the public, either directly to Points of Dispensing (PODs) or through intermediate receiving, staging, and storage (RSS) centers, which may be operated by state, county, or local agencies. PODs can be administered by both public and private sector agencies and may provide useful models for the distribution of vaccines.

Addressing Vaccine Hesitancy and Misinformation Although vaccines are widely understood as safe and effective public health interventions, increasing numbers of individuals are delaying or

refusing vaccinations. “Vaccine hesitancy” has been used to describe a spectrum of attitudes toward vaccines ranging from skepticism to refusal and denial. While the reasons for rising levels of vaccine hesitancy are complex, experts have cited reduced fear of infectious diseases; distrust in government, science, and the medical community; the advent of “natural products”; challenges in effectively communicating scientific information to parents; and the spread of misinformation about vaccine safety. Vaccine refusal has contributed to low levels of vaccination in certain communities, leaving them vulnerable to outbreaks of vaccine-preventable diseases. In 2019, vaccine hesitancy was declared a “top threat to global health” by the World Health Organization.

The challenges of promoting vaccine confidence may be heightened in the context of a novel COVID-19 vaccine expedited through the FDA testing and approval process and deployed on a large scale. Recent polling indicates that only half of Americans reported that they intended to get a COVID-19 vaccine, with 31 percent reporting that they were not sure if they would get vaccinated and 20 percent saying that they will refuse. Likewise, numerous studies have pointed to the central role of digital and social media in organizing and advancing anti-vaccine misinformation, which is likely to accelerate as entities such as schools and health care systems move to require the vaccine. Recent research mapping pro-and anti-vaccine communities on Facebook indicates that, while anti-vaccine communities were smaller, anti-vaccine information pages were faster-growing and less insular, using campaign-style tactics to reach other communities who may be receptive to anti-vaccine narratives. The study’s authors conclude that these views may dominate in a decade absent new policy approaches to interrupt this shift toward negative views of vaccines. Anti-vaccine misinformation is also often targeted at insular communities that may have a historical distrust of government or medical institutions.

Given these dynamics, planning for mass distribution of the COVID-19 vaccine should include multifaceted communications strategies that address a range of attitudes and knowledge regarding vaccines. States should also consider strategies to proactively address vaccine hesitancy and misinformation campaigns that may fuel distrust and refusal, particularly within at-risk and underserved communities.