

# COVID-19 Vaccine Prioritization Guidance and Allocation Framework



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**Publication Number**

820-112

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# CONTENTS

- Executive Summary..... 2
- Introduction ..... 5
- COVID-19 and Health Equity Considerations..... 6
- Guidance Development Process..... 10
- Engagement Findings..... 12
- Equitable Framework Overview ..... 18
- Applying the Framework for Equitable Allocation..... 20
- Allocation Guidance within Each Phase..... 21
- Coordination Overview ..... 32
- Appendices..... 35

## RECORD OF CHANGES

### Date of Original Version:

CHANGE NUMBER	DATE OF CHANGE	DESCRIPTION OF CHANGE
1	1/18/2021	<ul style="list-style-type: none"><li>• Changed 1b tier 1 to age 65 and up instead of age 70 and up.</li><li>• Clarified language based on public feedback</li><li>• Proofreading edits</li></ul>
2	1/20/2021	<ul style="list-style-type: none"><li>• Proofreading edits</li></ul>
3	3/4/2021	Added phase eligibility timing
4	3/4/2021	Changes to Phase 1A: Added definition of eligible caregiver
5	3/4/2021	Changes to Phase 1B tier 1: Added pre-kindergarten-12 <sup>th</sup> grade and child care workers as eligible
6	3/4/2021	Changes to Phase 1B tier 2: <ul style="list-style-type: none"><li>• Added people who are pregnant and people with a disability that puts them at high risk as eligible</li><li>• Removed age range for qualifying worker eligibility (moving workers age 16-49 from tier 4)</li></ul>
8	3/4/2021	Added vaccine equity strategies to Community Engagement and Communication section.
9	3/4/2021	Added potential plan to segment Phase 1B tier 3 by age
10	3/4/2021	Added link to COVID-19 data dashboard and resources
11	3/17/2021	Updated phase descriptions and some dates
12	3/19/2021	Updated phase descriptions
13	3/24/2021	Updated Phase 1b tier 2 description
14	3/31/2021	Updated description and date of Phases 2 and 3
15	4/15/2021	Updated dates for final phases
16	1/10/2022	Proofreading and organizational edits

## EXECUTIVE SUMMARY

We are committed to providing a coronavirus vaccine to anyone who wants one in Washington state. Due to a limited supply, we initially did not have enough to offer vaccines to everyone. We had to make tough decisions about who got the vaccine first. This is called vaccine allocation and prioritization. This document shares the Washington State Department of Health's (DOH) guidance on this process, which is based on:

- Vaccine supply and uptake
- New information from clinical trials and local data
- New federal guidance and vaccine recommendations
- Ongoing feedback from impacted communities, partners, sectors, and industries

### Our Commitment

DOH is committed to safe and effective vaccines, transparent decision, and equitable vaccine allocation.

1. We will only distribute vaccines that are shown to be safe and effective in clinical trials and will be transparent in sharing information on what is known about the benefits and risks.
2. We will only distribute the vaccine to groups for whom the vaccine is approved or recommended.
3. We will prioritize people, communities, and groups that are at higher risk for COVID-19 following the Advisory Committee on Immunization Practices (ACIP) recommendations.
4. We hear the concerns of our communities.

### Framework Process Overview

We consulted COVID-19 experts and engaged communities who have been disproportionately impacted by COVID-19 including communities of color, refugees, immigrants, farmworkers, people with disabilities, people experiencing homelessness, and people with underlying health conditions. We conducted 90 interviews and focus groups with 568 people across the state and received 18,000 responses to a survey available in multiple languages. In commitment to our Government-to-Government relationship with Tribal Nations, we have a separate and specific plan for engaging Tribal Nations and American Indian/Alaska Native communities.

### Community Engagement Findings

The following themes emerged across all engagement efforts. Please visit the [COVID-19 Vaccine Engagement webpage](#) for more information and the full report.

#### ***Understanding COVID-19 Risks***

1. Older adults are at risk due to their work, where they live, family gatherings, or cultural shared spaces
2. Those who face barriers to health care or quality health care are at risk
3. People with underlying health conditions are at risk
4. People who live in congregate living situations or in multi-generational homes are at higher risk
5. People who are exposed to others in workplaces where proper protocols are not taken are at greater risk

#### ***Disproportionate impacts: Many interconnected layers***

1. COVID-19 affects many individuals within families and between families
2. Impacts reach people in their homes
3. Impacts happen in the workplace.

4. The social safety net is necessary to catch people but it too is damaged by COVID-19.
5. The wellness of low-income people and POC is fragile; the fragility is further exacerbated by COVID-19.
6. COVID-19 requires health resources that are not easily accessible to many communities.

### ***COVID-19 prevention***

1. COVID-19 preventive behaviors are difficult to follow without adequate support and enforcement.

### ***Misinformation and Distrust***

1. Historical trauma and mistrust of government and health care entities have led to vaccine hesitancy.
2. Community trust is impacted by misinformation on how the government manages COVID-19 vaccine.
3. Many people rely on digital media for information, regardless of whether the sources are accurate.
4. There are a lot of conspiracy theories and misinformation regarding the COVID 19 vaccine.
5. Those who are unable to access timely, accurate information or only see misinformation and disinformation are at risk.

### ***Fears about the vaccine: safety, development, efficacy, logistics***

1. There are many concerns and fears about the COVID-19 vaccine.
2. The most-cited fears cluster around safety and efficacy.
3. Concerns about the process of development, the quality/rigor of the science, and the challenges of conquering a mutating virus form the foundation of many fears.
4. Fears are exacerbated by a perceived lack of transparency, lingering questions, and silencing of scientists.

### ***Vaccine prioritization***

1. There is support for prioritizing high-risk workers in health care settings, but we also need to intentionally define a high-risk role or environment.
2. Prioritization for key groups including farmworkers, elders, people with disabilities, and communities of color should be stronger.
3. Many essential service sectors feel left out and under-prioritized.
4. There is overall support for the National Academies of Medicine Equitable COVID-19 Allocation Framework's principles, criteria, and equity considerations.

### ***Motivation to get the vaccine***

1. Vaccination is essential to help reopen the economy and protect people from death and serious disease.
2. Social, emotional, and mental health benefits of getting vaccinated are motivators for vaccine acceptance.

### ***Communications, engagement, and outreach activities***

1. Community engagement should start early and be led by trusted members in the community.
2. People want culturally and linguistically appropriate information.
3. Communities trust people/organizations that look like them and have a reputation for community care.
4. Public leaders, scientists, and institutions should speak directly, clearly, and apolitically.
5. Consider the access and format needs of community members for all COVID-19 communications.
6. Ensure all public health, health care, and vaccine providers have the same communications resources.
7. Transparency and building trust should be a central goal of communication efforts.

### ***Equitable distribution***

1. Common health care access barriers experienced by vulnerable communities should be proactively addressed; the same barriers will impact vaccine access.

2. Multi-dose series and cold-storage requirements may create challenges in serving some communities.
3. Vaccine clinics should be set up in places that are safe, familiar, and accessible.

We incorporated the input of these experts and community partners into our guidance and the framework. As phases were finalized and implemented, we continued an inclusive, transparent, fair, and evidence-based process.

## COVID-19 Vaccine Equitable Allocation Framework

We developed our framework using a review of existing evidence and research, and extensive feedback from disproportionately impacted communities, groups, and partners.

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

### ETHICAL PRINCIPLES

- Maximum benefit
- Equal concern
- Mitigation of health inequities

### PROCEDURAL PRINCIPLES

- Fairness
- Transparency
- Evidence-based

### CRITERIA

- Risk of acquiring infection
- Risk of severe morbidity and mortality
- Risk of negative societal impact
- Risk of transmitting infection to others

## WA State Equitable Allocation & Prioritization Framework

PHASE 1A	PHASE 2 & 3	PHASE 4
<p><b>TIER 1</b></p> <ul style="list-style-type: none"> <li>• High-risk workers in health care settings</li> <li>• High-risk first responders</li> <li>• Long-term care facility residents</li> </ul> <p><b>TIER 2</b></p> <ul style="list-style-type: none"> <li>• All other workers at risk in health care settings</li> </ul>	<ul style="list-style-type: none"> <li>• All people 16 years and older</li> </ul>	<ul style="list-style-type: none"> <li>• People under age 16 years of age (based on clinical trial data, federal guidance, and vaccine supply)</li> </ul>
<div style="background-color: #1a522d; color: white; padding: 5px; text-align: center;"><b>PHASE 1B</b></div>		
<p><b>TIER 1</b></p> <ul style="list-style-type: none"> <li>• All people 65 years and older</li> <li>• People 50 years and older living in multigenerational households</li> <li>• Workers in childcare settings</li> <li>• Pre-K-12 educators and school staff</li> </ul> <p><b>TIER 2</b></p> <ul style="list-style-type: none"> <li>• High-risk critical workers who work in certain congregate settings:               <ul style="list-style-type: none"> <li>• Agriculture; food processing; grocery stores; corrections, prisons, jails, or detention facilities; public transit; fire, law, social workers and other first responders</li> </ul> </li> <li>• People who are pregnant</li> <li>• People with a disability that puts them at high risk</li> </ul> <p><b>TIER 3</b></p> <ul style="list-style-type: none"> <li>• People 16 years and older with 2 or more comorbidities or underlying conditions</li> <li>• All people 60 years and older</li> </ul> <p><b>TIER 4</b></p> <ul style="list-style-type: none"> <li>• People, staff, and volunteers in congregate living settings:               <ul style="list-style-type: none"> <li>• Correctional facilities; group homes for people with disabilities; congregate settings for people experiencing homelessness that live in or access service in such settings</li> </ul> </li> <li>• Other critical workers in certain congregate settings: restaurants/food services; manufacturing; construction</li> </ul>	<p style="text-align: center;"><b>EQUITY IS A CROSS-CUTTING FOCUS</b></p> <p>Certain population groups have been prioritized with an aim to mitigate health inequities recognizing that specific populations are disproportionately impacted by COVID-19 due to external social factors and systemic inequities. Examples of populations disproportionately affected due to such factors include:</p> <ul style="list-style-type: none"> <li>• People of color</li> <li>• People with limited English proficiency</li> <li>• People in shared housing, crowded housing, and multi-generational homes</li> <li>• People in poverty and low-wage earners</li> <li>• People with disabilities that are connected to underlying health conditions that may put a person at higher risk for COVID-19</li> <li>• People with access barriers to healthcare</li> </ul> <p>Washington State has also developed a <a href="#">social vulnerability index</a> which includes social determinants of health factors to identify highest vulnerability areas. This will be one of several inputs informing vaccine allocation decisions to ensure equitable allocation.</p> <p><b>NOTE</b> Immigration status and health insurance status do not impact an individual's eligibility.</p> <p style="text-align: right; font-size: small;">Update March 31, 2021</p>	

## Implementation & Conclusion

Our guidance and framework exist to facilitate a smooth, safe, equitable, and effective vaccine distribution process across Washington state. We will continue to coordinate with the federal government, providers, partners, and community organizations and update the guidance and framework as needed. For up-to-date information about the COVID-19 vaccine, visit [www.CovidVaccineWA.org](http://www.CovidVaccineWA.org).

## INTRODUCTION

COVID-19 vaccines are a critical tool to help us reduce the burden of COVID-19 disease in Washington state. The Washington State Department of Health (DOH) is committed to safe, equitable, and effective application of the vaccine and other tools. Initial federal guidance indicated that we would have a limited supply of any vaccine deemed safe and efficacious enough for distribution. As a result, DOH began developing a framework for the prioritization and allocation of the vaccine. This document explains the development process and outlines our guidance and framework for equitable vaccine allocation to all eligible populations in Washington state.

DOH started with the [National Academy of Science, Engineering and Medicine's Equitable Allocation for COVID-19 Vaccine](#) as a framework to gather input. Next we engaged communities, groups, partners, and workers in sectors most disproportionately impacted by and concerned about COVID-19. The outreach therefore included communities facing underlying systemic factors like racism and other forms of oppression.

Our COVID-19 Vaccine Prioritization Guidance and Allocation Framework was updated and adapted over time. The guidance was reviewed and occasionally updated as a result of:

- More comprehensive and formal engagement with Tribal Nations and American Indian/Alaska Native communities
- Recommendation changes from the Centers for Disease Control and Prevention (CDC) and their Advisory Committee on Immunization Practices (ACIP), or from the Western States Scientific Safety Review Workgroup
- Local information regarding transmission, changes in the epidemic, and/or changes in the socio-economic context related to reopening plans
- More information released about vaccines, such as:
  - Safety and effectiveness of the vaccines
  - Type of vaccine, dosing, storage, and administration requirements
  - Number of doses available
  - Availability of new COVID-19 vaccines
  - Changes to vaccine recommendations or approval status.

## Our Commitment

The Department of Health is committed to safety, transparency, and equity in our vaccine allocation and prioritization. We assure you:

1. **We will only distribute vaccines that are shown to be safe and effective in clinical trials**, and will be transparent in sharing information on what is known about the benefits and risks. Washington has joined four other states (California, Nevada, Oregon, and Colorado) to conduct an independent review of the safety and efficacy of any vaccine authorized or approved by the Food and Drug Administration (FDA) for distribution.
2. **We will only distribute the vaccine to groups for whom the vaccine is authorized or recommended.** Clinical trials tell us for which populations groups the vaccine is demonstrated to be safe and effective.
3. **We will prioritize people, communities, and groups that are at higher risk for COVID-19 following the Advisory Committee on Immunization Practices (ACIP) recommendations.** We recognize this pandemic has not impacted communities equally, and that there are inequities in what protective resources communities have access to, like personal protective equipment. We will lead with equity in our prioritization.

4. **We hear the concerns of our communities.** We will provide transparent, timely, and accessible information so communities can make informed decisions about their health.

## Tribal Nations and American Indian/Alaska Native Engagement Plan

We honor the sovereignty and treaty rights of tribes, and we are committed to upholding our responsibilities described in Chapter 43.376 RCW (Government-to-Government Relationships) and engaging tribes and Indian Health Care Providers through established channels.

The DOH Tribal Relations Director organized a Tribal Roundtable on October 27, 2020, which provided an initial opportunity for the COVID-19 vaccine planning team to share progress updates and ask for input on how to engage tribes and Urban Indian Health Programs on COVID-19 vaccine topics and decisions moving forward. The COVID-19 vaccine planning team will continue using our established channels to collaborate and consult with Tribal Nations and engage Urban Indian Health Programs. This includes additional tribal roundtables and attending DOH/HCA Monthly Tribal Meetings to share information and continue COVID-19 vaccine related discussions. In addition, the COVID-19 vaccine engagement team will work closely with the DOH Tribal Relations Director to plan and carry out culturally appropriate engagement with tribal organizations and urban Indian organizations.

## COVID-19 AND HEALTH EQUITY CONSIDERATIONS

The COVID-19 pandemic has shed light on existing health inequities, amplified them, and revealed their root causes. The inequities in cases, hospitalizations, and deaths, among other telling metrics, are the result of broader societal and structural factors like racism and other forms of oppression. These structural factors result in differential access to resources, services, and opportunities like access to health care.

Inequities experienced by individuals can be exacerbated or alleviated by their intersecting identities. For example, recent research has shown that nurses of color are more likely to die from COVID-19 than their white counterparts. While occupation data are not available for all COVID-19 deaths, [available data](#) showed that registered nurses accounted for 30 percent of COVID-related deaths among health care workers nationally. Approximately 24 percent of registered nurses in the United States are individuals of color, but people of color accounted for 58 percent of deaths from COVID-19 among registered nurses. By comparison, 75 percent of registered nurses are white and accounted for 40 percent of deaths. [Another study](#) showed more broadly that health care providers with COVID-19 who died tended to be older, male, Asian, Black, and have an underlying medical condition when compared with health care providers with COVID-19 who did not die.

This section highlights and explains these disparities as well as how they guided our value of **Equity as a Cross-Cutting Focus** in creating the phased plan.

### Disparities in Cases, Hospitalizations, and Deaths

There are stark differences in COVID-19 cases, hospitalizations, and deaths for certain communities. The disparities we see in exposure and illness affect many of the same historically marginalized groups that experience other health inequities. This is true at both the state and national level (see **Appendix A** for key national data on the impact of COVID-19 on certain populations from the National Academies). There are other communities that experience inequities related to COVID-19 that are not well captured in our data systems, for example people with disabilities. Additionally, a lack of disaggregation for large groups, for example by race/ethnicity, can mask differences in outcomes at a sub-population level.

Other Department of Health reports further detail the disparities that appear within currently available data. The Department of Health acknowledges these limitations and is actively working to promote data equity and address the systemic and technical challenges to more representative data collection systems. Some sources are:

- [COVID-19 morbidity and mortality by race, ethnicity and spoken language in Washington state report](#)
- [COVID-19 Confirmed Cases by Industry Sector](#)
- [Washington state COVID-19 data dashboard](#)

The following data are provided by the Washington State Department of Health.

The subsequent data were compiled at the initial writing of this guidance document and these data are updated regularly on the DOH Data Dashboard, Summary Data Tables, and Data Reports. Please view our [COVID-19 data dashboard](#) for up-to-date rates, hospitalizations, deaths, and vaccination rates.

### Confirmed Case Rates

In terms of age-adjusted confirmed or probable COVID-19 case rates:

- Native Hawaiian and Other Pacific Islander (NHOPI) and Hispanic populations have the highest rates, while white and Asian people have the lowest.
- NHOPI and Hispanic populations have rates approximately five times higher than Asian and white populations.
- Black populations have rates approximately two times higher than Asian and white populations.
- American Indian/Alaska Native people account for 2 percent of COVID-19 cases but only 1 percent of the total population.

Table 4. Percentages of confirmed COVID-19 cases hospitalized by primary language spoken

Language	Cases	Hospitalizations	Percent language specific hospitalizations
English	72,584	4,342	6%
Spanish	18,305	1,042	5.7%
Marshallese	311	48	15.4%
Vietnamese	526	53	10.1%
Russian	789	149	18.9%
Chinese (all)	140	24	17.1%
Ukrainian	201	54	26.9%
Somali	242	15	6.2%
Tagalog	100	22	22%
Amharic	108	12	11.1%
Other	1,348	160	11.9%

Employment data also show disparities in COVID-19 cases among certain industries. In a report published on November 10, 2020, lab-confirmed cases of COVID-19 among residents reported through 11:59 PM on September 13, 2020 showed:

- People in the **health care and social assistance** industry sector account for 25 percent of COVID-19 cases even though only 13 percent of Washington’s employed population is employed in this sector.
- People in the **agriculture, forestry, fishing and hunting** industry sector account for 11 percent of COVID-19 cases even though only 3 percent of Washington’s employed population is employed in this sector.

## Hospitalization Rates among Confirmed Cases

Among confirmed or probable COVID-19 cases:

- Native Hawaiian and Other Pacific Islander (NHOPI) populations have the highest hospitalization rates and white populations have the lowest. NHOPI hospitalization rates are 11 times higher than white populations.
- Hispanic populations have hospitalization rates six times higher than white populations.
- Black and American Indian and Alaska Native populations have hospitalization rates that are three times higher than whites.
- Certain language groups have hospitalization rates that suggest increased exposures and/or barriers to care may contribute to more severe disease. (See **Table 4.**)
- American Indian and Alaska Native people account for 2 percent of COVID-19 hospitalizations but only 1 percent of the total population.

## Death Rates among Confirmed Cases

Among confirmed COVID-19 cases:

- White populations have the lowest death rates of all racial/ethnic groups when stratified by age.
- Native Hawaiian and Other Pacific Islander populations have death rates six times higher than whites.
- American Indian and Alaska Native (AI/AN) and Hispanic populations have death rates four times higher than whites.
- Black populations have death rates about twice as high as white populations.
- AI/AN people account for 3 percent of total COVID-19 deaths but only 1 percent of the population.

## Causes of Health Inequities in COVID-19 Health Outcomes

Adverse health outcomes from COVID-19 arise from the virus itself, and from the unintended consequences of Washington state government mandates and initiatives to contain it. Again, these impacts are felt most by those who are historically and currently marginalized.

### Access Barriers

Many communities experience barriers to accessing critical health information and services due to race/ethnicity, language, culture, nationality, immigration status, or disability status. In addition, structural, institutional, financial, social, cultural, and sociodemographic factors impact their access both now and historically.

Types of access barriers include:

- **Economic barriers** such as insurance status and cost of care.
- **Structural barriers** such as limited or no transportation; work, school, or child care limiting someone’s time and availability; lack of culturally and linguistically appropriate services; inaccessible clinic environment and conditions; lack of access to broadband.
- **Social barriers** include differential treatment by providers; experience of discrimination; health literacy; and historical trauma.

## Employment Conditions

Many employment-related factors impact the health of workers. Certain workers may face increased risk of exposure to COVID-19, lost jobs or income due to COVID-19 restrictions, or workplaces where they are unable to socially distance or are not given personal protective equipment.

**EXAMPLE** Low-income workers are less likely to be able to socially distance while at work or to work remotely. People of color are more often working jobs that are not amenable to teleworking and they more often use public transportation that puts them at risk for exposure to COVID-19. In addition, people of color are more likely to work in service industries, such as restaurants, retail, and hospitality, which puts them at higher risk for loss of income during the pandemic. (SAMHSA, 2020; Benfer, E. & Wiley, L., 2020; and Artiga, S., Garfield, R., & Orgera, K., 2020).

## Housing

Individuals experiencing homelessness and individuals living in shared or transitional housing are at increased risk for COVID-19 exposure. In addition, stay-at-home orders or other COVID-19 response initiatives have unintended consequences on the health and well-being of survivors of domestic violence.

**EXAMPLE** People of color are more likely to live in multigenerational family co-housing and low-income and public housing. These situations make it difficult to social distance, quarantine, or self-isolate (SAMHSA, 2020; Benfer, E. & Wiley, L., 2020; and Artiga, S., Garfield, R., & Orgera, K., 2020). Also, individuals experiencing homelessness may be at particular risk of COVID-19 due to their mobility (it is difficult to track and prevent transmission); lack of access to hygiene supplies; limited access to health care; lack of a medical home; and limited access to safe public spaces and shelters as a result of shutdowns. This can further impact their health by keeping them exposed to weather, extreme heat and cold, and wildfire smoke, all of which have occurred during the pandemic.

## Other Unintended Consequences

The Washington state government has worked to prevent the spread of COVID-19 through travel restrictions, social distancing measures, and isolation and quarantine protocols. In addition, COVID-19 cases have brought increased strain on the health care system. While these measures can prevent the spread of COVID-19, they can have negative consequences on other parts of people's health. People who are likely to experience the unintended health consequences of pandemic control measures and increased health care strain include, but are not limited to, pregnant people; people with unrelated acute, severe, or chronic health conditions; people of color; and individuals with disabilities.

**EXAMPLE** Sixty-one percent of Black adults and 60 percent of Hispanic adults reported that the COVID-19 pandemic has impacted their mental health, in comparison with 55 percent of white adults.

## Equity as a Cross-Cutting Factor

As illustrated in the previous sections, the root causes of differences in COVID-19 cases, hospitalizations, and deaths are due to long-standing systemic inequities, as are the differences in access to COVID-19 information, services, and treatment in culturally and linguistically responsive ways. As a result, Washington state is intentionally taking a pro-equity approach to COVID-19 vaccine prioritization and allocation.

We have focused on the following groups as affecting all phases of our prioritization and allocation framework. The focus on these cross-cutting groups were well supported by the impacted communities, partners, groups, and sectors who participated in our engagement and public feedback opportunities.

- **People with access barriers to health care:** People with limited transportation, people with limited English proficiency, individuals with disabilities, people without health insurance, undocumented people
- **People at higher risk for exposure:** Farm and factory workers, essential workers, people who live in congregate housing, people experiencing homelessness, people who are incarcerated or detained, people in workplaces with outbreaks
- **People essential to health and wellbeing of populations at higher risk:** Doulas, caregivers (both formal and informal), home care aides, health care interpreters, community and mutual aid volunteers, community health workers
- **People who have been disproportionately impacted by COVID-19 because of systemic inequities:** Communities of color, people with limited English proficiency, individuals with disabilities, low-income people
- **People at risk for severe illness:** Older adults and elders, pregnant people, people with underlying medical conditions that put them at a higher risk for severe disease or death if they get COVID-19
- **People who are at higher risk for spreading COVID-19 to high-risk populations:** Caregivers, people living in multi-generational households, children and youth, essential workers, people who must travel for work
- **People who live in areas with greater spread:** Geographic hotspots and outbreaks, congregate housing with outbreaks

## GUIDANCE DEVELOPMENT PROCESS

To develop our COVID-19 vaccine prioritization guidance and allocation framework, we emphasized proactive community engagement, transparency, evidence, and fairness. First, we reviewed content from several sources including the CDC’s Advisory Committee on Immunization Practices (ACIP); the World Health Organization; Johns Hopkins Center for Security; and the National Academies of Sciences, Engineering, and Medicine.

Since we knew that official ACIP guidance would not be available until later, we used the National Academies’ [Framework for Equitable Allocation of COVID-19 Vaccine](#) to gather initial feedback and initiate planning.

### Community Engagement Methods

#### Focused Engagement Approach

To hear from communities most impacted by COVID-19 about the prioritization and allocation framework, we used a mixed methods approach and conducted 90 separate interviews, group interviews, focus groups, and community conversations. These were conducted primarily by phone and video chat with 568 individuals across the state over a three-week period in October 2020.

The Department of Health’s internal COVID-19 Community Engagement Task Force led these efforts and partnered with several existing Emergency Language and Community Outreach Services contractors statewide to carry out additional culturally appropriate community engagement efforts within their own communities. The information gathered through these activities was supplemented by advocacy letters from disproportionately impacted businesses and other sectors, as well as by qualitative open-ended responses to survey questions. See **Appendix F** for all question sets.

We engaged community members, partners, and representatives and asked participants to self-identify the communities they belong to and/or represent. Most often, people self-identified with more than one community. Over the course of all focused engagement efforts, we identified representation from the following communities, groups, and sectors (**Table 3**).

Participants identified as being connected with 28 counties (defined as a county in which a participant lives or works) or said they were connected statewide (**Table 4**). We did not focus our engagement efforts on geographic communities, but we are able to identify geographic-specific feedback.

Table 3: Community engagement group representation

Disproportionately Impacted Communities <sup>1</sup>	Essential Sectors, Services Sectors, and Industries	Health Care and Public Health Partners	Other High Priority Communities, Groups, and Sectors
Black/African American community Asian/Asian American community Native American Native Hawaiian and other Pacific Islanders community Marshallese, Micronesian, and COFA (Compact of Free Association) communities Latinx community Immigrant and refugee communities Asian diaspora African diaspora Latin American diaspora Former Soviet Union (FSU) diaspora Undocumented communities People with underlying health conditions Older adults Pregnant people Individuals with disabilities People experiencing homelessness People who are incarcerated Low-income communities Uninsured communities	Essential and front-line workers Agricultural sector Migrant workers Farmworkers Seafood industry Food bank services Business community Public transportation Hospitality industry Public utilities Parks and recreation Technology sector	Local Health Jurisdictions Community health clinics Community Health Workers and promotoras Behavioral health and substance use disorder services Community blood centers Rural medical services Pharmacy Post-acute and Long-Term Care Veterinary care	Children with special health care needs Youth Youth in foster care College and university students Parents Early learning and early childhood LGBTQ+ community Rural communities Border communities Sub-urban communities Faith-based communities Veterans Women
<sup>1</sup> Communities that have experienced the greatest COVID-19 inequities related to cases, hospitalizations, deaths, and risk of severe illness. Participants self-identified as being in these groups and were often in more than one group.			

Table 4: Community engagement counties

All (statewide)	Ferry	Kitsap	Pend Oreille*	Thurston*	<b>*Focused engagement efforts</b>
Adams	Franklin*	Kittitas*	Pierce*	Wahkiakum	
Asotin*	Garfield	Klickitat*	San Juan*	Walla Walla*	
Benton*	Grant*	Lewis*	Skagit*	Whatcom*	
Clallam*	Grays Harbor*	Lincoln	Skamania*	Whitman	

Clark*	Island*	Mason*	Snohomish*	Yakima*	
Cowlitz*	Jefferson*	Okanagan*	Spokane*		
Douglas	King*	Pacific*	Stevens		

## Focused Engagement Analysis

For all activities, a designated note taker or the facilitator took notes. As needed, engagement activities were facilitated in-language or with the assistance of an interpreter or Communication Action Real-time Transcription (CART) services. We redacted all participant names, saved all transcripts as text documents, and then uploaded the content into Dedoose (version 8.3.35). A contractor analyzed qualitative data using thematic analysis. The codebook was developed iteratively and derived from assessment goals, data, and the prioritization framework. Each transcript was coded individually, and the codebook was adapted as necessary. Each code report was summarized into a table of theme domains and subdomains with associated quotes.

## Broad Engagement Approach

We also collected feedback from the broader public through a web-based survey (see **Appendix F** for survey questions and full results). This survey was provided in several languages (see **Table 5**) and shared through existing partner channels, DOH listservs, the DOH website, and social media accounts. We selected these languages because they are common in Washington state and we have had success reaching people who speak them through other web-based communications during the pandemic.

Table 5: Survey respondents by language

Language	Number of Respondents
English	17,678
Spanish	70
Vietnamese	36
Chinese (simplified)	36
Chinese (traditional)	160
Russian	29
Ukrainian	12
Tagalog	2

The survey was split into three parts: 1. How are you feeling about COVID-19?; 2. How should we decide who gets the vaccine first?; and 3. Tell us about yourself (optional). In addition to analyzing the overall survey results (**Appendix F**), we filtered and analyzed the results by the respondent’s area of work and whether they identified as someone at increased risk for COVID-19 because of their race/ethnicity, disability status, overall health, or age.

Our analysis included all in-language surveys that had at least 10 respondents. These survey results supplement what we learned through the qualitative, focused engagement efforts with these respective communities. We also collected information about the specific county respondents reside in and will provide those county-specific reports of the results to our local health jurisdiction partners.

## SELECT ENGAGEMENT FINDINGS

Main themes related to vaccine prioritization and allocation

The following themes are the initial findings that emerged across engagement activities including interviews, focus groups, community conversations, and surveys. This is a small selection of the overall engagement findings. Please visit the [COVID-19 Vaccine Engagement webpage](#) for more information and the full report.

## Understanding COVID-19 Risks

1. *Older adults are at risk due to their work, where they live, family gatherings, or cultural shared spaces*

- Older adults who live in intergenerational homes, multi-family housing, nursing homes or other congregate care settings, jails, and homeless shelters are at higher risk for exposure, as are older adults who receive assistance from their family or neighbors.
- Some older adults have occupations that may put them at increased risk, including fishing boat managers (also likely to be Black, Indigenous, or people of color), teachers, utility and water operators, and other occupations where they can't make choices about the safety of their jobs. Those in working class jobs are unable to reduce their workplace risk and are too reliant on income from those positions to leave or stay home even when isolation is warranted.

***“Being part of the Asian community, we put a lot of resources and respect toward our elders. My concern is really toward my grandparents and other members that I really think of as staples of our community.”***

2. *Those who face barriers to health care or quality health care are at risk*

- The Latinx community, including farmworkers and those working at food processing plants, may be uninsured or underinsured. In addition, fear of losing their job, the cost of tests and treatment, and worries about their status (if they are undocumented), are likely to prevent them from seeking care.
- Rural communities often face delays in getting care and those without transportation cannot access care.
- Low-wage workers without health insurance often do not access health care. In addition, low-wage workers may not seek care because they would become food insecure if they miss work.
- Communities of color have limited access to testing, may be homebound with limited access, and have comorbidities that are a direct result of a lower quality and quantity of health care. Native Americans struggle to get health care.
- Transgender and homeless queer youth may not have access to health care.

***“[Farmworkers] are going to go to work or die.”***

3. *People with underlying health conditions are at risk*

- Latinx, Indigenous, Black people, other communities of color, and immigrants and refugees often have underlying conditions, such as diabetes, cancer, asthma, or other pulmonary conditions as well as higher health disparities overall due largely to systemic oppression.
- Medically fragile children and children with disabilities are at higher risk.
- People with disabilities may have multiple health conditions, rely on home health workers, and have marginalized immune systems.
- Older people are more likely to have heart disease, diabetes, COPD, and compromised immune systems that put them at greater risk.

- People with mental illnesses, especially those who are homeless, may be more likely to congregate together or spread COVID-19 without knowing it.
4. *People who live in congregate living situations or in multi-generational homes are at greater risk*
- Workers who live where they work, such as farmworkers, fish processors, and rural utility district work site employees are at greater risk. They live in shared quarters with shared bathrooms, and many sleep in bunk beds that are not socially distanced.
  - Black people, Indigenous communities, and other communities of color, including immigrants and refugees, reported that they often live close to one another, with multiple generations in one household.
  - The high cost of living also forces low-wage workers across the spectrum to live in overcrowded or dense housing situations. Families living in low-quality housing may have underlying respiratory diseases, which are exacerbated by stay-at-home orders. Low-wage workers are also likely to rely on public transportation, further exposing them to the virus.
  - People experiencing homelessness, especially homeless queer youth, are at particular risk. Those who are transient may not be able to test/treat/isolate, and for those who do want to access shelter beds, the number of beds is reduced due to an effort to separate people for social distancing.
  - People with disabilities, older adults, and staff in congregate care living settings, are at higher risk especially if the setting employs shift staff who are at high risk themselves. In addition, isolating people in long-term care facilities can be detrimental to their mental health.
  - People who are incarcerated cannot be isolated and do not have options to isolate themselves.
  - University students living in congregate housing are at risk. Students have higher social and mental health needs for personal contact and may take more risks.

***“Agricultural workers living in cabins: They have 40 people to 2 bathrooms.”***

***“Bunk beds are not social distancing.”***

5. *People who are exposed to coworkers and/or the general public at work and/or work in settings where proper protocols are not taken are at greater risk*
- People working in jails and prisons, health workers, front line workers, pharmacists, restaurant and grocery workers, utility workers, critical infrastructure workers, contact tracing professionals, public transport workers, volunteer firefighters, people who work in hospitals, parks and recreation staff, hatchery staff, long-term care workers, farmworkers, sex workers, veterinarians and veterinary staff are at increased risk. Child care workers, school staff and nurses, teachers, workers who leave their children in congregate child care, and other workers that are exposed to people or work in settings where proper safety precautions aren't taken, are at high risk.
  - People who work in food processing may work in closed spaces, spaces that do not adapt well to social distancing, or spaces where installing separation barriers would create safety issues. In these settings where spread occurred, 75 percent or more of the crew were infected. Farmworkers are at risk on buses that bring them to the field and in their sleeping accommodations.
  - Black and Brown communities, including immigrants and refugees, are highly represented in jobs that pose greater risk because of exposure to others, or they work in places that don't have enough safety protocols in place or are the last to receive PPE. Examples include farmworkers and food processors (as

stated above), dairy workers, meat packing plant workers, public transportation workers, housekeepers, nail salon workers, fishery staff, community-based organization staff who meet with clients, home health care workers, grocery store staff, community workers who go with clients to their appointments, Uber or Lyft drivers, retail industry workers, and health workers. In addition, older adults in these communities often work in high-exposure jobs.

- Sex workers are at risk when seeing clients; with sex workers who are queer and trans Black, Indigenous, and other people of color disproportionately impacted.
- Low-wage workers often need to work to support their families and may have multiple high-risk jobs where their attendance is critical to support others impacted by COVID-19. This may include working in service jobs in community-based organizations, such as homeless shelters. People with disabilities often work in lower-paying jobs (home health workers, grocery stores, restaurants) where they have higher risk of encountering people with COVID-19. Students who work in retail or at restaurants may rely on their salaries but not receive adequate protection from COVID-19 exposure from their workplaces. In addition, low-wage workers often take public transportation and don't have funds to purchase their own PPE.

*“I got infected at work in the cafeteria. People would take off their mask to eat and leave the mask on the table. If you arrived at that table after that person and did the same, right there you caught the virus.”*

*“I was infected at work. In our work place there was not enough disinfection. They didn't give us gloves or masks and it is very easy to get infected.”*

*“Our crews [fishery crews] are a pretty diverse group. The higher up the managerial people tend to be older and are approaching high-risk for their health. We also have minority populations. Our company in particular employs Asian and Pacific Islanders. Some other are Somali Americans. That should be considered when you think about the category of risk.”*

## Disproportionate Impacts: Many interconnected layers

1. COVID-19 affects many individuals within families and between families
  - Children: Most children in Washington were unable to return to in-person schooling during the first year of the pandemic. The safety nets provided at school (teacher attention, school nurse, special education aides) are either absent or overwhelmed in the online environment. For low-income, rural, limited English proficiency, disabled and low-tech students, online schooling is challenging if not impossible. Children experienced loss of housing, hunger, postponement of well-child medical care, and sometimes deaths of relatives and friends. Older children may be responsible for younger children's care. Children with special needs are especially impacted when they lose support services or have to care for themselves.
  - Young adults: College and university students experience mental health impacts resulting from isolation, loss of job/pay covering the cost of education, assumption of family care for younger siblings, and many of the same impacts as their younger counterparts.
  - Working-age adults/parents: Adults are impacted by employment, housing, and physical and mental health factors to varying degrees. Adults of color and low-income adults are particularly impacted as individuals, as parents, and as caregivers of older adults. When they become ill from COVID-19, essential workers find it difficult to access child care.

- Older adults: Seniors living in extended family homes are exposed to risk via their housing situation and in the case of low-income seniors, via their workplace. This is particularly true for people of color, immigrants, and disabled seniors. Older adults are particularly affected by the intersectionality of age, ethnicity, race, profession, and poverty.

## 2. Impacts happen in the workplace

- Job-related impacts are felt most intensely by low-income workers. They often work in high-risk environments without the ability or autonomy to reduce their personal risk.
- The same elements of the workplace that increase the risk for contracting COVID-19 prevent these individuals from quarantining at home if they become sick with the disease:
  - Lack of health insurance or sick pay, low wages, and the necessity to purchase one's own PPE lead to people going to their job while sick; or plunges them into poverty when medical crises hit.
  - Shift work, multiple low paying jobs, crowded workplaces and the inability to work from home increase COVID 19-related stress, financial insecurity, and ongoing risk of exposure.

## Misinformation and Distrust

### 1. Vaccine hesitancy due to historical trauma, and mistrust of government agencies and health care entities

- There is an overwhelming distrust of federal and government agencies, health care systems, and health care entities due to historical events and trauma (i.e., Tuskegee experiment). There is a long history of medical experimentation, including harm and testing on Black communities, Indigenous communities, disability communities and communities of color. These communities have also experienced racism and discrimination within health care that contributes to this mistrust.
- There are concerns about the safety and efficacy of COVID-19 vaccines due to their perceived rapid development, and a lack of transparency about vaccine development.
- All groups expressed fear that BIPOC communities will be the first individuals vetted to take the vaccine and utilized as test subjects.
- There is collective agreement and support to partner with community representatives and community members for transparent vaccine information, communication, and distribution efforts.

***“Generational trauma is huge in the Black and Brown community especially around vaccinations, around government testing, and around the government. There is no trust there.”***

***“I am not willing to be the guinea pig for this government.”***

## Fears about the vaccine: safety, development, efficacy, logistics

### 1. The fears cited most often clustered around safety and efficacy

- People across all communities and groups have questions and concerns about the safety and efficacy of the vaccine.
- Fears about possible short- and long-term side effects from getting the vaccine were the predominant worry. For healthy people, side effects were seen as creating an additional risk, while for individuals with

disabilities and underlying health conditions, vaccines were perceived as potentially making current problems worse.

- Efficacy, durability, and reliability all caused respondents to express hesitation and concern.

***“I think our community needs more education in regard to COVID vaccine from people from our community, especially about what harms it can have.”***

## Vaccine Prioritization

1. *There is support for prioritizing high-risk workers in health care settings, but we need to intentionally define a high-risk role or environment*

- Not all health care environments and settings have the same access to personal protective equipment (PPE), and not all workers within a setting have equitable access to PPE.
- There are other people beyond nurses and doctors who work in high-risk health care settings or with high-risk patients. Community Health Workers (CHWs) and *promotoras*, doulas, janitorial staff, caregivers, and aides move through these settings too.
- More than 90 percent of all communities and groups who participated in the general feedback survey, interviews, or focus groups—across all language and cultural groups—agreed that high-risk health care workers should receive priority for the COVID-19 vaccine.

***“Essential medical personnel need to save the rest of us, and if they get the shot, we will follow their example.”***

***“I think medical people should be given the vaccine first, not just because of their risk, but because seeing doctors and scientists, maybe especially from communities of color, and even those in government getting the vaccine early will hopefully give the general public confidence that it is safe.”***

2. *Prioritization should be stronger for key groups including farmworkers, elders, people with disabilities, and communities of color.*

- Community conversations revealed strong support for some groups to be a higher priority for vaccine, including farm/agriculture (and H2-A- “guest”) workers, people with disabilities, people experiencing homelessness, and elders.
- There is a need to think about the other individuals who surround high risk groups. Many farm/food processing workers are living in multi-generational households. People with disabilities may have caregivers that put them at risk.
- People who are incarcerated may have identities and risk factors that put them in a different phase of priority, such also having a disability or comorbidities. Also, we need to consider the potential of corrections staff getting sick.
- There is a need to think more broadly about “congregate settings.” Agricultural workers living in cabins would fall under congregate settings. People with disabilities may also be in congregate living situations.

***“There is no real mention of race in this plan. It needs to be called out.”***

***“Farmworkers and essential workers need to be at the top countered with the equity issues of how bodies of color have been used as test subjects in the past.”***

*“Pacific Islanders are top highest infected more than any other group.”*

3. *Many essential services sectors feel left out and under-prioritized.*
  - Certain groups are very concerned that frontline workers (or highly impacted people) won’t be considered in the first round of vaccinations. Many groups expressed feeling left out, forgotten, not supported, or not considered.
  - Nonprofit, service, and volunteer organizations do not feel supported or considered as essential.
  - There are critical infrastructure workers in almost every sector who have no alternatives if they get sick, and we could see long-term effects on our state’s infrastructure if their work goes undone. From hatchery staff protecting and maintaining our food supply, to data and cyber security teams, to utility operators, to foster care, many of these workers feel like they haven’t been considered essential.
  - The hospitality industry has by far the highest number of individuals on unemployment in the state and nationally, and the long-term economic impact on these workers reaches all aspects of their wellness.

*“Child care, custodial, and maintenance workers should be moved up. They keep the community going, clean, safe.”*

4. *There is overall support for the National Academies of Medicine Equitable COVID-19 Allocation Frameworks’ principles, criteria, and equity considerations.*
  - The overwhelming majority of people who participated in all engagement activities including the public feedback survey, interviews, and focus groups—across all language and cultural groups—supported the inclusion of the working principles and criteria. The framework includes recommendations for equitable vaccine allocation.

*“Generational trauma is huge in the Black and Brown community especially around vaccinations, around government testing, and around the government. There is no trust there.”*

## EQUITABLE FRAMEWORK OVERVIEW

This section outlines our working principles, goal, criteria, and phases. Some of these changed as the COVID-19 pandemic evolved.

### Principles

Consistent with the National Academies approach, this guidance was developed keeping in mind six foundational principles described below. These principles are similar to those of other frameworks, such as those from the Advisory Committee on Immunization Practices (ACIP) and the World Health Organization. The overwhelming majority of people who participated in all engagement activities including the public feedback survey, interviews, and focus groups—across all language and cultural groups—supported the inclusion of these six principles.

### Ethical Principles

1. **Maximum benefit** encompasses the obligation to protect and promote the public’s health and its socioeconomic well-being in the short and long term.
2. **Equal concern** requires that every person be considered and treated as having equal dignity, worth, and value.
3. **Mitigation of health inequities** includes the obligation to explicitly address the higher burden of COVID-19 experienced by populations affected most heavily, given their exposure and compounding health inequities.

## Procedural Principles

4. **Fairness** requires engagement with the public, particularly those most affected by the pandemic, and impartial decision making and even-handed application of allocation criteria and priority categories.
5. **Transparency** includes the obligation to communicate with the public openly, clearly, accurately, and straightforwardly about the allocation framework as it is being developed, deployed, and modified.
6. **Evidence-based** expresses the requirement to base the allocation framework—including its goal, criteria, and phases—on the best available and most up-to-date scientific information and data.

*“I feel like the most important principles are equal regard and evidence-based research as everyone is at risk of this deadly virus. I am not sure exactly how you guys improve these principles more or less just ensure everyone is treated equally while also trying to reduce the sickness and deaths by COVID-19.”*

## Goal

Guided by these principles, we have adopted the following overall goal: **To reduce severe morbidity and mortality and negative societal impact due to the transmission of SARS-CoV-2.**

## Criteria

The framework leverages four risk-based criteria to set general priorities among population groups and to provide guidance that recognizes the differences between populations. The overwhelming majority of people who participated in all engagement activities including the public feedback survey, interviews, and focus groups—across all language and cultural groups—supported including these four criteria:

1. **Risk of acquiring infection:** Individuals have higher priority if they have a greater chance of being in settings where SARS-CoV-2 is circulating and of being exposed to enough of the virus to make them sick.
2. **Risk of severe morbidity and mortality:** Individuals have higher priority if they have a greater risk of severe disease or death from being sick with COVID-19.
3. **Risk of negative societal impact:** Individuals have higher priority if they serve in a needed role within society, and other people’s lives and livelihood depend on them directly and would be at risk if they fell ill.
4. **Risk of transmitting infection to others:** Individuals have higher priority if there is more chance they will transmit the virus to others.

We used existing data, studies, surveys, interviews, and focus groups with partners to assess different population groups against these risks. We continually monitor CDC updates related to these groups. We relied on these data, local data, and research summarized in the National Academies’ publication (see **Appendix A**) to ensure our assessment and subsequent guidance were evidence-based and consistent with our principles. Our guidance was also informed by disproportionately impacted communities, groups, and partners. We continued to review and gather input to adapt this guidance and framework over time.

## Phases

Our guidance is based on the feedback received from community partners, several Washington state COVID-19 expert groups, such as the Disaster Medical Advisory Committee, COVID-19 Vaccine Scientific Advisory Workgroup, and the Vaccine Advisory Committee (see **Appendix B** for participant lists), along with federal guidance. As a result, our guidance provides greater specificity around sub-populations than the National Academies' equity framework. This additional specificity helps us risk-stratify populations when vaccine supply is limited. Otherwise, the guidance is consistent with the National Academies' equitable framework and that of the Advisory Committee on Immunization Practices.

Given our principles, goal, and criteria, Washington state offers a four-phase approach to equitable COVID-19 vaccine allocation as outlined in "Allocation Guidance within Each Phase." This guidance is based on the best available current evidence, but the dynamic nature of COVID-19 pandemic and the vaccine landscape means that this approach will adapt over time.

Population groups overlap and there are individuals who fit into multiple categories. If this is the case for an individual, the highest phase should take precedence. Further, there are significant differences within each group. The next section ("Applying the Framework for Equitable Allocation") provides further guidance to identify sub-populations that are at highest risk based on the criteria this plan outlines. Also, the order of the populations within a phase or tier does not suggest any type of prioritization or risk stratification.

## APPLYING THE FRAMEWORK FOR EQUITABLE ALLOCATION

Statewide engagement confirmed broad support for a standardized approach that will ensure consistent and equitable allocation of COVID-19 vaccine across Washington. As such, this section provides more detailed guidance regarding:

- Factors informing moving from one phase to the next
- Prioritizing allocation of vaccines to different provider sites within a phase
- Prioritizing allocation of vaccines within populations

All of these are designed to ensure consistent application of the principles and criteria to achieve our shared goal.

### Factors Informing Moving to a New Phase or Tier

If there is limited vaccine supply, DOH will use the equitable allocation framework to identify which populations should get vaccine first. DOH relies on four key factors to determine when it will move to the next phase:

- **Vaccine coverage trends of prioritized populations** – assessing the vaccine coverage of currently prioritized populations and the uptake trends to estimate demand; will also consider variation in time it will take for vaccine uptake in different populations
- **Vaccine supply** – how much vaccine is currently available in the state; inventory trends
- **Vaccine projections** – how much vaccine supply is projected to arrive in the state in the coming months based on information provided by the federal government
- **Current scientific data** – current information related to vaccine efficacy and safety, and epidemiological context

### Prioritizing within a Phase or Tier

When we enter each phase or tier, there will not be enough vaccines to cover all prioritized groups across vaccine provider sites. DOH decides how much vaccine to allocate to different provider sites across the state based on the following factors:

- Estimated size of prioritized populations in geographic areas to achieve proportional allocation (also referred to as pro rata)
- Emerging vaccine data, such as safety or clinical data on use of the vaccine(s) with certain populations
- Implementation issues such as cold chain capacity, the ability of a site to administer all vaccine doses before they expire, provider site willingness to vaccinate outside their own staff or patients, provider site engagement with local health jurisdiction planning efforts, inventory information and trends, and need to limit brand offerings.
- Epidemic conditions, such as high transmission or outbreak settings
- Social vulnerability factors and equity impact

Washington state applies a social vulnerability index to incorporate social vulnerability factors and equity in allocation decisions. The index uses Census tract variables, including socio-economic determinants (e.g. income), household composition and disability, race/ethnicity and language, and housing type/transportation to ensure allocation is based upon need (see [Washington Tracking Network](#) and select “Social Vulnerability to COVID-19”). This is to ensure that special effort is made to deliver vaccine to the most vulnerable areas (defined as the 25 percent highest ranked areas against this index in the state), not to start in these areas.

We will adjust these efforts based on emerging circumstances while remaining consistent with the principles, criteria, and goal stated above.

## ALLOCATION GUIDANCE WITHIN EACH PHASE

This guidance is the result of months of gathering input and ideas from expert groups and community partners. Guidance for phases will follow current information, federal guidance, and the principles and criteria noted above. The Department of Health will update this guidance as needed based on:

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

In this guidance, population groups overlap and some people fit into multiple categories. When this is the case, the higher phase takes precedence. Size estimates of these populations at the time of drafting this plan are in **Appendix C**. Also, the listed order of the populations does not suggest any type of prioritization or risk stratification. In all circumstances, someone who has previously had a COVID-19 infection is still eligible for COVID-19 vaccine. Serologic testing is not recommended prior to vaccination. Vaccines should be administered according to age groups for which the specific vaccine is authorized or approved.

### Phase Eligibility Timing

All people aged 5 and older are eligible to get the vaccine. The table below outlines the dates that various groups became eligible, along with one possible future phase.

Phase	When it opened	Who is in it
1A	Dec 14, 2020	<ul style="list-style-type: none"> <li>• <a href="#">See prioritization guidance</a></li> </ul>
1B tier 1	Jan. 18, 2021	<ul style="list-style-type: none"> <li>• <a href="#">See prioritization guidance</a></li> </ul>

		<ul style="list-style-type: none"> <li>• Pre-kindergarten - 12<sup>th</sup> grade educators and staff (<i>added March 2</i>)</li> <li>• Child care staff (<i>added March 2</i>)</li> </ul>
1B tier 2	March 17, 2021	<ul style="list-style-type: none"> <li>• High-risk critical workers in certain congregate settings</li> <li>• People age 16 or older who are pregnant</li> <li>• People age 16 or older who have a disability that puts them at higher risk</li> </ul>
1B tier 3 & 4	March 31, 2021	<ul style="list-style-type: none"> <li>• People 16 years or older with 2 or more comorbidities or underlying conditions</li> <li>• People 60 years and older</li> <li>• People, staff and volunteers in certain congregate living settings – specifically, correctional facilities, congregate settings where people experiencing homelessness live or access services, and group homes for people with disabilities</li> <li>• Other at-risk critical workers in certain congregate settings – specifically, restaurants/food services, manufacturing, and construction</li> </ul>
2, 3	April 15, 2021	<ul style="list-style-type: none"> <li>• All people age 16 years and older not already covered</li> </ul>
4	May 12, 2021 November 2, 2021	<ul style="list-style-type: none"> <li>• People age 12-15</li> <li>• People age 5-11 (using pediatric dose)</li> </ul>

## Phase 1

### Phase 1a - Tier 1

#### Overarching Groups:

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

Phase 1a focuses on (a) high-risk workers in health care settings and high-risk first responders to protect our medical care response capacity and (b) residents and staff of nursing homes; assisted living facilities; and other community-based, congregate living settings where most individuals over age 65 are receiving care, supervision, or assistance. The goal is to avoid hospitalizations, severe disease, and death. The table below identifies the desired objectives and guidance on prioritization in this phase. Our recommendations closely align with the Advisory Committee on Immunization Practices (ACIP) and include risk stratification in the case of limited vaccine.

This guidance also was developed based on input and review by experts such as Washington advisory groups (Vaccine Advisory Committee, Disaster Medical Advisory Committee, COVID-19 Science Advisory Working Group, Association for Professionals in Infection Control), health care providers, and local health jurisdictions (including health officers).

PHASE 1A-1 OBJECTIVE	PHASE 1A-1 GUIDANCE
<p><b>To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations</b></p>	<p><b>High-risk workers in health care settings</b></p> <p><b>High-risk first responders</b></p> <p><i>In the context of limited vaccine, this guidance includes the following sub-prioritization considerations to help identify who is at greatest risk:</i></p> <ul style="list-style-type: none"> <li>• Personnel without known infection in prior 90 days</li> <li>• Workers in sites where direct patient care is being frequently delivered to confirmed or suspected COVID-19 patients, including sites where suspected patients are directed for COVID testing and care <ul style="list-style-type: none"> <li>○ Example setting: hospital sites managing suspected/confirmed COVID-19 patients; emergency departments; urgent care; clinics (walk-in, respiratory); home; isolation and quarantine facility</li> <li>○ Example types of workers: health care workers; technicians; security; environmental, janitorial, and facility staff; non-remote translators; counselors; home health aides, caregivers, and companions</li> </ul> </li> <li>• Workers frequently performing high-risk exposure procedures with suspected or confirmed COVID-19 patients <ul style="list-style-type: none"> <li>○ Example procedures: endotracheal or cough inducing intubation; cough induction or cough inducing procedure (e.g. nasogastric tube); bronchoscopy; suctioning; turning the patient to the prone position; disconnecting the patient from a ventilator; invasive dental procedures and exams; autopsies; respiratory specimen collection; cardiopulmonary resuscitation; upper endoscopy; laparoscopic surgery; placement of chest tubes for pneumothorax</li> </ul> </li> <li>• Workers exposed to/handling potentially SARS-CoV-2 containing specimens</li> <li>• COVID-19 testing site staff at high risk of exposure to suspected COVID-19 patients</li> <li>• First responders at high risk of exposure to suspected or confirmed COVID-19 patients via high public exposure and procedures <ul style="list-style-type: none"> <li>○ Licensed emergency medical service frontline staff regardless of agency (e.g. fire, ambulance, hospital)</li> <li>○ Emergency workers providing patient transport/ambulatory support regardless of agency</li> <li>○ Personnel working in the field to provide oversight of these emergency medical service positions</li> </ul> </li> <li>• Workers with elevated risk of acquisition/transmission with populations at higher risk of mortality or severe morbidity <ul style="list-style-type: none"> <li>○ Workers at long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance (e.g. health care, environmental facility management, counselors, dining staff, etc.)</li> <li>○ Home health aides, care aides, caregivers (paid or unpaid), companions, etc.</li> <li>○ Workers with patients undergoing chemotherapy or dialysis, who have chronic renal disease, etc.</li> </ul> </li> <li>• Workers (including pharmacists and occupational health staff) administering vaccines to Phase 1a and 1b populations</li> </ul> <hr/> <p><b>Residents and staff of long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance and are unable to reside independently in the community:</b></p>

	<ul style="list-style-type: none"> <li>• Example: skilled nursing facilities – facility engaged primarily in providing skilled nursing care and rehabilitation services for residents who require care because of injury, disability, or illness</li> <li>• Example: assisted living facilities – facility providing help with activities of daily living; residents often live in their own room or apartment within building/group of buildings</li> <li>• Examples of possible settings: adult family homes; group homes for people with disabilities (physical, developmental, intellectual); mental/behavioral health institutions; residential homeless shelters</li> </ul> <p><i>Where sub-prioritization is needed, consider:</i></p> <ul style="list-style-type: none"> <li>• Congregate skilled nursing facilities caring for the most medically vulnerable residents where they face the joint risk factors of severe disease/mortality and transmission due to their living settings</li> <li>• After skilled nursing facilities, consider broadening to other facilities, including: <ul style="list-style-type: none"> <li>○ Assisted living facilities and adult family homes</li> <li>○ Residential care communities</li> <li>○ HUD 202 low-income senior housing</li> <li>○ Intermediate care facilities for individuals with developmental disabilities</li> <li>○ State veterans homes</li> </ul> </li> </ul>
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*Phase 1a (Tier 1) Additional Guidance*

- We use the term “workers in health care settings” and not “health care workers” because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g. contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g. ambulatory, direct patient care, support services). The CDC provides [similar guidance](#) on defining health care personnel.
- Pay special attention to workers in health care settings who are at high risk of exposure and may have inconsistent or limited use of personal protective equipment (PPE) as well as those working in settings with inadequate environmental controls for recommended air exchange.

Phase 1a - Tier 2 (after completion of Tier 1)

*Overarching Group:*

- **All other workers at risk in health care settings**

The CDC’s definition of health care settings refers to places where health care is delivered and includes, but is not limited to, acute care and long-term acute care facilities; inpatient rehabilitation facilities; nursing homes and assisted living facilities; home health care; vehicles where health care is delivered (such as mobile clinics); and outpatient facilities, such as dialysis centers, physician offices, and others.

PHASE 1A-2 OBJECTIVE	PHASE 1A-2 GUIDANCE
<b>To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations</b>	<p><b>All other workers at risk of acquiring or transmitting COVID-19 in health care settings</b></p> <ul style="list-style-type: none"> <li>• Workers who are at risk of getting or transmitting COVID-19 because they interact less than 6 feet away from patients, coworkers, or specimens and are unable to remain socially distant (i.e, not including remote workers)</li> </ul>

### Phase 1a (Tier 2) Additional Guidance

- We specifically use the terminology “workers in health care settings” and not “health care workers” because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g. contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g. ambulatory, direct patient care, support services).
- Specifically, for caregivers: eligible caregivers (licensed, unlicensed, paid, unpaid, formal, or informal) support the daily health and functional needs of another individual who is at high risk for COVID-19 illness due to advanced age, long-term physical condition, co-morbidities, or development or intellectual disability. For the caregiver to be eligible, the care recipient:
  - Must need caregiving support for their daily health and functional needs
  - Can be an adult or minor child. For dependent minor children, the caregiver is eligible if that child has an underlying health condition or disability that puts them at high risk for severe COVID-19 illness. For example, a caregiver of a minor child with Down syndrome.
- Across Washington, it is important that health care systems actively reach out to and provide access to COVID-19 vaccination for the community-based health care workforce outside their systems and in their community. This includes other health care providers, school nurses, and behavioral health providers, among others, to compete this phase and ensure we have a protected health care system.

### Phase 1b

Phase 1b includes people who are high to moderate risk of disease based on these four risk criteria:

- Risk of acquiring COVID-19 infection
- Risk of severe morbidity and mortality from COVID-19
- Risk of negative societal impact
- Risk of transmission to others

These groups may be stratified into different tiers if vaccine supply is limited. In addition, we have applied equity as a cross-cutting lens and considered situations when certain groups are disproportionately affected due to social factors and/or other systemic inequities in order to mitigate for these factors.

Summary:

Phase 1b Tiers (in order)	Groups
Tier 1	<ul style="list-style-type: none"> <li>• All people 65 years and older</li> <li>• People 50 years and older in multigenerational households</li> <li>• Workers in child care settings</li> <li>• Pre-kindergarten - 12<sup>th</sup> grade educators and staff</li> </ul>
Tier 2	<ul style="list-style-type: none"> <li>• High-risk critical workers who work in certain congregate settings</li> <li>• People who are pregnant</li> <li>• People with a disability that puts them at high risk for COVID-19</li> </ul>
Tier 3	<ul style="list-style-type: none"> <li>• People 16 years and older with 2 or more co-morbidities or underlying conditions</li> <li>• People 60 years and older</li> </ul>

Tier 4	<ul style="list-style-type: none"> <li>• People, staff and volunteers in certain congregate living settings – specifically, correctional facilities, congregate settings where people experiencing homelessness live or access services (e.g. shelters, temporary housing), and group homes for people with disabilities</li> <li>• Other critical workers at risk in certain congregate settings: restaurants/food services; manufacturing; construction</li> </ul>
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Phase 1b - Tier 1

Overarching Groups:

- **All people 65 years and older**
- **People 50 years and older in multigenerational households**
- **Workers in child care settings**
- **Pre-kindergarten – 12<sup>th</sup> grade educators and staff**

The first two groups of this tier are included to protect those who are driving hospitalization rates and face high rates of severe morbidity and mortality in order to reduce the burden on hospitals that keeps us in an emergency state. There are some elders who may be vulnerable and unable to live independently similar to those in community-based, congregate care settings (Phase 1a) but their families care for them at home. In addition, many families—especially those disproportionately affected by COVID-19—live in multigenerational homes that put the elders in the household at significantly higher risk for acquiring infection. Because these individuals are among disproportionately affected groups, they are also at risk for higher rates of severe morbidity and mortality.

PHASE 1B-1 OBJECTIVE	PHASE 1B-1 GUIDANCE
<b>To prevent hospitalization and rates of severe morbidity and mortality</b>	<b>All people 65 years and older</b> (about half of whom have co-morbidities that increase risk for severe outcomes if infected with COVID-19)
<b>To prevent acquiring infection, hospitalization, and rates of severe morbidity and mortality</b>	<p><b>People 50 years and older living in a multigenerational (2 or more generations) household</b></p> <p>These individuals would be at risk either due to:</p> <ul style="list-style-type: none"> <li>• Vulnerability – specifically, an older adult or elder who cannot live independently <i>and</i> is being cared for by a relative or in-home caregiver or being cared for by someone who works outside the home</li> <li>• Risk of exposure – specifically, an older adult or elder who is living with and providing kinship care (along the lines of a grandparent with a grandchild)</li> <li>• This group does not include an older adult who is able to live independently and is taking care of the individual’s family/children</li> </ul>

On March 2, 2021, [Gov. Jay Inslee](#) and the [Washington State Department of Health](#) followed the federal directive calling for all workers in child care settings and pre-kindergarten through 12<sup>th</sup> grade educators and staff to be eligible for the vaccine immediately. These groups initially were in Tiers 2 and 4 with other workers at high risk in a congregate setting. However, not only do they face the risks of acquisition and transmission, but remote care and education is also associated with very high risk of negative societal impact. There was strong evidence remote schooling was negatively affecting pre-kindergarten through 12<sup>th</sup> grade students in educational advancement and access to meals and support services for children, which disproportionately affects low-income families.

PHASE 1B-1 OBJECTIVE	PHASE 1B-1 GUIDANCE
<p><b>To protect those who are at high risk of exposure given the nature of work, to reduce negative societal impact by maintaining critical infrastructure for social and economic systems, and to reduce the negative societal impact on families and children (that disproportionately affects low-income families)</b></p>	<p><b>Workers in child care settings</b></p> <p><b>Pre-kindergarten - 12<sup>th</sup> grade educators and staff</b></p> <ul style="list-style-type: none"> <li>• Consider the full spectrum of workers, including administrators, environmental services staff, maintenance workers, school bus drivers, paraeducators, and any other worker essential to child care and education.</li> <li>• Specifically, this group includes those who face substantially high risk of exposure given work conditions because they are operating in a congregate setting interacting with co-workers or youth over extended periods of time.</li> <li>• Eligible child cares include: <ul style="list-style-type: none"> <li>○ Licensed family home child care providers, and the family members living in their home.</li> <li>○ License-exempt providers that are family, friends, and neighbors who accept Working Connections Child Care subsidy. These in-home providers can serve up to 6 children.</li> <li>○ Early Childhood Education and Assistance Program (ECEAP), Washington’s state-funded preschool providers. This is similar to the national Head Start program, which is named in the directive.</li> <li>○ License-exempt school-age and youth development providers who have been providing care to school-age children since the pandemic began and schools were closed. As schools moved to online and hybrid models, these programs continued to provide child care for school-age children.</li> </ul> </li> <li>• Attention should be given to the specific programs that reach children with special health care needs, individual educational plans, technological gaps, and migrant education programs.</li> </ul>

Phase 1b - Tier 2

Overarching Groups:

- **High-risk critical workers who work in certain congregate settings**
- **People who are pregnant**
- **People with a disability that puts them at high risk**

Phase 1b – Tier 2 includes a subset of [high-risk critical worker groups](#) who work in certain congregate settings. Occupational risk factors for COVID-19 include setting (time inside vs. outside), proximity (to co-workers or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), and barriers to health care access. Specific groups of workers operating in congregate settings—such as agricultural workers, food processing, and incarceration— have experienced significantly elevated rates of infection given the nature of their working and/or living conditions. In addition, the working and living conditions contribute to transmission at work and in the community. Other critical worker groups are included in future phases.

PHASE 1B-2 OBJECTIVE	PHASE 1B-2 GUIDANCE
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<p><b>To protect those who are at <i>high risk</i> of exposure and transmission given the nature of working and living conditions, to prevent hospitalizations and rates of severe morbidity and mortality, and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems</b></p>	<p><b>Critical workers with significantly high risk of exposure and transmission in certain congregate settings</b></p> <p>Congregate setting refers to an environment where individuals work or live in an enclosed space where they are interacting with a high volume of people (for example, a supermarket) over an extended time and are not able to consistently maintain social distance (be more than 6 feet apart).</p> <p>This does not include all critical worker groups, only the subset outlined below. This subset is focused on people who are working in a congregate/enclosed setting within 6 feet of others over an extended time (3 or more hours in a 24-hour day). <b>Therefore, workers who can socially distance, work remotely or work offsite not in a congregate setting are not included.</b> Specific groups and guidance are:</p> <ul style="list-style-type: none"> <li>• <i>Congregate agriculture:</i> Those who work and/or live in a congregate setting interacting with a high volume of co-workers (vs. animals) over extended periods of time (i.e., &gt;3 hours in 24-hour day). Relevant roles are more likely to include crop selection, production and packaging vs. equipment maintenance.</li> <li>• <i>Congregate food processing:</i> Those who work and/or live in a congregate setting interacting with high volume of co-workers (vs. animals) over extended periods of time (i.e., &gt;3 hours in 24-hour day). Also includes workers in fishing vessels.</li> <li>• <i>Workers in congregate grocery stores or food banks:</i> Those who work in a congregate setting interacting with high volume of co-workers over extended periods of time (i.e., &gt;3 hours in 24-hour day). Consider prioritizing retail stores of higher density/volume (e.g. grocery stores, higher volume retail/convenience stores providing groceries) vs. settings where people are more able to be socially distant (e.g. wineries, coffee shops).</li> <li>• <i>Congregate staff in correction facilities, prisons, jails, detention facilities, and court settings:</i> Those who are interacting with high volume of individuals in a congregate interior setting over extended periods of time (i.e., &gt;3 hours in 24-hour day). Consider the spectrum of workers (e.g. facility management, security, counselors, residents who work) who fit the exposure criteria.</li> <li>• <i>Congregate public transit:</i> Those who work in an enclosed (vs. outdoor) congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e., &gt;3 hours in 24-hour day) to help transport people. Settings may include bus, train, ferry, airport, and other high-density transportation settings, or lower-density settings where individuals are tightly constricted over an extended time, like taxis, limos, and ride-share private vehicles over 4 people. It does not include those who can work remotely or in office where they can practice social distancing.</li> <li>• <i>First responders not covered by an earlier phase or tier:</i> Those who work in a congregate setting interacting with a high volume of coworkers or general public over extended periods of time (&gt;3 hours in a 24-hour day). This group includes firefighters, law enforcement, social workers, public health workers, and others playing similar roles (e.g. tactical teams, homeless service providers) responding to public health and safety. It does not include administrators or those who can work remotely, except for public health and first responder functions critical for maintaining the COVID-19 pandemic response and continuity of operations.</li> <li>• <i>Early learning and child care program workers</i> permitted to operate under DOH guidance for child care, youth development, and day camps that were not covered in phase 1B, tier 1.</li> </ul>
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Phase 1b Tier 2 also includes a subset of people with underlying conditions that put them at increased risk for severe illness from COVID-19 and are anticipated to face challenges accessing care.

PHASE 1B-2 OBJECTIVE	PHASE 1B-2 GUIDANCE
<p><b>To prevent hospitalization and rates of severe morbidity and mortality</b></p>	<p><b>Pregnant people</b></p> <p><b>People with a disability that puts them at high risk.</b> This includes individuals with Down syndrome, a developmental disability, or an intellectual disability; or who are deaf/hard of hearing, blind/low-vision, or deafblind; AND that disability or an underlying medical condition increases their risk for severe outcomes per the <a href="#">CDC’s list of the conditions that put people at increased risk of severe illness from COVID-19</a>. This includes three groups:</p> <ul style="list-style-type: none"> <li>○ People with a physical or intellectual disability that prevents them from using protective measures (e.g. severe autism, epilepsy).</li> <li>○ People with a physical or intellectual disability that is clinically associated with severe outcomes if infected with COVID-19 (e.g. Down syndrome, neurological conditions).</li> <li>○ People with a physical or intellectual disability AND at least one of the comorbidities or medical conditions that increases risk or may increase risk of severe illness from COVID-19 per the <a href="#">CDC’s list of the conditions that put people at increased risk of severe illness from COVID-19</a>.</li> </ul>

Phase 1b - Tier 3

Overarching Groups:

- **People 16 years and older with 2 or more co-morbidities or underlying conditions**
- **People 60 years and older**

Phase 1b – Tier 3 includes people who have certain medical conditions that put them at increased risk for severe COVID-19 illness leading to increased hospitalization, severe illness, and death. The list of conditions is based on the list provided by the CDC (see: [People with Certain Medical Conditions](#)). This tier also includes people over 60 years old given high rates of hospitalization and severe morbidity and mortality associated with this age bracket.

PHASE 1B-3 OBJECTIVE	PHASE 1B-3 GUIDANCE
<p><b>To prevent hospitalization and rates of severe morbidity and mortality</b></p>	<p><b>People 16 years and older with 2 or more co-morbidities or underlying conditions</b> per the <a href="#">CDC’s list of the conditions that put people at increased risk of severe illness from COVID-19</a>. All conditions on the list are included for consideration.</p> <p><b>People 60 years and older</b></p>

*Additional Guidance for Groups Particularly Vulnerable to Severe Morbidity and Mortality*

- Local health jurisdiction medical countermeasures teams should identify strategies or contingency plans to reach populations who may have multiple conditions and experience health inequities (e.g. lower-income households, racial/ethnic groups who experience disparities in COVID-19 impact, groups with limited English proficiency, people with access barriers to health care, people with disabilities, people living in homes with more people than rooms). This is especially important as many of these groups may have no or limited access to health care providers to link them to vaccination providers.

Particularly high-risk groups that may require tailored strategies to manage second-dose reminders and follow-up include visitors to homeless shelters, substance use disorder facilities, agricultural workers, and

people who are in high-risk groups but have no health care provider. Partners can use the [Washington Tracking Network social vulnerability index](#) to identify the most vulnerable Census tract areas.

## Phase 1b - Tier 4

### Overarching Groups:

- **People (residents, staff, volunteers) in certain congregate living settings – specifically, correctional facilities, prisons, jails, and detention centers; group homes for people with disabilities; and congregate settings (shelters, temporary housing) where people experiencing homelessness live or access services**
- **An additional subset of at-risk critical workers in certain congregate settings – specifically, restaurants and food services, manufacturing, and construction**

Phase 1b – Tier 4 includes additional subsets of people in certain congregate settings where there is a high to medium risk of exposure and transmission and who have not been covered in earlier tiers. Risk is due to setting (time inside vs. outside), proximity (to co-workers or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protective measures, cleaning (frequency), barriers to health care access, and similar measures. The first group in phase 1B tier 4 includes people in specific congregate living settings where local data indicate high rates of infection and transmission; people in these settings tend to have a high prevalence of underlying conditions and vulnerabilities that put them at higher risk for severe outcomes. Residents of other congregate living settings, like communal residence, should evaluate their eligibility via other groups and phases. The second group in Tier 4 is a subset of critical workers operating in congregate settings that have indicated high rates of infection and transmission. Other critical workers in congregate settings will be eligible in Phase 2.

PHASE 1B-4 OBJECTIVE	PHASE 1B-4 GUIDANCE
<p><b>To prevent hospitalization and severe morbidity and mortality, including in settings that increase potential exposure - and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems</b></p>	<p><b>People (residents, staff, volunteers) in certain congregate living settings</b> given high rates of infection and transmission and high prevalence of underlying conditions and vulnerabilities that put them at higher risk for hospitalization and severe outcomes. This does not include all congregate living settings. Specific settings include:</p> <ul style="list-style-type: none"> <li>• Residents and staff in group homes for individuals with disabilities, including serious mental illness, developmental and intellectual disabilities, and physical disabilities as well as residential substance use disorder facilities not already covered in Phase 1.</li> <li>• People in prisons, jails, detention centers, and similar facilities and staff who work in such settings not already covered in previous phases or tiers.</li> <li>• Residents and staff working in congregate settings that serve people experiencing homelessness that access services or live in congregate settings (e.g. temporary housing, shelters) who are not already covered above.</li> <li>• People residing in domestic violence shelters and staff who work in such settings.</li> </ul> <p><b>Certain critical workers with medium-high risk of exposure and transmission in certain congregate settings</b></p> <p>Congregate settings are environments where individuals work in an enclosed space, interact with a high volume of people over an extended time, and are not able to consistently remain more than 6 feet apart from others. Workers in these settings</p>

	<p>who are able to socially distance, work remotely or work off-site not in a congregate setting are not included.</p> <p>This does not include all critical worker groups, just a subset outlined below based on local data on high infection rates. Other critical workers in congregate settings (e.g. library, shipping/packaging, utility) are eligible in Phase 2. Included groups are:</p> <ul style="list-style-type: none"> <li>• <i>Restaurants and food services:</i> Those who work in an enclosed congregate setting where they less than 6 feet from a high volume of individuals over an extended period of time (&gt;3 hours in 24-hour day).</li> <li>• <i>Manufacturing:</i> Those who work in an enclosed congregate setting interacting with a high volume of individuals over an extended period of time (&gt;3 hours in 24-hour day).</li> <li>• <i>Construction:</i> Those who work in a congregate setting (indoor or outdoor) where it is not possible to be 6 or more feet from others and the worker is interacting with a high volume of individuals over an extended period of time (&gt;3 hours in 24-hour day).</li> </ul>
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*Phases 2 & 3*

*Phases 2 & 3 Overarching Group:*

- **All people 16 years and older not already covered**

Initially, we had a Phase 2 that included (i) All critical workers who are in industries essential to the functioning of society and are unable to perform roles remotely and (ii) People 16 years and older with 1 comorbidity or underlying condition. Phase 3 included all people 16 years and older not already covered. **However, Phases 2 and 3 were combined** after the U.S. Secretary of Health and Human Services directed that all persons eligible to receive COVID-19 vaccine should be eligible as of May 1, 2021.

PHASE 2 & 3 OBJECTIVE	PHASE 2 & 3 GUIDANCE
<b>To protect those who are at moderately high risk of exposure</b>	<b>All people 16 years and older who are not already covered</b>

*Phase 4*

*Overarching Groups:*

- **Children under the age of 16**

The last phase of eligibility includes people under the age of 16. Timing and age ranges of eligibility were based on clinical trial data, federal guidance, and vaccine supply.

Because vaccine supply was sufficient to keep up with demand by the time children were eligible for the vaccine, our phase system was no longer in place, and all children in each age bracket were eligible as soon as the recommendation was made.

PHASE 4 OBJECTIVES	PHASE 4 GUIDANCE
<p><b>To protect those who are at <i>moderately</i> high risk of exposure and who may spread disease to others in congregate settings like schools and child cares</b></p>	<p><b>Children age 12-15</b> <b>Children age 5-11</b></p>

## COORDINATION OVERVIEW

### Allocation Roles & Responsibilities

The federal government is managing overall allocation of COVID-19 vaccine across the states and territories, and to tribal nations through the Indian Health Service or states. The federal government will rely on the ACIP to develop recommendations for who will receive vaccine and a framework to guide prioritized allocation of vaccine. Each state is responsible for providing estimated sizes for the prioritized populations within that framework to inform allocation. The Department of Health will work with local health jurisdictions, health partners, statewide and local agencies, business partners, education systems, and more to estimate the size of prioritized populations, identify geographic distribution of these populations, and assess the capacity of providers to administer vaccine.

Given that this is guidance, patience and flexibility is requested from our partners as the prioritized populations may adjust over time. Ultimately, the Department of Health is responsible for determining allocation across sites using the factors noted in the “Prioritizing within Each Phase” section. However, the federal government is working with CVS and Walgreens pharmacy chains to provide vaccine to long-term care facilities who opt in. The federal government is also distributing vaccines to pharmacies—a process that is managed separately. The federal government is also engaging other national health care partners and federal agencies for direct vaccine distribution, such as select national pharmacies, Veterans Hospital Administration, Bureau of Prisons, Department of Defense, Department of Homeland Security, and others.

### Information Systems & Safety Monitoring

Washington state will use several information platforms to assess provider capacity, monitor supply, and track vaccine coverage (see **Appendix E** for overall visual). The state will request enrolled provider sites to submit information to support allocation decisions needed for when vaccine supply is limited. This could include a survey to enrolled providers to identify size of populations prioritized for vaccination served by the enrolled site. Additional population and enrolled provider site information will also be collected during provider enrollment.

To enroll, providers will enter required CDC provider enrollment data regarding populations served, facility type, and vaccine storage units into a program called REDcap. The Washington state vaccine program will export the data from REDCap and import into the CDC IZ Datalake to support processing provider vaccine orders and inclusion in Vaccine Finder for reporting daily inventory. Providers are required to have an active exchange Information Sharing Agreement (ISA) with the Washington State Immunization Information System (WAIS). This agreement allows providers to use the IIS to order, receive, and track their vaccines. The data can be entered into the WAIS in multiple ways. The Washington state vaccine program also uses a program called PrepMOD to share dose-level accountability from this system into the WAIS to monitor inventory levels at provider sites and allow providers to offer online scheduling to patients. In addition, the Washington state vaccine program updated data

requirements of providers regarding patients to enable monitoring vaccine coverage of prioritized populations. The program provides coverage information on the Department of Health website's [Data Dashboard](#).

In addition to these systems for monitoring supply, demand, and coverage, other systems are in place to monitor vaccine safety after administration and communicate safety information. This approach includes:

- Using established systems to implement heightened safety monitoring for COVID-19 vaccines.
- Developing new platforms and leveraging other federal data sources to complement existing systems.
- Communicating clearly on the existing vaccine safety process and systems and providing COVID-19 vaccine safety data and monitoring results once available.

Washington state uses ongoing analysis of the Vaccine Adverse Event Reporting System (VAERS) data to identify any safety concerns reported to the federal government. This information is collated and shared regularly to the Vaccine Advisory Committee and Vaccine Science Advisory Workgroup for local review and guidance.

Washington also promotes the V-Safe smartphone app from the CDC. The app allows people to use their smartphone to tell the CDC about any side effects after getting the COVID-19 vaccine. They also get reminders about when to get any additional vaccine doses due.

## Community Engagement & Communication

We are committed to providing COVID-19 vaccine in a safe, equitable, and effective manner that includes ensuring communities across Washington have access to the information they need to make informed decisions about their health. We coordinate and disseminate the information through existing systems and partners to ensure the right messages reach the right people in the right way. We proactively work to build new systems and partnerships to connect with communities who are not reached by our current channels. We recognize that we do not have all the information and that the situation will continue to evolve. We are committed to sharing updates in a transparent, timely, and accessible way while collaborating with key partners to ensure all COVID-19 vaccine messaging and information is community-informed, culturally relevant, linguistically appropriate, and accessible.

Our communication and engagement objectives will be accessible and culturally and linguistically appropriate, and include:

- Create new and strengthen existing community partnerships to build trust, confidence, and bi-directional communication channels, particularly with communities most disproportionately impacted by COVID-19.
- Collaborate with key partners to ensure all COVID-19 vaccine messaging and information is community-informed, culturally relevant, linguistically appropriate, and accessible.
- Invest in key partners, organizations, and groups to recognize their role as trusted messengers and channels.
- Provide timely, accurate, and credible information to the people of Washington on the COVID-19 vaccine. This information addresses questions and concerns we are hearing from communities, and includes the benefits and risks of vaccination, risks of COVID-19 disease, and vaccine safety data.
- Encourage continuing safe behavior practices, such as masking, social distancing, gathering in small groups, and hand washing.

To start, we will work to build confidence in the process to create and authorize COVID-19 vaccines and the vaccines themselves by sharing accurate and credible information about vaccine safety. We also will explain who will be prioritized when the vaccine is available and why. Then we will focus our communications on sharing who is currently approved for the vaccine, what they need to know, and where to get vaccinated. Our communications

work is an iterative process and audience feedback, outreach, and evaluation will be a continuing part of the process to make sure our communications are effective and relevant.

To formalize our commitment to equity, we adopted eight strategies for equitable COVID-19 vaccine distribution:

1. Engage communities to inform vaccine prioritization and planning
2. Integrate a pro-equity approach into vaccine allocation and distribution
3. Prioritize allocation and support to providers who effectively serve disproportionately impacted communities
4. Invest in trusted community leaders, messengers, and organizations
5. Ensure all communications, education and outreach efforts are culturally and linguistically appropriate and accessible
6. Strengthen the public health system's ability to center communities in vaccine outreach and access
7. Foster opportunities for collaboration
8. Support a trauma-informed approach to vaccine conversations

**More information about our vaccine equity strategies are available at [www.doh.wa.gov/Emergencies/COVID19/VaccineInformation/Engagement](http://www.doh.wa.gov/Emergencies/COVID19/VaccineInformation/Engagement).**

## Supporting Eligible Individuals to Know When and Where to Get a Vaccine within a Phase or Tier

As noted above, we want to help people know what phase they are in, when it is their turn to get vaccine, and where they can go. We used multiple communication strategies to reach out to different groups to share these messages in a community-informed, culturally relevant, linguistically appropriate, and accessible manner.

In addition, we used technology to facilitate this process and support our own understanding of demand to inform planning and implementation. An innovative survey tool (called Phase Finder) allowed a person to answer questions about their age, health condition, living conditions, employment role, etc. An algorithm then informed the person of what phase they are in and let them know if their phase is eligible to seek vaccine.

If the person is eligible, they can use the Phase Finder confirmation when going to the vaccine site. If the individual is not yet eligible, they can get an alert when their phase is eligible.

The Phase Finder tool was successful and effective during phased distribution. Phase Finder was discontinued after all people were eligible for vaccine on April 15 and phases were no longer in use.

## Conclusion

We want to acknowledge and thank all the individuals, communities, partners, and groups who participated in the planning and implementation process. We greatly value the feedback we have received and the time that others have invested in this ongoing effort.

We also wish to reiterate our overall gratitude. Many people shared the impacts of COVID-19 on their lives, their questions about the vaccine, and what they want us to consider as we made difficult decisions about vaccine prioritization. We heard your stories and experiences and we appreciate your trust in sharing them with us.

In partnership and with gratitude,

**The Washington State Department of Health COVID-19 Vaccine Planning Team**

## Appendices

### Appendix A: Key Data on the Impact of COVID-19 on Specific Populations from the National Academies & Application Excerpt

POPULATION	KEY IMPACT DATA
Black	Compared to non-Hispanic White populations, this group has a case rate that is 2.6 times higher, a hospitalization rate that is 4.7 times higher, and a death rate that is 2.1 times higher (United States) (CDC, 2020 a,b)
Hispanic/Latinx	Compared to non-Hispanic White populations, this group has a case rate that is 2.8 times higher, a hospitalization rate that is 4.7 times higher, and a death rate that is 1.1 times higher (United States) (CDC, 2020 a,c)
American Indian and Alaska Native	Compared to non-Hispanic White populations, this group has a case rate that is 2.8 times higher, a hospitalization rate that is 4.6 times higher, and a death rate that is 1.4 times higher (United States) (CDC, 2020 a,b)
Native Hawaiian and Pacific Islander	Group has experienced mortality from COVID-19 at a rate up to 5 times its proportion of the population compared to the general population (United States) (Wong, 2020)
Older adults (≥65 years)	Group accounts for approximately 80% of reported deaths related to COVID-19 (United States) (CDC, 2020d)  Population-level COVID-19 mortality risk is estimated to be 16- to 52-fold higher (United States) and 30- to 100-fold higher (worldwide) for this group than for younger people (Ioannidis et al., 2020)
Older adults (>80 years)	Group is experiencing a mortality rate 5-fold greater than average (United States) (Nikolich-Zugic et al., 2020)  Group is experiencing an “overwhelming percentage” of severe outcomes due to COVID-19 (worldwide)
People with underlying or comorbid conditions	Group is 6-fold more likely to be hospitalized and 12-fold more likely to die from COVID-19 as people without underlying conditions (United States) (CDC, 2020e).  Group is at greater risk of SARS-CoV-2 infection (Sanyaolu et al., 2020)
People who live and/or work in congregate settings	Older adults living in senior living facilities are at a high risk of severe COVID_19 (Nikolich-Zugic et al., 2020)  Long-term care facility residents accounted for half of >10,000 COVID-19 deaths reported by April 2020 (United States) (Chidambaram, 2020)

Sex	Men with COVID-19 are more at risk for worse outcomes and death than women, independent of age (China) (Jin et al., 2020)
Children	<p>Children and adolescents account for 10 percent of COVID-19 cases and less than 0.3 percent of deaths (United States) (AAP and CHA, 2020)</p> <p>Among children with COVID-19, 1.8 percent of cases resulted in hospitalization (United States) (AAP and CHA, 2020)</p> <p>78 percent of deaths among adolescents (under 21) reported to the DCD between mid-February and the end of July 2020 were people from Black, Hispanic and Latinx, or American Indian and Native Alaskan communities (Bixler et al., 2020)</p>
People who are pregnant or breastfeeding	<p>Group may be at increased risk of developing severe COVID-19 disease that requires intensive care unit admission and mechanical ventilation (Cohen, 2020b)</p> <p>Black and Hispanic women who are pregnant appear to be disproportionately at risk of severe disease and hospitalization (United States) (Ellington et al., 2020)</p> <p>Babies born to women infected with SARS-CoV-2 during pregnancy appear to be more likely to be born preterm or require neonatal intensive care (Allotey et al., 2020)</p>

**NOTE** The following groups are omitted from the table due to lack of COVID-specific epidemiological data: people who are undocumented, people with mental and physical disabilities, and people experiencing homelessness.

**EXAMPLE** Application of criteria for prioritization to different sub-groups using scientific data, community input, and local data to inform prioritization. Note: 1 – 5 (Low to High) and WA outbreaks considers frequency and relative overall size of outbreaks in Washington state.

POPULATION GROUP	RISK OF INFECTION	RISK OF MORBIDITY / MORTALITY	RISK OF TRANSMISSION	RISK OF NEGATIVE SOCIETAL IMPACT	EQUITY	WA OUTBREAKS
Ag workers	4	3	5	5	5	+
Food process.	4	3	5	5	5	+
Manufact. Line	4	3	5	5	5	+
Congregate construction	4	3	5	5	5	+
Incarceration Facil. Staff	3	2	5	4	5 (residents)	+
Child care	3	3	3	5	5	
K-12 staff	2	3	3	5	4 (students)	

## Appendix B: COVID-19 Expert Group Participant Lists

### Vaccine Advisory Committee

#### *Chair*

- Dr. Kathy Lofy, State Health Officer, Department of Health (Chair)

#### *Managed Care*

- Dr. John Dunn, Kaiser Permanente

#### *American Indian Health Commission for Washington (AIHC)*

- Wendy Stevens

#### *State Agency Health Care Purchasers*

- Jean Gowen, Health Care Authority
- Christopher Chen, Health Care Authority

#### *National Association of Pediatric Nurse Practitioners (NAPNAP)*

- Tara Tumulty, MSN, CPNP, ARNP

#### *Naturopathic Medicine*

- Dr. Mary Alison Koehnke, ND, Washington, Association of Naturopathic Physicians

#### *Washington Academy of Family Physicians (WAFP)*

- Dr. Susan Westerlund
- Dr. Usha Rao

#### *Washington Chapter of the American Academy of Pediatrics (WCAAP)*

- Dr. Daniel Moorman
- Dr. Stephen Pearson

#### *Washington State Association of Local Public Health Officers (WSALPHO)*

- Dr. Amy Person, Health Officer, Benton Franklin Health District
- Dr. Rachel Wood, Health Officer, Lewis County Public Health and Social Services
- Sarah Murray, Walla Walla County Department of Community Health
- Tristen Lamb, Public Health Director, Kittitas County Public Health Department

#### *Public Health--Seattle & King County*

- Dr. Jeffrey Duchin, Chief, Communicable Disease Control

#### *Internal Medicine Organization*

- Dr. Mary Anderson, Washington Chapter of American College of Physicians

#### *Washington State Pharmacy Association*

- Dr. Jenny Arnold, Pharm.D., Director of Pharmacy Practice Development

#### *Office of the Superintendent of Public Instruction (OSPI)*

- Annie Hetzel, MSN, RN, NCSN, School Health Services Consultant

#### *Child care*

- Anita Alkire MS, RN, Public Health Nurse Consultant, Child Care Health Program at Public Health – Seattle and King County

#### *Urban Indian Health Institute*

- Amy Poel, Epidemiologist

*Northwest Tribal Epidemiology Center*

- Tam Lutz, Project Director

*Consultants*

- Dr. Linda Eckert, Consultant
- Dr. Beth Harvey, Consultant
- Dr. Edgar Marcuse, Consultant

For more information, visit:

<https://www.doh.wa.gov/ForPublicHealthandHealth>

[careProviders/PublicHealthSystemResourcesandServices/Immunization/VaccineAdvisoryCommitteeVAC](https://www.doh.wa.gov/ForPublicHealthandHealth/careProviders/PublicHealthSystemResourcesandServices/Immunization/VaccineAdvisoryCommitteeVAC)

## SARS-CoV-2 Vaccine Scientific Advisory Workgroup

### Members:

- Dr. John Dunn, Kaiser Permanente
- Dr. Jeff Duchin, Public Health Seattle-King County
- Dr. Edgar Marcuse, Emeritus Faculty, University of Washington; Seattle Children’s Hospital
- Jenny Arnold Pharm.D, Washing State Pharmacy Association
- Dr. Alisa Kachikis, Faculty University of Washington
- Kirsten Senturia PhD Faculty University of Washington
- Dr. Mary Koehnke, ND
- Dr. Stacy Cecchet, Washington State Department of Health
- Emily Hilderman DNP, ARNP
- Darcy Jaffe, Washington State Hospital Association
- Albert Munanga, DrBH, MSN, RN
- Dr. Rewa Choudhary, Seattle Children’s Hospital
- Heather Kim, pharmacy student
- Kathy Bay, RN, DNP, Washington State Department of Health
- Amy Sullivan, PhD, Washington State Department of Health

## Disaster Medical Advisory Committee

### Members

- Iain Asplin, MD, PhD, Pediatric Critical Care Physician, Mary Bridge Children's Hospital
- Eileen Bulger, MD, Trauma Surgeon, Harborview Medical Center
- Joel Edminster, MD, Emergency Medical Services Medical Director, City of Spokane - Fire Department
- Aaron Grigg, MD, Ambulatory Primary Care Clinician (pediatrics), Yakima Valley Farm Workers Clinic
- Mary King, MD, MPH, Pediatric Critical Care Physician, Harborview Medical Center
- Hal Quinn, MD, Ambulatory Primary care Clinician (Pediatrics), Mercer Island Pediatrics
- Adam Richards, RN, Director of Nursing, Providence Sacred Heart Medical Center & Children's Hospital
- David Roesel, MD, MPH, Hospitalist (Adult), Northwest Hospital & Medical Center
- Vicki Sakata, MD, Emergency Medicine Physician, Northwest Health Care Response Network

- Yuan-Po Tu, DVM, MD, Ambulatory Primary Care Clinician (adult), The Everett Clinic - Mill Creek
- Curtis Veal, MD, Adult Critical Care Physician, Swedish Medical Center
- Bradley Younggren, MD, Emergency Medicine Physician, EvergreenHealth Kirkland

## Appendix C: Size Estimates of Population Groups

Below is a chart with our best estimates of the size of different population groups.

PHASE	POPULATION GROUP	SIZE ESTIMATE (not overlapping)
1a - Tier 1	High-risk workers in health care settings	<b>320,000</b>
	High-risk first responders	<b>30,000</b>
	Residents of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance	<b>100,000</b>
1a – Tier 2	Other workers at risk in health care settings	<b>300,000</b>
1b – Tier 1	People 65 and older	<b>1,044,000</b>
	People 50-64 in a multigenerational home	<b>300,000</b>
	Pre-K-12 educators and staff	<b>150,000</b>
	Workers in child care settings	<b>150,000</b>
1b – Tier 2	High risk workers in certain congregate settings	<b>460,000</b>
	People who are pregnant	<b>60,000</b>
	People with disability at high risk	<b>50,000</b>
1b – Tier 3	16-64 year olds with 2 or more co-morbidities or underlying conditions	<b>900,000</b>
	People 60 to 64 years of age not already covered	<b>150,000</b>
1b – Tier 4	People (residents, staff, volunteers) in certain congregate living settings	<b>50,000</b>
	High risk workers in certain congregate settings (restaurant, constr, manuf)	<b>420,000</b>
2	16-64 year olds with only 1 co-morbidity not already covered	<b>980,000</b>
	Critical workers who are not able to work remotely	<b>200,000</b>
3	All people 16 years and older not already covered	<b>440,000</b>
4	All people under 16 years of age	<b>1,405,000</b>

## Appendix D: Draft Worker Risk Stratification Resource Tool

Agencies outside health care may need to risk stratify their workers to identify eligibility by phase. Workers may also want to assess their own level of risk. Below is a **draft version of a tool** that is being developed in consultation with several agencies and will need to be refined with federal guidance. The criteria guiding this risk stratification are the same as the overall framework: risk of acquisition; risk of severe morbidity or mortality; risk of transmission; and risk of negative societal impact [note: this last risk elevates critical workers at highest risk over non-critical workers at highest risk in the phased approach] (see [State of Washington’s Safe Start guidance](#) for the most recent list of critical workers). The framework below was developed as a tool to help worker organizations and the workers themselves to think about identifying roles in their sector or industry that are at highest risk vs. moderate risk vs. low risk. This is a guide, not a checklist. So a highest-risk worker does need to fit

all the classifications but several (e.g. approximately 3 or more) of the classifications. Similarly, roles should fit according to the classifications that generally describe the nature of the role. If you need additional guidance to think about risk, please consult [CISA guidance](#) and [OSHA guidance](#).

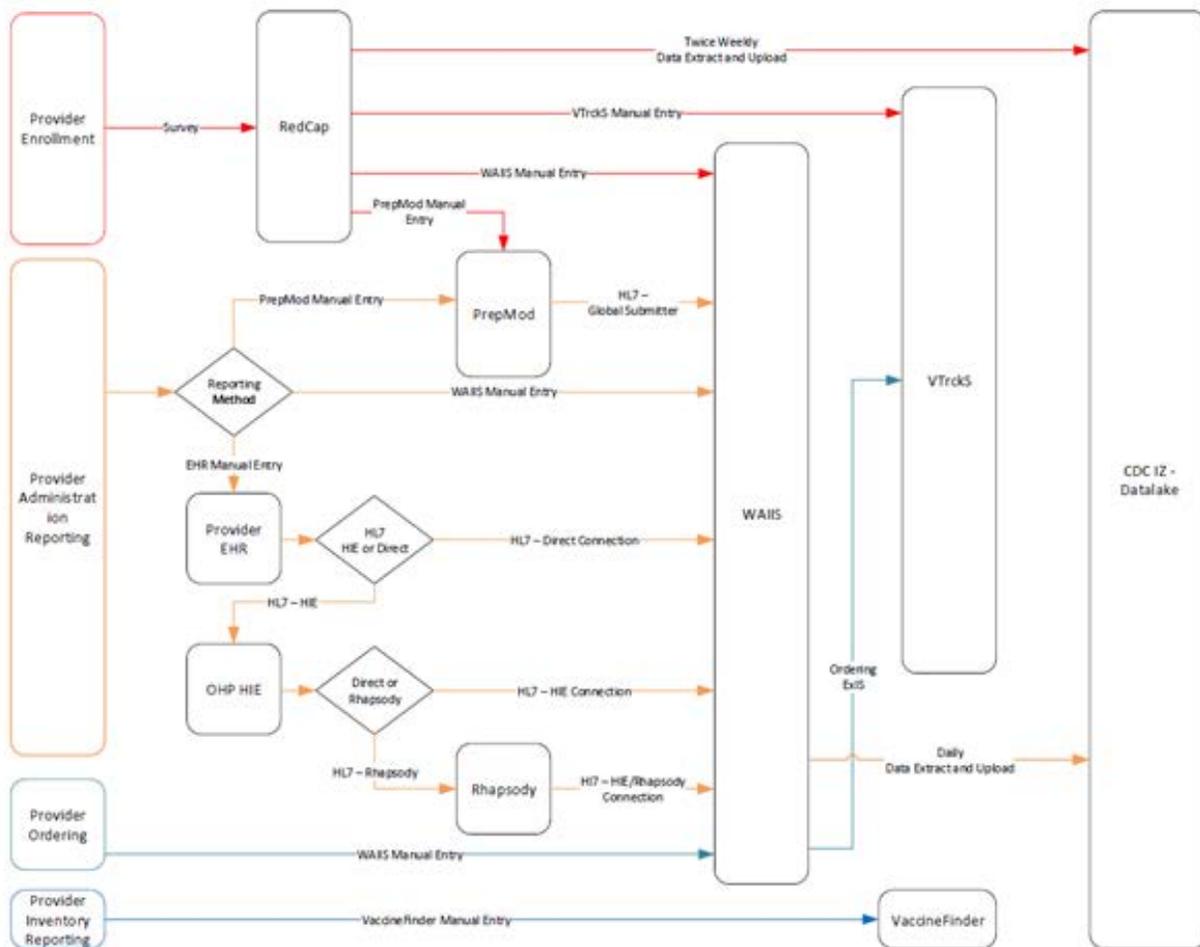
Classifications	Highest risk (3 or more of the factors below)	Moderate risk (1-2 of the factors under highest risk or fit with description below)	Low risk (fit with description below)
<b>Work setting:</b> Do workers work together inside or outside?	Predominantly inside	Mix of inside and outside	Predominantly outside
<b>Housing situation:</b> Do they live together (e.g. sleep, eat meals)?	Yes	No or very limited	No
<b>Transport situation:</b> Do they travel to or from work in crowded settings and/or travel together during work?	Yes (Over an hour within 6 feet of others)	Mixed (Less than an hour cumulative over 24 hours at 6 feet)	No (Travel together; over 6 feet separation)
<b>Engagement with vulnerable populations:</b> Does the role directly care for/engage with vulnerable groups? <sup>1</sup>	Yes	Sometimes	No
<b>Proximity:</b> How physically close are workers (and customers) to each other?	Less than 6 feet (2 meters)	N/A	More than 6 feet (2 meters) or N/A
<b>Duration:</b> How long does an average direct interaction with another person last?	15 minutes or longer cumulative per 24 hrs for interaction	Less than 15 minutes cumulative per 24 hrs for interaction	No direct contact
<b>Type of contact:</b> Do workers touch shared surfaces, common items, and other workers or customers?	Significant sharing of surfaces and items with customers and/or coworkers	Limited sharing of surfaces and items with customers and/or co-workers	Low to no sharing of surfaces and items with customers and/or co-workers
<b>Capability to assess possible infection:</b> Are there screening protocols that protect workers (and customers) from interactions with contagious people?	Not able to consistently screen all people with direct contact (workers, customers) for COVID-19 symptoms, exposure, and fever	Able to consistently screen all people with direct contact (workers, customers) for COVID-19 symptoms, exposure, and fever	Able to consistently screen all people with direct contact (workers, customers) for COVID-19 symptoms, exposure, and fever or N/A given remote

<sup>1</sup> Roles might be doula, caregiver, health care interpreter, community volunteer, community health worker. Vulnerable populations include people over 65, people with comorbidities, pregnant women, and people with disabilities.

<b>Number of different contacts:</b> How many close contact interactions with other people occur daily?	More than one direct contact/day with close contacts or any contacts if not able to screen	Few contacts with ability to screen	No close contact interactions
<b>Cleaning:</b> How frequently can shared or common facility surfaces be sanitized and cleaned?	Challenging to consistently sanitize and clean surfaces	Able to consistently sanitize and clean surfaces	Able to consistently sanitize and clean surfaces or N/A given remote working status
<b>Ability to protect themselves:</b> How consistently are these workers able to socially distance and use protective measures?	Not able to implement protective measures, including social distancing	Not able to consistently implement protective measures, including social distancing	Able to consistently implement protective measures, including social distancing or N/A given remote working status
<b>Personal protective equipment:</b> How adequate is the worker's supply and access to PPE?	Inadequate or inconsistent access to PPE needed given nature of work	Has consistent access to adequate PPE or N/A given nature of work	N/A
<b>Disabilities:</b> Are workers unable to observe protective measures such as wearing face masks or other PPE due to an underlying disability?	Yes	N/A	N/A
<b>Health care access:</b> Do the workers in this role generally have <b>access barriers</b> to health care?  For example: <ul style="list-style-type: none"> <li>• People with limited transportation</li> <li>• People who live far from health care services</li> <li>• People with limited English proficiency</li> <li>• Individuals with disabilities</li> <li>• People without insurance</li> <li>• Undocumented people</li> </ul>	Majority	Some	Limited

## Appendix E: COVID-19 Vaccine Information System Visual

Source: Washington State Department of Health



## Appendix F: Community Engagement Questions

Results of the survey, interviews, and focus groups – and all future engagement activities – are available at <https://www.doh.wa.gov/Emergencies/COVID19/VaccineInformation/Engagement>.

### Public Feedback Survey Questions

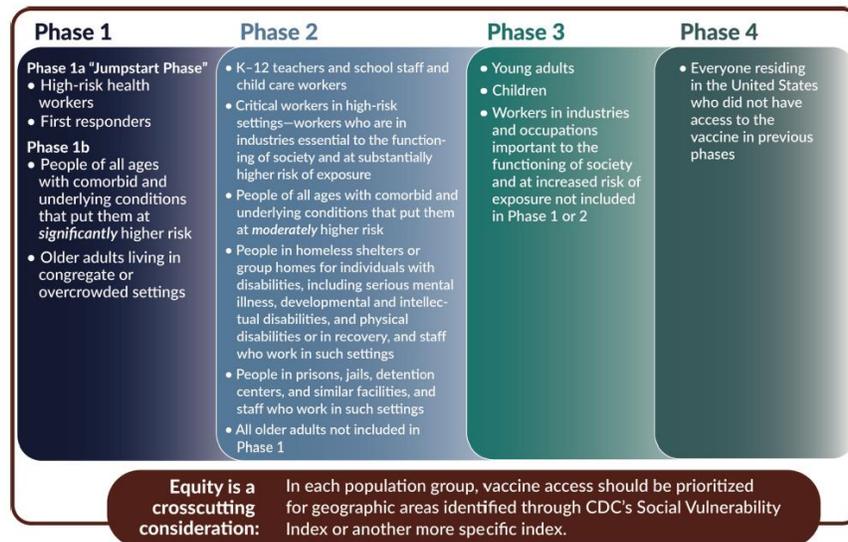
#### **PART ONE: HOW ARE YOU FEELING ABOUT COVID-19?**

- 1) How worried are you about getting COVID-19?
- 2) How bad is being sick with COVID-19?
- 3) How much would the COVID-19 vaccine protect you and your family from COVID-19 disease?
- 4) Do most people in your life get vaccinated?
- 5) Do you think you will get the COVID-19 vaccine?
- 6) Do you have any fears about the COVID-19 vaccine?
- 7) If you get the COVID-19 vaccine, where would you prefer to get it?

#### **PART TWO: HOW SHOULD WE DECIDE WHO GETS THE VACCINE FIRST?**

- 8) How much do you agree with the inclusion of these six principles?
  1. Maximization of social benefits
  2. Equal regard
  3. Mitigation of health inequities

4. Fairness
  5. Evidence-based
  6. Transparency
- 9) How much do you agree with these four considerations?
1. Risk of acquiring infection
  2. Risk of severe morbidity and mortality
  3. Risk of negative societal impact
  4. Risk of transmitting disease to others
- 10) The National Academies of Medicine created this phased approach to vaccine allocation for COVID-19. Final prioritization depends upon things that were unknown as these processes were first developed, such as which groups will be approved for the vaccine. Please review the image below and provide feedback on the specific questions that follow.



- 11) How much do you agree with how these different groups are prioritized? Check only one column.
1. High risk health workers
  2. High-risk first responders
  3. People with underlying conditions that put them at significantly risk
  4. Older adults living in congregate and overcrowded settings
  5. K-12 teachers and staff and child care workers
  6. Critical workers in high risk settings (example: people at high risk for exposure)
  7. People with underlying conditions that put them at moderately higher risk
  8. People in homeless shelters or group homes for individuals with disabilities
  9. People in prisons, jails, detention centers
  10. Young adults
  11. Children
- 12) Until there is enough vaccine for all people, we will continue to have to make difficult decisions about who should be offered the vaccine first. We will be looking at many different factors. How would like us to consider the following factors?
- People with access barriers to health care
  - People at risk for severe illness
  - People at higher risk for exposure
  - People who are at higher risk for spreading COVID-19 to high risk populations
  - People essential to health and wellbeing of populations at higher risk

- People who live in areas with greater spread
- People who have been disproportionately impacted by COVID-19 because of systemic inequities

### **PART THREE: TELL US ABOUT YOURSELF (optional)**

- 13) Do you work in any of the following sectors? Essential business includes workers, businesses, and industries who are deemed essential by the State of Washington’s Safe Start guidance and are at higher risk for COVID-19 exposure.
  - a) Health care – And I think my position makes me at high risk for COVID-19
  - b) Health care – And I don’t think my position makes me at high risk for COVID-19
  - c) Essential business – And I think my position makes me at high risk for COVID-19
  - d) Essential business – And I don’t think my position makes me at high risk for COVID-19
  - e) First responder - And I think my position makes me at high risk for COVID-19
  - f) First responder – And I don’t think my position makes me at high risk for COVID-19
  - g) Teacher or school staff
  - h) Early learning or day care provider
  - i) None of the above
- 14) Do you identify as someone who is personally at increased risk for COVID-19 because of your race/ethnicity?
- 15) Do you identify as someone who is personally at increased risk for COVID-19 because of your disability status?
- 16) Do you identify as someone who is personally at increased risk for COVID-19 because of your overall health or age?

### **Key Informant Interview Questions**

1. We would like to collect some very basic information to help put this feedback into context. If you are willing, can you please share:
  - a. The community/organization/workplace/business/industry/sector you represent. You can also just say “community member” if you prefer.
  - b. The county or counties that you are connected to. This can be where you live & work as a community member or the counties your organization serves.
2. How have you been impacted by COVID-19?
  - a. Do you know anyone who has tested positive for COVID-19?
  - b. Do you know anyone who has been very sick or died from COVID-19?
3. Who in your community/organization/workplace/business/industry/sector is most impacted by COVID-19? How are they impacted?
4. How worried are you about getting COVID-19?
  - a. How worried are you about someone in your community/organization/workplace/business/industry/sector getting sick with COVID-19?
5. What are the best ways to stop COVID-19 from spreading?
6. Washington state could have a vaccine for COVID-19 in the next year. What have you been hearing about the vaccine in your community/sector/etc.? What are people saying in terms of looking forward to it or being concerned about it?
  - a. How are you feeling about the vaccines?

- b. Do you think you will want to get the COVID-19 vaccine?
- 7. When would you want to get the vaccine? Right when it is available for you, or some other time?
  - a. What would make you/your community/sector/etc. more comfortable with the vaccine?
  - b. What do you need from the Washington State Department of Health to have more trust and confidence in the vaccine?
  - c. What could the Department of Health do that might cause you/your community/sector/etc. to be MORE concerned when we begin promoting it and distributing it?
  - d. Is there someone in your life who you trust enough to follow their suggestion to get the COVID-19 vaccine? Who would that be for you?
- 8. What barriers may people within your community/organization/workplace face to getting the vaccine?
- 9. Do you have any fears about the COVID-19 vaccine? What are your fears?
- 10. What do you want to know about the COVID-19 vaccine?
  - a. What is the best way to share information like this with you?
  - b. Who do you trust for information about the COVID-19 vaccine?
- 11. Until there is enough vaccine for all people, we will have to make difficult decisions about who should be offered the vaccine first. What should we think about when making these decisions?
- 12. This is a framework for prioritizing and allocating COVID-19 vaccine that was created by the National Academies of Medicine. The most current recommendations are to start with high-risk health workers and first responders, then offer vaccine to people with two or more health conditions that put them at higher risk for COVID-19 and older adults living in shared housing. Once there is more vaccine, Phase 2 includes teachers, school staff, people in homeless shelters, people with disabilities in shared housing, people who are detained & incarcerated, and people who work in essential businesses and are at high-risk for COVID-19.
  - a. Do you agree with these initial priorities?
  - b. Where do you see yourself/your community/business/sector/etc.? Do you agree with how yourself/your community/business/sector/etc. is prioritized?
  - c. Some of these groups are actually quite large and we may have to prioritize within them. One of the things we're looking at is what puts someone at a higher risk for getting or spreading COVID-19 within each of these groups. Thinking about your community/business/sector/etc. what are some of those factors that could put a certain person at higher risk?
  - d. What impact would it have on the community you serve/your customers/your business operations/etc. if someone got sick with COVID-19?
  - e. What else do you want us to know or consider?
- 13. If you could protect three people in your life from getting COVID-19, who would you protect and why?

## Appendix G: Citations

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