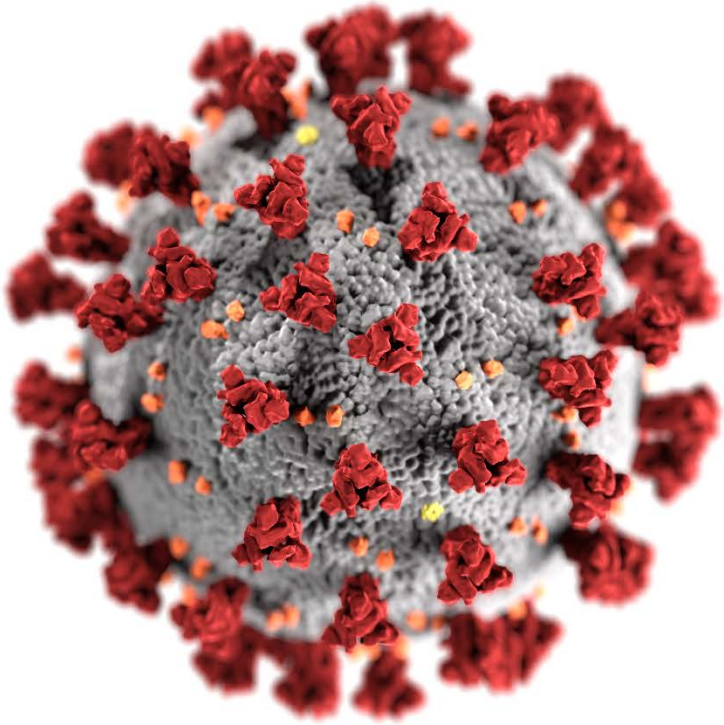


COVID-19 Vaccination Program Interim Playbook for Jurisdictions Operations Annex

Considerations for Increasing COVID-19 Vaccination: Reaching and Increasing Uptake in Priority Populations

Centers for Disease Control and Prevention

January 2021

Version 1.0

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

COVID-19 Vaccination Program Interim

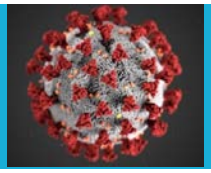
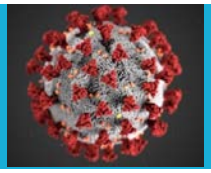


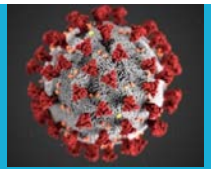
Table of Contents



Introduction

Purpose of document

- To serve as a companion document to the COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations (i.e., "Playbook")
- To provide new guidance and considerations to jurisdictions regarding when and how to transition from vaccinating initial populations of focus to reaching and increasing uptake in additional priority populations
- To provide a framework for balancing equitable access, service delivery, and vaccine demand
- To provide tools for engaging priority populations and increasing vaccine confidence
- To provide strategies to leverage private-public partnerships



Considerations for Transitioning Between Phases

On December 1, 2020, the Advisory Committee on Immunization Practices (ACIP) recommended phased allocation of COVID-19 vaccines to specific, priority populations while vaccine supply is limited, with expansion of populations recommended for vaccination as COVID-19 vaccine supply allows. ACIP recommendations are intended to help guide the most equitable distribution of the first available vaccine doses. These recommendations are divided into phases[1] to support jurisdiction prioritization during varying levels of vaccine supply.

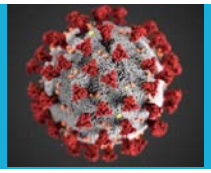
- Phase 1a includes healthcare personnel and long-term care facility residents.
- Phase 1b includes persons ≥75 years of age and frontline essential workers (non-healthcare).
- Phase 1c includes persons 65–74 years of age, persons 16–64 years of age with high-risk medical conditions, and other essential workers.
- Phase 2 includes all other persons aged ≥16 years of age not already recommended for vaccination in Phases 1a, 1b, or 1c.

Decisions about when to transition from one phase to the next should include considerations of supply, demand, and equitable vaccine distribution and access, as well as local, state, or territorial context and epidemiology. Jurisdictions should remain flexible to maximize use of all doses by increasing access to vaccination and using the principles of supply-chain management as well as tools to help with planning (e.g. microplanning applications like Tiberius (Palantir Technologies Inc., Denver, CO)). It is not necessary to vaccinate all people in one phase before initiating the next phase; phases can overlap. If vaccination provider sites within a jurisdiction are moving independently through the phases and are more than one phase apart (e.g., some sites are ready to move to Phase 1c while others are still in Phase 1a), jurisdictions should assess vaccine supply, demand, and equitability of vaccine distribution across the entire jurisdiction. This assessment can include examining ways to expand vaccination access, demand, and capacity as well as addressing vaccine hesitancy within the jurisdiction; this can result in vaccine being redistributed between sites within jurisdictions.

The following situations offer examples of when transitioning to the next phase and expanding vaccine availability to additional populations could be warranted:

- When demand in the current phase appears to have been met (e.g., appointments for vaccination are <80% filled for several days in a row)
- When supply of authorized vaccine increases substantially (e.g., more vaccine doses are available than are necessary to complete vaccination of persons in the current phase)
- When most persons (e.g., 60%–70%) in the current phase are vaccinated, despite efforts to increase both access and demand

[1] The phases identified in the Playbook were structured prior to the release of ACIP recommendations and are, therefore, slightly different than those recommended by ACIP. The phases in this Annex are in alignment with current ACIP recommendations.



- When vaccine supply within a certain location is in danger of going unused unless vaccination is expanded to persons in the next phase

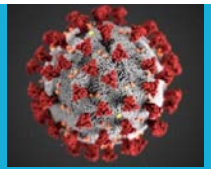
Jurisdictions should closely monitor vaccine uptake to assess vaccination coverage and determine when their population is ready to move to the next phase of vaccination. In addition to state-specific websites and commonly used web pages, there are several data resources available to assist states:

- CDC COVID Tracker: COVID Tracker is CDC's externally facing website that presents information on different COVID-19 specific data points, including vaccination data. Using COVID Tracker, states can actively monitor total vaccine doses distributed and administered within their jurisdiction and at the national level, people initiating vaccination (receiving a first dose), as well as the vaccine uptake in key populations, including those in the Federal Pharmacy Partnership for Long-Term Care Program. Data from COVID Tracker are obtained from the CDC Immunization Data Lake (*see Playbook, Section 9)* and contain all doses administered from each jurisdiction (including data from the Vaccine Administration Management System [VAMS], Federal Pharmacy Partnership for Long-Term Care Program, and certain federal entities (federal entity data reported separately from jurisdictions).
- Tiberius: The Health and Human Services' (HHS) Tiberius platform (*see Playbook, Section 15)* is a tool featuring allocation, distribution, and administration information for each jurisdiction. Tiberius is an internally facing tool that allows jurisdictions to view their specific vaccine allocation, distribution, and administration data by various demographic characteristics—in many cases, down to the county level. Vaccine administration information in Tiberius is populated by data from the CDC Immunization Data Lake. Jurisdictions are encouraged to use this in-depth information about vaccine allocation, distribution, and uptake to determine when they are ready to transition to the next phase of vaccination and ensure distribution in an efficient and equitable manner.

Fully vaccinating populations while expanding access

Once COVID-19 vaccination has been expanded to additional phases, jurisdictions should strive to improve vaccination coverage by continuing to offer and promote vaccination to all persons in earlier phases who have not yet been vaccinated. These persons could have been more hesitant or lacked easy access to vaccination. See the "Planning–Developing Strategies to Reach the Population" section below for strategies to improve access and increase demand.

More information and other considerations for transitioning between phases can be found here: https://www.cdc.gov/vaccines/covid-19/phased-implementation.html.



Prioritization and Sub-Prioritization of Populations

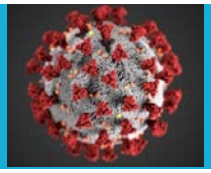
ACIP defines frontline essential workers as the subset of essential workers likely at greatest risk for work-related exposure to SARS-CoV-2, the virus that causes COVID-19, because their work-related duties must be performed on site and involve being in close contact (within 6 feet for a total of 15 minutes or more) to the public or coworkers. An interim list of essential worker categories mapped to standardized industry codes and titles can be found on CDC's website. This list is intended to help state, local, tribal, and territorial officials and organizations prepare for the allocation of initially limited COVID-19 vaccine supply by mapping essential industries to corresponding COVID-19 vaccination phases and workforce categories, as recommended by ACIP. Additional information on the essential workforce can also be found in the Cybersecurity Infrastructure and Security Agency's (CISA) Guidance on the Essential Critical Infrastructure Workforce. Frontline essential workers recommended by ACIP to receive vaccination in Phase 1b are firefighters, police officers, corrections officers, food and agricultural workers, U.S. Postal Service workers, manufacturing workers, grocery store workers, public transit workers/transportation, and those who work in the education sector (teachers and support staff members) as well as day care workers. Essential workers recommended by ACIP to receive vaccination in Phase 1c including people who work in water and wastewater, food service, housing construction, finance, information technology, communications, energy, legal services, media, public safety, and public health.

Considerations for sub-prioritization of populations in Phase 1b and 1c

When vaccine supply is limited, jurisdictions may need to sub-prioritize—or assign a higher priority to—vaccination of certain groups or persons within a given priority group. As jurisdictions make these complicated decisions, it will be important to ensure equitable access to vaccination for persons at highest risk of severe disease and those who perform essential services and functions. Sub-prioritization among groups of non-healthcare essential workers might differ by jurisdiction and encompass a variety of workers that are critical to public health, safety, security, and the economy at jurisdictional and national levels.

The following are characteristics or factors that might warrant sub-prioritization within groups of frontline or other essential workers:

- Groups of workers that are the most critical to maintaining core societal functions
- Groups of workers with unavoidable higher risks of exposure because of their inability to perform work duties remotely and necessity of working without adequate protection while in close contact with coworkers or members of the public (e.g., persons in meatpacking plants who might be working in close quarters or personal care assistants who are providing care for people in group homes)
    - Considerations can be informed by the length of time workers are exposed to each other and the public as well as the number of contacts they have during a typical workday.
- Groups of workers at sites with potential for high transmission rates and outbreaks (e.g., correctional and detention facility workers)



- Ensuring equitable access for populations disproportionately affected by COVID-19 due to social and structural factors
    - Considerations for sub-prioritization can be informed by CDC's Social Vulnerability Index, CDC's COVID-19 Hospitalization Surveillance Network (COVIDnet), or other similar jurisdictional epidemiological indices.

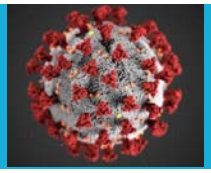
Sub-prioritization might be needed among groups included in Phases 1b and 1c based on factors other than essential worker characteristics, including underlying medical conditions, age, and congregate living status as noted below:

- Underlying medical conditions: CDC identifies certain underlying medical conditions, such as obesity, diabetes, and hypertension, as high risk for severe COVID-19. However, persons with other medical conditions might also be at increased risk of severe disease and should consult with a healthcare provider about personal risk factors. As COVID-19 vaccines become more widely available in provider locations and pharmacies, healthcare providers may use clinical judgment to determine an individual patient's priority for vaccination.
- Age: ACIP recommends prioritizing adults ≥75 years of age for vaccination in Phase 1b, and adults 65–74 years of age in Phase 1c. When vaccine supplies are limited, sub-prioritization of adults in both groups may be warranted, such as prioritization of those with underlying medical conditions over older adults without any of those conditions.
    - Additionally, communities that have been disproportionately affected by COVID-19 and have a younger population distribution, can choose to adopt a different lower age limit for vaccination prioritization appropriate to state, local, or territorial epidemiology.
    - When supply is sufficient, state, local, or territorial jurisdictions can consider moving quickly from Phase 1b to Phase 1c to allow for expanded access to COVID-19 vaccines for all adults 65 years of age and older.
- Congregate living settings: Increased rates of transmission have been observed in congregate living settings. Based on local, state, or territorial epidemiology and implementation considerations, jurisdictions can choose to vaccinate persons who reside in congregate living facilities (e.g., correctional or detention facilities, homeless shelters, group homes, or employer-provided shared housing units) at the same time or just after frontline staff because of their shared increased risk of disease.

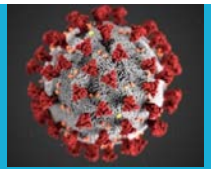
More information and other considerations for sub-prioritizing groups can be found here: https://www.cdc.gov/vaccines/covid-19/phased-implementation.html.

Balancing vaccine supply, access, equity, and demand

To achieve high uptake, jurisdictions must strike a balance between vaccine supply, access, and demand. If there is low uptake, which can manifest as low coverage, jurisdictions will need to quickly understand the reasons and address them before vaccine wastage occurs. In some cases, low uptake could be related to health system challenges (supply, access, service delivery) and, in other cases, it could be related to low demand (awareness, social/behavioral factors, vaccine confidence). Often, low uptake results from a combination of factors that require concerted efforts to ensure adequate supply,



decrease barriers to access, and build trust to increase vaccine confidence and demand for vaccination across all priority communities and populations. For instance, if limited numbers of appointments are filled or lower numbers of vaccinations at a mass clinic are identified, jurisdictions should consider changing dates and times to ensure equitable access. In addition, increased communication using various methods should be considered to ensure people know the vaccine is available and how to get vaccinated. Ensuring vaccination sites are located near public transportation options could also assist in increasing access. When demand is found to be low, jurisdictions are encouraged to work with community groups and community leaders to understand and address any population concerns.



Planning–Developing Strategies to Reach the Population

Estimate priority population size

The first step in planning is to identify and estimate the size of priority populations within a jurisdiction. Estimates of these groups should be as accurate as possible to minimize potential waste of vaccine, constituent products, or ancillary supplies. Partner agencies and organizations can be helpful in determining accurate estimates of these population groups. Such organizations might include the jurisdiction's emergency management agency, labor department, and chamber of commerce, as well as healthcare coalitions, local advocacy groups, unions, chronic disease/nutrition groups, the U.S. Department of the Interior, federal executive boards, and the Association of Continuity Professionals. Jurisdictions can also use Tiberius and other tools available to them, for estimating the size of key populations.

Map vaccine providers for most equitable access

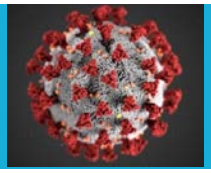
To improve vaccination among priority population groups, jurisdictions must ensure these groups have access to vaccination services. To inform COVID-19 vaccination outreach efforts at the programmatic and provider levels, jurisdictions need to know where these groups are located. Jurisdictions should create visual maps of these populations, including places of employment for the critical infrastructure workforce category, to assist in COVID-19 vaccination clinic planning, especially for satellite, temporary, or off-site clinics. To ensure equitable access to vaccination services among priority populations and identify areas where additional providers might be needed, jurisdictions could also use mapping tools to identify areas with health disparities (e.g., CDC's Social Vulnerability Index Interactive Map). Maps of critical populations should then be overlaid with maps of enrolled providers by provider type and populations served by these providers. Jurisdictions might also want to consider encouraging and supporting healthcare personnel who are existing trusted sources and work in areas serving these priority population groups to enroll as vaccination providers.

Promote equitable access to vaccination

In addition to factors like geographic proximity, other factors (e.g., methods used to make a vaccine appointment, days/times when vaccination is offered, ability to communicate in languages other than English, materials tailored to different literacy levels, or transportation challenges) affect a person's ability and willingness to be vaccinated. Communication, outreach, and partnership building within communities are key to identifying and addressing these barriers, building trust, and increasing demand for vaccination. For example, jurisdictions should consider people's ability to make an online vaccine appointment, or to take time off to get vaccinated (e.g., leaving work or arranging childcare) or deal with vaccine side effects if they impact ability to work or care for dependents. Another example would be aligning vaccination points of distribution (PODs) near public transportation sites to overcome transportation barriers.

Plan communication efforts to support vaccine confidence

Communication around COVID-19 vaccination is important for all phases of the vaccine rollout. Jurisdictional efforts should aim to promote awareness about the risk of COVID-19 infection, benefits of

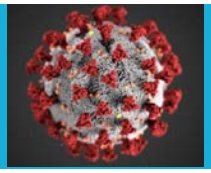


vaccination, transparency about safety monitoring, timeline for vaccine rollout and rationale for prioritization. It's also critical to promote confidence in vaccines, vaccinators, and health systems.

Communication and education/community outreach teams should be adequately staffed and resourced to address daily communication needs of the program, effectively engage with diverse communities online and offline, and quickly and effectively respond to any crisis.

The following minimum recommended activities should be considered before broadening populations eligible for vaccination. Communication strategies should be regularly revisited to capture additional priority audiences and update approaches to reaching them.

1. Update communication strategy and key messages.
    - In strategy, include the priority audience, desired behavior, and the interventions, trusted messengers, channels, and messages that are needed to promote the desired behavior.
    - Identify and provide media training for additional spokespersons who reflect and are respected by groups eligible for vaccination.
    - Develop strategies tailored for reaching priority populations, communities, and people who might encounter access or demand challenges to being vaccinated, including tailored messages and interventions (see the "Building vaccine confidence" section).
    - Update basic talking points and presentation templates (e.g., web links, posters, public service announcements, etc.) to promote COVID-19 vaccination for different audiences who will be eligible to receive vaccines.
    - Update social media and media monitoring rhythm and search terms to track and understand common perceptions and concerns in expanded priority populations.
2. Address healthcare personnel questions and concerns about COVID-19 vaccination and vaccine confidence.
    - Ensure vaccination providers are knowledgeable about evidence-based immunization strategies and best vaccination practices, including specific information on COVID-19 vaccine. This is particularly important when enrolling new providers. A list of immunization training and educational materials, including basic and COVID-19-vaccine-specific information, can be found here: https://www.cdc.gov/vaccines/covid-19/training.html.
    - Use resources from the COVID-19 Vaccination Communication Toolkit For Medical Centers, Clinics, and Clinicians to facilitate conversations about vaccine confidence among healthcare staff.
    - Support healthcare personnel in providing vaccine information and having effective vaccine conversations with patients both online and offline (e.g., job aids, webinars, articles in patient portals, social media content).
3. Conduct communication, education, and outreach activities to raise awareness, address questions, and build vaccine confidence among key public audiences.

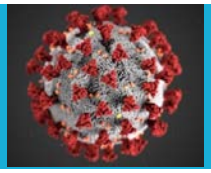


- Establish a rhythm of communication from a credible and steady messenger for all key audiences, especially expanded populations, such as regular press conferences or web page updates. Consistency and responsiveness are key.
- Identify trusted messengers from within these audiences that speak powerfully to different audiences online and offline and cultivate a relationship with them to amplify messages and provide feedback to the jurisdiction.
- Adapt CDC materials or create additional communication materials in different formats for specific audiences to promote consistency in reaching these populations across jurisdictions.
- If time allows, pretest these materials through focus groups or online surveys.
- Establish or strengthen partnerships with the private sector and community- and faith-based organizations to share communication materials and collaborate on joint communications (e.g., radio public service announcements, employee newsletter, social media channel takeover) and community engagement activities (e.g., webinars, town halls, listening sessions).
- Track questions received by your immunization program and misinformation circulating online in order to identify common concerns that could be addressed with updated materials.

Building vaccine confidence

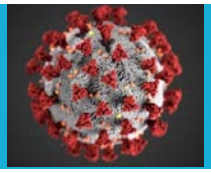
To achieve high demand for vaccines across all at-risk populations, people must have confidence and trust in the vaccines, the vaccinators, and the health system that provide them. This is particularly important in communities of color and other communities disproportionately affected by COVID-19 who might have low trust in the health system. Building confidence requires consistent engagement with communities where information is regularly shared, questions and concerns are discussed and fully addressed, and barriers to equitable access are lowered. Promoting vaccine confidence should be followed by improving vaccine access to ensure that vaccine is both acceptable and accessible, particularly for disproportionately affected communities or those who have faced historic barriers to accessing health services. This might involve ensuring that vaccination clinics are available during different times of day to accommodate varying shifts and schedules or conducting mobile clinics in multiple locations. Clear communication about who is prioritized and why, is important for reaching priority populations.

Jurisdictions should recognize that current implementation challenges might increase anxiety and frustration and perpetuate reduced trust in government or perceptions of bias in existing systems. However, jurisdictions can work to minimize anxiety and frustration for people who really want the vaccine but can't get it or need to wait their turn by providing them with action-oriented options. Examples include learning more about vaccines in community meetings, having conversations about COVID-19 vaccines with their family and friends, or supporting eligible family members in getting vaccinated by driving a grandparent to the vaccination provider site or volunteering to babysit for a neighbor who needs time for a vaccine appointment. When people get vaccinated, they can post selfies on their social media feeds, sign up for v-safe, a smartphone-based tool (released in December 2020)



that uses text messaging and web surveys to check in with vaccinated people for adverse events after a COVID-19 vaccination, or share their reasons for vaccination with their family and friends.

The CDC Vaccinate with Confidence framework for COVID-19 vaccines can serve as a guide on how to build vaccine confidence at the jurisdiction level. Fact sheets, presentations, templates, and guidance documents are available on CDC's website, including those designed for different audiences, such as healthcare personnel, jurisdictions, community organizations, and long-term care facilities.



Implementing Strategies to Increase Population Access to COVID-19 Vaccine

As vaccine supply increases, leveraging a wide variety of potential community COVID-19 vaccination providers and settings is essential to providing equitable access to COVID-19 vaccination for all people in all communities. Public health programs should understand their jurisdiction's overall potential COVID-19 vaccine administration capacity, (*see Playbook, Section* 6), using a variety of COVID-19 vaccination provider types and settings across all geographic areas within the jurisdiction.

Jurisdictions should continuously monitor provider enrollment, doses ordered and administered, and vaccination coverage to ensure equitable access to vaccination and uptake among disproportionately affected populations and other groups with historically low access to vaccination services. As monitoring activities indicate, efforts should be made to enhance access and demand among these groups.

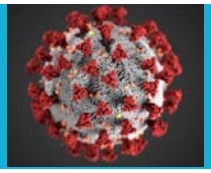
A successful vaccine administration strategy requires a mix of vaccination provider sites: pharmacies, primary care physician offices, federally qualified health centers, on-site vaccination clinics, small mobile vaccination clinics, closed PODs, large-scale open PODs/mass vaccination clinics, and satellite, temporary, or off-site clinics. To scale up vaccination efforts, public health programs must identify populations, plan outreach and communication, select vaccination provider sites, direct people to vaccination provider sites, and ensure follow-up reporting. Public health programs must also be responsible for vaccine logistics and operations (ordering, transport, storage, management, clinic planning, second dose reminders, etc.). To successfully manage each of these areas and vaccinate the population quickly, it is important to use the most appropriate vaccination provider site(s) for each population. It will also be important to leverage private-public partnerships within the community to augment vaccination activities (e.g., partnerships with community- and faith-based organizations).

Selecting vaccination provider sites

Selecting vaccination provider sites requires balancing increasing access to vaccine, throughput (number of persons that can be vaccinated), and operational considerations. **Figure 1** provides an example of considerations to assist in determining the most ideal site(s) for each population group.

Several factors should be considered when selecting a vaccination provider site for a population. These factors include whether the population is mobile (i.e. can easily access health services via private or public transport), easily identifiable, and responds well to outreach. Information about these factors may help identify the most appropriate strategy for a given population. Some considerations are listed below:

- For populations with limited mobility, including those who might be homebound or have other access issues, on-site vaccination is essential. Engaging home health agencies and community nurses who serve these populations can be helpful. At present, vaccines cannot be transported more than once. To minimize wasted doses when vaccinating home-bound populations, jurisdictions may consider vaccinating other people in the home if there are extra doses.
- Mobile populations (essential workers and others) who can be easily identified through credentials (identification, badges) and who may be willing to seek vaccination after basic



outreach (e.g., emails, posters, etc.), could be directed to sites that are already accessible in the community, such as pharmacies/retail clinics. These sites could offer a faster solution to vaccination access, as long as each site can vaccinate the required number of people.

- For select essential worker populations that require more intense outreach, jurisdictions might want to consider providing more direct access to vaccination through on-site vaccination clinics in occupational settings or mobile vaccination units that travel within the community for healthcare personnel who do not have access to occupational health services. Closed PODs may also be designated to serve these types of groups.
- For mobile populations who are not easily identifiable through identification or badges, the best vaccination provider strategy will depend on how well the group responds to outreach (i.e., whether they will seek a location to get vaccinated). If they respond well to outreach, the best option could include sites with low burden in terms of logistics and operations. These would need to be coupled with solutions to help identify eligible persons (i.e., through providing vouchers that can be used at closed PODs or in pharmacies).
- For mobile populations that are easily identifiable but might need additional outreach, the best option will be a trusted community vaccination service, such as mobile vaccination or on-site clinics in trusted community venues.
- For broad-scale efforts to reach the general population once vaccine supply is plentiful, consider mass vaccination clinics/open PODs that will allow for maximum throughput without the need for priority population eligibility screening.

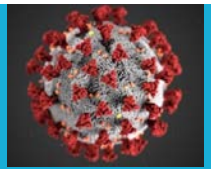
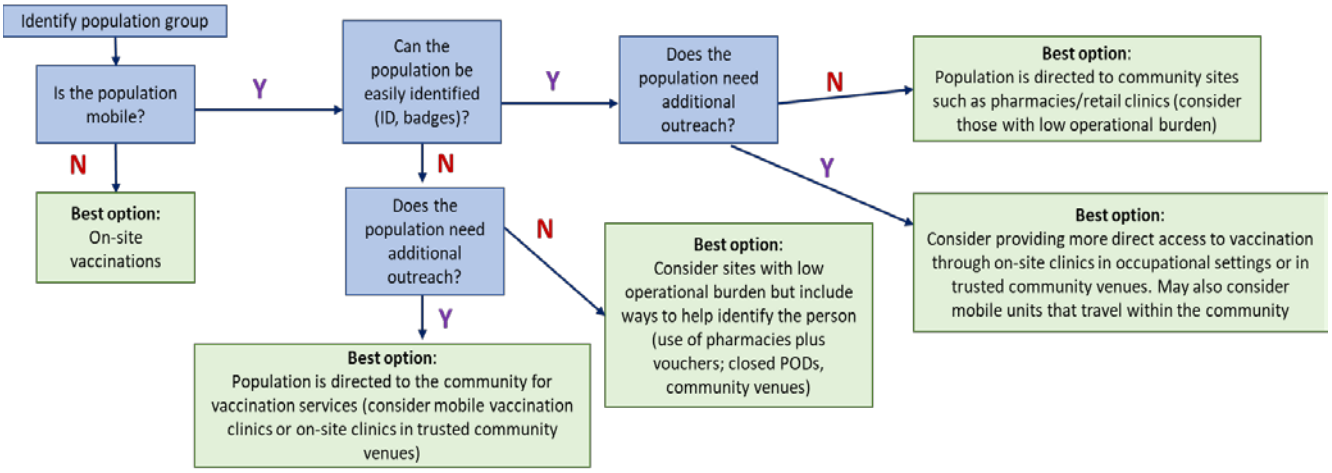


Figure 1: Framework for selecting vaccination provider sites for specific populations

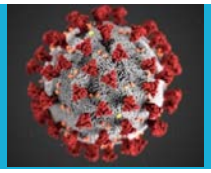


Vaccination provider site considerations and throughput

Determining the type and number of locations to mobilize depends on many variables, including population (e.g., size, occupation, age), programmatic operational burden, scalability, and throughput. Assessments can be scaled up based on assumptions of vaccination stations and workforce. Assume each vaccination station will include one vaccinator working a 10-hour shift. Additional workforce is also needed to support clinic operations. The model below in **Table 1** presents considerations for various vaccination provider sites outside the healthcare system, and assumes that every vaccination station will require appropriate infection control procedures as well as staff who manages registration, triage, vaccine preparation (including storage and handling), vaccine administration, and postvaccination patient monitoring and discharge.

Table 1: Vaccination provider site considerations

Vaccination provider site	Programmatic operational burden	Easily scalable if enough supply?	Works well in low supply situation	Estimated No. of vaccination stations	Monthly throughput/site (doses)
On-site vax clinic	High	No[2]	Y	2–4	Variable
Small clinics/mobile vax clinics	Medium	No[2]	Y	2	4,020 (201 doses/day)
Medium/pop-up clinics	Medium	Depends	Y	5	24,000 (1,200 doses/day)
Large-scale, open PODs/mass vax clinics	High	Depends	N	10	79,680 (3,984 doses/day)
Pharmacy retail	Low	Yes	Y	3–5	1,680–2,800



					(84–140 doses/day)

[2]On-site vaccination clinics and small/mobile clinics could be augmented by expanding hours to include evenings and weekends and/or by offering drive-through services.

Types of clinics for consideration include:

- Federally qualified health centers (FQHCs)
- Mobile vaccination units
- Pop-up community clinics
- Pharmacy partnerships
- Mass vaccination clinics

Role of public health vs. private partnerships

With private partners taking on high-volume vaccination of the general public and with pharmacies, urgent care clinics, and other private organizations providing additional support as vaccination provider sites, the logistical and operational burden is lowered for public health. This permits public health agencies to focus vaccination efforts on increased communication, tailored messaging for populations that might require additional outreach, and strategies to increase vaccine access through mobile clinics, mini-clinics in trusted community locations, or on-site vaccination support for select communities (see **Table 2** below). Public health programs can support partners by helping to direct populations to vaccination provider sites, while private partners can support public health programs in operationalizing the vaccination program within communities (e.g., on-site vaccination support, mobile vaccination). The logistics of the vaccination process involve several steps. Ensuring success at each step can be augmented through private-public partnerships, as noted in **Figure 2**.

Table 2: Role of private partners vs. public health

Private Partners	Public Health
Focus on vaccination operations/logistics to: • Improve uptake in the general population (*high volume*). • Increase access to vaccination provider sites.	Focuses on reaching populations that might require tailored outreach, including: • Rural populations • Communities of color • Highest risk essential workers that might need more intense outreach • People experiencing homelessness

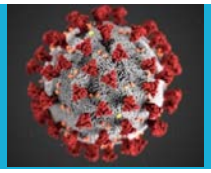
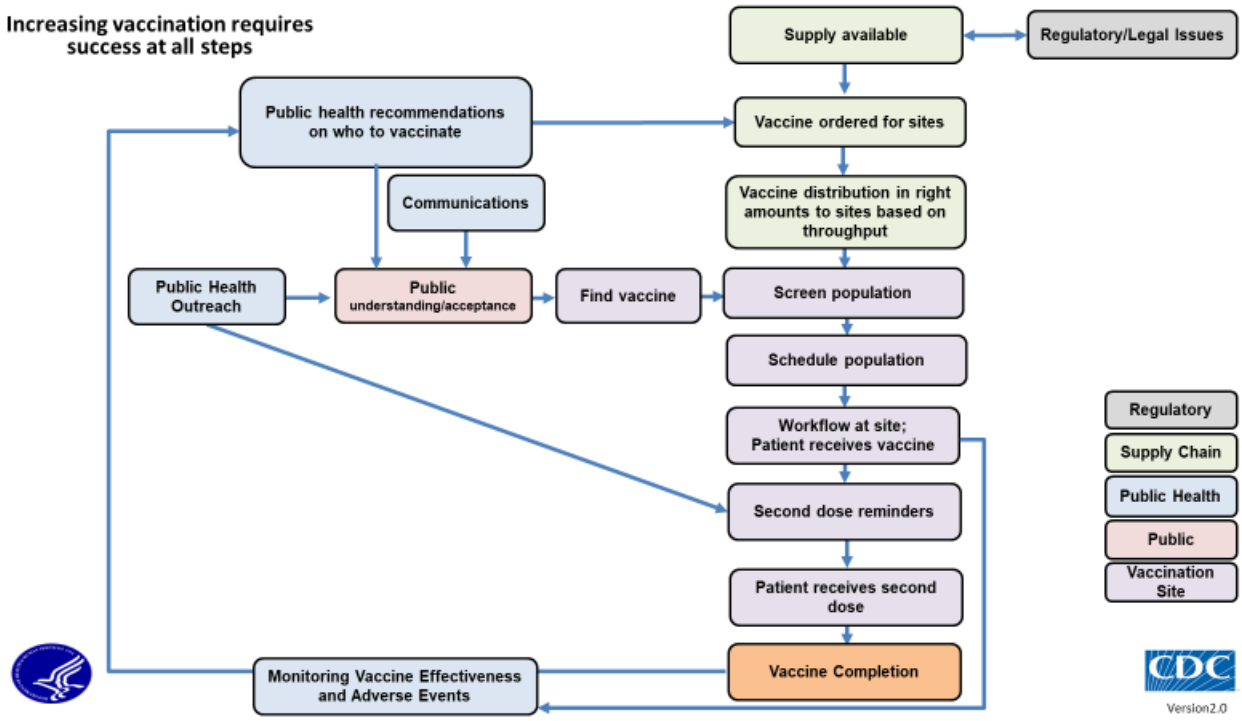
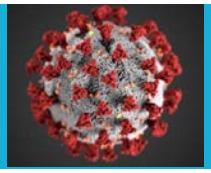


Figure 2: Vaccination process





Private-Public Partnerships – Pharmacy Programs

The Federal Retail Pharmacy Partnership Strategy for COVID-19 Vaccination is a public-private partnership established by the federal government that involves 21 national pharmacy partners and network administrators representing over 40,000 retail pharmacy locations nationwide. With more than 90% of people in the United States living within five miles of a pharmacy, pharmacies are uniquely positioned to support broad COVID-19 vaccination efforts. Pharmacies have built-in expertise in vaccination campaigns reaching large portions of the population based on annual flu vaccination efforts. In addition, many pharmacies have existing strategies and infrastructure in place for second-dose management because of their experience in administering the two-dose Shingrix shingles vaccine.

Jurisdictions can leverage private-public partnerships with pharmacies to augment community access to COVID-19 vaccine, both for priority population groups when supply is still limited and for more broad distribution as vaccine supply increases. The U.S. Government and CDC have developed two programs in addition to the Federal Pharmacy Partnership for Long-Term Care Program, to facilitate distribution of COVID-19 vaccine allocation to pharmacies for administration in communities across the country:

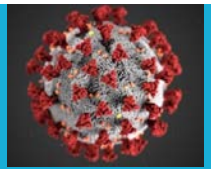
- The Federal Retail Pharmacy Partnership Strategy will launch on a national scale, with select pharmacy partners receiving a direct allocation of COVID-19 vaccine. Timing and scale of activation (how many partners, how many stores) will depend on various factors, including supply. The program will roll out incrementally in close coordination with jurisdictions and will be expanded when there is enough vaccine supply to turn on the program equitably nationwide.
- The Allocation Transfer Program provides jurisdictions an opportunity to transfer vaccine allocation to federal pharmacy partners to help vaccinate priority populations against COVID-19 before the Federal Retail Pharmacy Program launches nationwide.

Federal retail pharmacy partnership strategy for COVID-19 vaccination

As vaccine supply increases, the federal government will begin an incremental rollout of the Federal Retail Pharmacy Partnership Strategy for COVID-19 Vaccination, which will allow federal pharmacy partners to begin ordering vaccine directly from the federal government for distribution to broad population groups. The program will be implemented using federally allocated vaccine and will not impact weekly jurisdictional allocations. Pharmacy partners will be required to report to CDC the number of doses of COVID-19 vaccine (a) ordered by store location in CDC's Vaccine Tracking System (VTrckS) and (b) on hand in each store reported through VaccineFinder. Pharmacy providers will also be required to report CDC-defined vaccine administration data elements to jurisdiction immunization information systems (IISs) or through other agreed upon methods (e.g., formatted data extracts) if IIS reporting is not available. Reporting agreements will be defined by CDC.

Vaccine allocation strategy

Pharmacy partners will receive a federal allocation of vaccine to begin the Federal Retail Pharmacy Partnership Strategy for COVID-19 Vaccination. The allocation provided for this program is **separate** from jurisdictions' weekly allocations.



Vaccine supply will be distributed from the COVID-19 Vaccination Program to pharmacy partners for distribution to retail locations based on various factors, including equity to access, demand, supply, and number of stores. This strategy is designed to capitalize on the pharmacy partners' expertise in managing supply and demand in their network of retail locations across the country, given that uptake and throughput might vary by jurisdiction over time. CDC will continuously monitor each pharmacy partner's inventory by jurisdiction to help ensure equitable access across the country and will collaborate with pharmacy partners to shift inventory to best meet public health needs.

Program launch

When the Federal Retail Pharmacy Partnership Strategy for COVID-19 Vaccination begins, there will not be enough vaccine for all of the 40,000+ retail pharmacy locations enrolled to start providing COVID-19 vaccine at the same time. As such, the Federal Retail Pharmacy Strategy for COVID-19 Vaccination will roll out incrementally. As COVID-19 vaccine supply increases, additional pharmacy locations will receive vaccine until the entire network of 40,000 locations is activated.

To support the program's launch, jurisdictions were asked to provide input on which federal pharmacy partners would get vaccine first. To assist in this process, CDC provided all jurisdictions with a recommendation of one or more pharmacy partners to receive vaccine from the federal government as part of the program's launch.

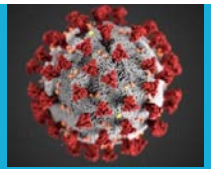
CDC selected these pharmacy partners based on a mapping exercise that showed which partners provide the best coverage to reach populations at highest risk of becoming severely ill from COVID-19, including people 65 years and older (the age-based population recommended for vaccination during Phase 1C, and those who are socially vulnerable (using the social vulnerability index). These mapping tools allowed CDC to identify the fewest number of pharmacy partners in each jurisdiction that would provide the best access to COVID-19 vaccine for many of people who need it most. As supply grows, pharmacy partners will be able to expand beyond their initial starting points and into other jurisdictions, based on their expertise of how to best meet demand. Other pharmacy partners will be engaged at this point as well.

Jurisdictions were recently asked to confirm which partners they preferred to begin receiving vaccine in their jurisdiction. These initial selections are just a starting point, and the number of pharmacy partners and sites receiving vaccine will increase as the program expands.

Priority populations

Pharmacy partners will focus on providing vaccine to broad populations, likely age-based to start, to maximize the volume of doses administered and improve population uptake. CDC recognizes that jurisdictions will be in different phases of vaccine rollout when the program begins and will work with jurisdictions to ensure the pharmacy partners selected for launch are prioritizing a population group for vaccination that falls within their jurisdiction's current prioritization schedule.

The Federal Retail Pharmacy Partnership Strategy for COVID-19 Vaccination is meant to augment vaccine availability for broad populations in each jurisdiction, while reducing the burden on jurisdictions related to provider enrollment and logistical coordination. Jurisdictions will need to continue to develop



public health strategies for certain populations such as rural populations, communities of color, and essential workers that require more intense outreach, including those who cannot easily access pharmacies or other healthcare providers.

Coordination of private-public partnership — key actions for pharmacies and public health

The program relies on collaboration with public health. This is especially important for communication efforts encouraging people to seek vaccination at pharmacy locations, particularly for populations and communities that might require more intense outreach. As the retail program launches, public health outreach to the community will be critical.

CDC will work with jurisdictions to ensure that pharmacies providing COVID-19 vaccine in their communities as part of the Federal Retail Pharmacy Partnership Strategy for COVID-19 Vaccination, are prioritizing vaccine recipients by age range according to the jurisdiction's current prioritization schedule (i.e., 75 or 65 years of age and older).

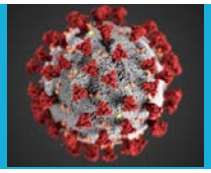
Allocation transfer program

CDC is providing jurisdictions with an opportunity to transfer vaccine allocation to federal pharmacy partners to help vaccinate priority populations against COVID-19 before the Federal Retail Pharmacy Partnership Strategy for COVID-19 Vaccination launches. The Allocation Transfer Program launched the week of January 11, 2021 and allows jurisdictions to transfer doses from state allocations to federal pharmacy partners to assist in vaccinating select populations. This option allows jurisdictions to skip having to enroll federal pharmacy partners as COVID-19 vaccination providers in their jurisdictions to assist with vaccination activities. Jurisdictions must coordinate with the pharmacy partner(s) in advance to develop a thoughtful plan that both parties agree with, before submitting a transfer request to CDC.

Guidance for developing vaccination plans with pharmacy partners

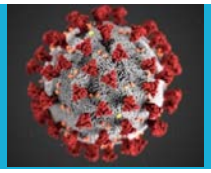
Jurisdictions should consider the following points when developing a vaccination plan with pharmacy partners.

1. The priority populations the pharmacy partner(s) will vaccinate against COVID-19
    - Jurisdictions can consider the following points when making this decision:
        - ACIP recommendations for populations to prioritize for vaccination during different phases of vaccine distribution
        - The estimated population size of these priority groups within the jurisdiction
2. If the pharmacy partner(s) need to conduct occupational or age-based screening prior to vaccination to ensure prioritized populations are receiving priority access to the vaccine
    - If yes, jurisdictions should discuss the following points with the pharmacy partner(s):
        - Types of screening tools necessary (e.g., occupational credentials, proof of age, vouchers, etc.)
        - Timing of screening (i.e. either prior to the vaccination appointment using an online form or email or on site at the time of appointment). If on site, infection control practices should be considered to limit number of people



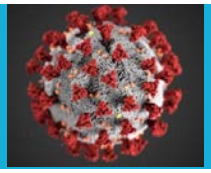
- Planning for people who request an appointment or come on site for vaccination but do not have proper identification according to the jurisdiction's screening criteria (e.g., considering whether it's appropriate to redirect these people to the local public health department). Discussions should involve scenario planning for how to respond to people who insist on vaccination without proper credentials, including security considerations and other implications of vaccinating outside the jurisdiction's prioritization schedule.

3. How the pharmacy partner(s) can best reach the populations being prioritized for vaccination
    - Some pharmacy partners might be able to provide satellite or mobile clinics to reach priority populations where they live or work, which can help increase vaccine uptake. If a jurisdiction coordinates satellite or mobile clinics with a pharmacy partner, it should plan at least two clinics at each location so that vaccine recipients can easily access their second dose and complete the vaccine series.
4. How to communicate to priority populations about where and how to access COVID-19 vaccine
    - When developing a communication strategy, jurisdictions might want to caution pharmacy partner(s) against widespread advertising about COVID-19 vaccine availability. Advertising through communication channels that are intended to reach the specific populations you are planning to vaccinate (e.g., employer communication vehicles, trade organization or third-party listservs, direct mail advertising, etc.) and ensuring appointments can be easily made, can help ensure priority populations are able to access to the vaccine first, before the general public.
5. How much vaccine to transfer to the pharmacy partner(s) on a weekly basis
    - Jurisdictions can consider the following points when making this decision:
        - The population size of the groups being prioritized for vaccination through use of pharmacy partner(s)
        - The number of retail locations the pharmacy partner(s) have in the jurisdiction and the number of vaccine doses they can administer on a weekly basis (throughput)
        - The amount of vaccine needed for satellite or mobile clinics, if applicable, taking into account that throughput might be different for off-site clinics compared to retail locations
        - Strategies to best optimize access to the vaccine without exhausting the jurisdiction's overall inventory
6. Which vaccine product to transfer to the pharmacy partner
    - Jurisdictions may transfer allocation of any COVID-19 vaccines authorized for emergency use by the U.S. Food and Drug Administration but must ensure pharmacy partner(s) have the capacity to store and handle the product before the request is submitted to CDC. The pharmacy partner(s) must agree to the vaccine allocation being provided. CDC recommends allocating only one vaccine product to each partner to simplify planning, reporting, and managing second doses.
7. If cross-coordination with neighboring jurisdictions is needed to ensure consistent and clear messaging to priority populations



- Jurisdictions that are a part of a tri-state area or that include cities that span state lines might want to coordinate to use the same pharmacy partner(s) to vaccinate a priority population. For example, if Kansas is using Walmart to vaccinate its teachers, Missouri might want to consider the same approach so that teachers in Kansas City will hear one consistent message on where to go in their community for vaccination.

8. How pharmacy partner(s) should manage excess vaccine or vaccine nearing its expiration date, if uptake among the agreed upon priority populations is low
    - Jurisdictions should anticipate that pharmacies might have excess vaccine inventory if uptake among priority populations is lower than expected. To prepare for this, jurisdictions should discuss plans with pharmacy partners to vaccinate those outside of the priority population in advance, so that no vaccine is wasted.



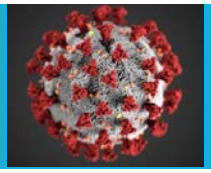
Monitoring and Program Oversight

Providers perform vital functions within the COVID-19 Vaccination Program, including properly storing, handling, and managing vaccine supply as well as administering vaccine to intended recipients. Thus, it is essential for providers to have a clear understanding of COVID-19 Vaccination Program requirements. Training, site visits, and other oversight measures are important for maintaining or improving providers' adherence to these requirements. Site visits, in particular, are a key opportunity to further develop and strengthen relationships with enrolled providers.

Although the guidelines for COVID-19 Vaccination Program oversight are still being established, awardee jurisdictions will eventually be responsible for conducting site visits either in person (preferred) or virtually to provide monitoring and quality assurance support (supportive supervision) and to promote quality improvement. These visits will involve reviewing and assessing COVID-19 vaccination provider operations with the following goals:

- To assess COVID-19 vaccination provider adherence to program requirements
- To identify and address areas where providers are doing well and areas needing additional follow-up
- To identify and address educational needs of COVID-19 vaccination providers to help them meet program requirements
- To ensure vaccine recipients are receiving properly managed and viable vaccine
- To ensure that vaccine is distributed according to jurisdictional priorities and ensuring equity in the distribution

Additional, detailed information on monitoring and oversight of the COVID-19 Vaccination Program will be released at a later date.



Conclusions

In conclusion, the considerations suggested in this document are meant to help inform assessments of current phase and decisions on when to transition to the next phase of the COVID-19 Vaccination Program. It's important to recognize that these considerations will likely need to be adapted to the local, state, or territorial context and could change over time. These considerations can also be applied to transitions among groups sub-prioritized within a phase, in conjunction with factors specific to jurisdictional needs. Jurisdictions requiring assistance implementing the strategies presented in this document can seek assistance from CDC.