



ARIZONA DEPARTMENT
OF HEALTH SERVICES

COVID-19 VACCINATION PLAN

Arizona Department of Health Services

December 14, 2020
2nd Edition

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Approval and Implementation

The Arizona COVID-19 Vaccination Plan is hereby approved. This is effective immediately and supersedes all previous instructions and guidance.

Director, Cara M. Christ, MD
Arizona Department of Health Services

Date

Record of Distribution

Date	Recipient	Platform

Record of Change

Date	Change	Page(s)
October 2020	New Plan	
December 2020	<ul style="list-style-type: none"> • Section 4A, Tables 2 and 2S • Section 5A, Figure 5 • Section 9A & 9B • Section 11E & 11F • Section 15A & 15B 	<ul style="list-style-type: none"> • p. 21-22 • p. 28 • p. 35-37 • p. 41 • p. 47-48

Introduction

The Arizona Department of Health Services (ADHS) has been continuously engaged in pandemic and all-hazards emergency preparedness since the initiation of the Centers for Disease Control and Prevention's (CDC) Public Health Emergency Preparedness (PHEP) program in 2002. In this time, the Department has conducted dozens of infectious disease preparedness exercises, engaged hundreds of community partners, and refined pandemic preparedness plans according to best practice and evolving federal guidance. Together, these efforts have better prepared the State for all types of infectious disease threats including the COVID-19 pandemic.

This document has been structured to address all of the planning suggestions and questions outlined in the COVID-19 Vaccination Plan Template for Jurisdictions provided by the CDC. In order to ensure compliance with this guidance, each question listed in the template is documented in this plan in italic text. This plan is intended to supplement and support information and processes outlined in the *Arizona Pandemic Influenza Response Plan*.

Section 1: COVID-19 Vaccination Preparedness Planning

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

Lessons learned from the 2009 H1N1 vaccination campaign informed the development of numerous plans and procedures, such as the *Arizona Pandemic Influenza Response Plan*, most recently updated in 2019. The 2009-2010 response also contributed to the creation of the *Arizona Crisis Standards of Care Plan*, which outlines strategies and tactics for the allocation of scarce medical resources. To begin COVID-19 vaccination program planning, the Department engaged a wide range of state, local, tribal, and health care stakeholders that had experience during the 2009 H1N1 vaccination campaign as well as recent mass vaccination experience during Arizona's 2019 Hepatitis A outbreak. This planning initiative, led by ADHS, addresses the guidance provided by the CDC Vaccination Program Interim Playbook.

Key participants in planning activities include ADHS, members of the Vaccine and Antiviral Prioritization Advisory Committee (VAPAC), and local vaccine allocators, including county and tribal health departments. VAPAC is comprised of Subject Matter Experts (SMEs) who are responsible for reviewing the CDC, Advisory Committee on Immunization Practices (ACIP), and National Academies of Sciences, Engineering, and Medicine (NASEM) guidance and providing recommendations to the Department to develop a state vaccine allocation plan.

Additional gaps in planning were identified during the 2019 Crimson Contagion exercise with federal, state, and local partners. To complement the Crimson Contagion exercise, ADHS conducted a follow-up full-scale exercise that included receiving a push package from the Strategic National Stockpile (SNS) and delivering assets to county partners within 24 hours. During the 2019 exercise, ADHS and Navajo Nation participated in several multi-state

coordination calls to discuss the role Indian Health Services (IHS) will play in directly allocating pandemic vaccine to IHS facilities.

Since participating in the Crimson Contagion exercise, and building on experiences with tribal partnerships during the H1N1 response, the Department has coordinated with tribally-operated 638 facilities to onboard them as local allocators. The expectation is that county health departments and 638 facilities that complete the provider onboarding process will be eligible to be local allocators and may receive a vaccine allocation from the state. The Department continues to engage tribal health departments, 638 facilities, and IHS in vaccination program planning.

B. Include the number/dates of and qualitative information on planned workshops or tabletop, functional, or full-scale exercises that will be held prior to COVID-19 vaccine availability. Explain how continuous quality improvement occurs/will occur during the exercises and implementation of the COVID-19 Vaccination Program.

ADHS hosted a virtual tabletop exercise (TTX) on September 30, 2020 with over 160 participants. The purpose of this exercise was to identify and educate state, county, tribal, and healthcare partners on the roles and responsibilities of the VAPAC as well as implications for local vaccine allocation. A second vaccine operational logistics TTX is planned for October 30, 2020. This event will assess logistical considerations of receiving, administering, and tracking COVID-19 vaccinations at the local level.

The TTX discussions are designed to inform stakeholders on state vaccine operations and identify gaps and lessons learned to effectively build a robust vaccination program. Both TTXs have an expected attendance of more than 150 federal (ASPR, FEMA), state, county, and tribal partners as well as observers from other state public health programs. To ensure continuous quality improvement throughout the exercises and the COVID-19 vaccination campaign, the Department will:

- Conduct a hot wash after each exercise.
- Distribute and evaluate participant evaluation forms.
- Develop an After Action Report and Improvement Plan (AAR/IP).
- Implement corrective actions.
- Identify and promote training opportunities.
- Track additional resource needs for local jurisdictions.

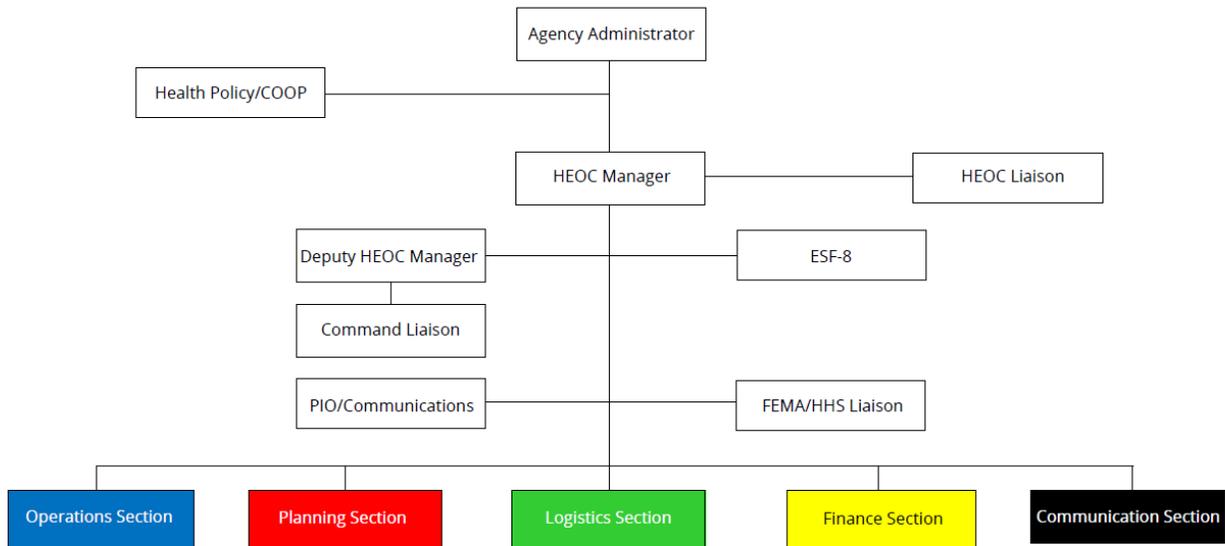
Additional training opportunities are being planned throughout October and November 2020 to reinforce COVID-19 provider onboarding requirements, vaccine logistics, mass vaccination, vaccine administration, and mobile points of dispensing (POD) operations.

Section 2: COVID-19 Organizational Structure and Partner Involvement

A. Describe your organizational structure.

ADHS has developed an organizational structure based on the Public Health Incident Management System (PHIMS) (see Figure 1). This structure closely aligns with the Incident Command System (ICS), which is used by response partners across all levels of government as well as health care system partners. The purpose of the PHIMS structure is to establish reporting relationships for public health emergency management and address staffing needs for the Department’s Health Emergency Operations Center (HEOC).

Figure 1 – HEOC PHIMS Chart



The HEOC will be used to manage the statewide vaccination campaign and ensure coordination across the Department and with response partners from other state agencies, county and tribal health departments, and health care system partners involved in vaccine administration. Staff from across the Department’s various Divisions are involved in ongoing HEOC operations and will support the vaccination campaign as needed.

Additionally, ADHS partners closely with 15 county health departments and 21 federally recognized tribes, which are responsible for administering local immunization programs in their respective jurisdictions. Since the H1N1 vaccination response in 2009, ADHS and local partners have developed a strong infrastructure and partnerships to distribute vaccines widely across the State. In 2020, the Department utilized existing intergovernmental agreements (IGAs) with county and tribal health departments to pass through CDC supplemental funding to support immunization program activities at the local level. Throughout the COVID-19 vaccination response, ADHS will continue to leverage local programs and community partnerships to distribute and administer vaccine.

B. Describe how your jurisdiction will plan for, develop, and assemble an internal COVID-19 Vaccination Program planning and coordination team that includes

persons with a wide array of expertise as well as backup representatives to ensure coverage.

Initial COVID-19 vaccine planning was based on the strategies and tools outlined in Arizona's Pandemic Influenza Response Plan (Supplement 6), post-H1N1 hot wash findings, AARs from a recent Hepatitis A Outbreak, and lessons learned from the Crimson Contagion National Level Exercise. To support these efforts, the HEOC implemented an internal Vaccine Branch under the Operations Section in April 2020 staffed primarily from the Arizona Immunization Program Office (AIPO). The focus of the Vaccine Branch is to develop high-level strategies and tactics and review items needed for a COVID-19 vaccination response. AIPO consists of approximately 30 full time staff responsible for implementing all aspects of the Vaccines for Children (VFC) and Vaccines for Adults (VFA) programs, maintaining the immunization registry, and providing vaccine education to multiple stakeholders. Central to this work is management of VFC/VFA program registration of over 800 providers, vaccine ordering, vaccine tracking and management, and program compliance monitoring.

ADHS also has various public health experts in statistics, epidemiology, GIS, communications and other areas that are assisting with COVID-19 vaccine program planning. Contracted staff will also be utilized to support the Arizona State Immunization Information System (ASIIS; Arizona's immunization registry) and assist with provider onboarding. Additional backup staff from the Arizona Immunization Program Office and other units of ADHS will be identified as needed to support the vaccination campaign and HEOC operations. ADHS may also leverage staffing offered by CDC to support Tiberius, VTrckS, VAMS, and other systems used to manage the vaccine response. Throughout the vaccine program implementation, the Branch will continue to meet multiple times each week to work on specific tasks and goals that support the COVID-19 vaccination response.

In July 2020, the HEOC implemented the Vaccine Task Force under the Planning Section, led by the PHEP Director with SMEs from AIPO, the Bureau of Public Health Emergency Preparedness, the Bureau of Epidemiology and Disease Control, Public Health Licensing, Communications staff, and ADHS medical directors. Internal Task Force meetings are held weekly for staff to share updates and address time sensitive tasks. The task force works under the following objectives:

1. Conduct outreach and recruitment to onboard vaccine providers.
2. Explore non-traditional vaccinators and reimbursement strategies.
3. Assess training and resource needs.
4. Identify and share best practices for mass vaccination programs.

Furthermore, the Task Force has identified sub-committees to focus on the following key areas:

- Provider Recruitment & Onboarding
- Alternative Vaccinators & Reimbursement Strategies
- Data Integration & Geographic Information Systems (GIS) Mapping
- Safety Monitoring & Messaging
- Employee Shot Clinics & POD Planning
- Training & Exercise
- Community Engagement & Communications

C. Describe how your jurisdiction will plan for, develop, and assemble a broader committee of key internal leaders and external partners to assist with implementing the program, reaching critical populations, and developing crisis and risk communication messaging.

The Department has leveraged existing relationships with statewide vaccine partners to build the Vaccine Task Force. The group consists of multiple external stakeholders with a wide array of expertise. Each partner will be essential in the development and implementation of this plan. The organizations and individuals invited to participate in the Vaccine Task Force routinely collaborate with the Department. Partnership with these entities is further documented in the *Arizona Pandemic Influenza Response Plan* and membership is articulated below.

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

A large contingent of staff from ADHS is supporting COVID-19 vaccination planning. Many of these individuals are participating in the HEOC's Vaccine Branch as well as the Vaccine Task Force. This includes the following staff:

- AIPO Program Manager
- AIPO Immunization Information System (IIS) Manager
- Vaccine Coordinators
- Immunization Accountability Manager (who supervises training staff)
- Local Immunization Coordinator
- CDC Public Health Advisor
- PHEP Bureau Chief
- PHEP Deputy Bureau Chief
- PHEP Partner Integration Section Chief
- PHEP Community Healthcare Preparedness Section Chief
- PHEP Medical Countermeasures Coordinator
- Communicable Disease Epidemiologists
- GIS staff
- Communications staff
- Public Health Prevention staff
- Bureau of Emergency Medical Services staff
- Public Health Statisticians
- ADHS Tribal Liaison
- ADHS Medical Directors
- ADHS Senior Leadership

Many of these individuals have extensive experience responding to public health emergencies and events including the 2009 H1N1 pandemic, vaccine preventable disease (VPD) outbreaks (e.g., measles, hepatitis A), seasonal wildfires, and other public health responses.

The Vaccine Task Force currently includes diverse, multi-disciplinary representation from a variety of federal, state, tribal, and local agencies. The Vaccine Task Force can be expanded as needed. Participating organizations include:

- U.S. Department of Health and Human Services (ASPR)
- Federal Emergency Management Agency (FEMA)
- Arizona Governor's Office, Senior Policy Advisor for Health
- Arizona Department of Health Services (ADHS)
- (Arizona) Division of Emergency Management (DEMA)
- Arizona National Guard
- Arizona Department of Administration (ADOA)
- Arizona Department of Housing (ADOH)
- Arizona Health Care Cost Containment System (AHCCCS)
- Arizona Tribal Emergency Committee (AzTEC)
- Indian Health Services (IHS)
- County Health Departments
- Tribal Health Departments and 638 facilities
- Inter Tribal Council of Arizona (ITCA)
- Arizona Hospital Association
- Health System Alliance of Arizona
- Arizona Pharmacy Association
- Arizona Medical Association
- Inpatient and outpatient providers and healthcare systems
- Large pharmacy chains
- Emergency Medical Services providers
- Arizona State University
- Health Insurance Plans and Providers

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

Arizona has 15 counties that include urban, rural and frontier areas. The state functions under home rule, where county public health departments report directly to their county board of supervisors and are responsible for the administration of public health programs in their jurisdiction. ADHS serves as the liaison with international, federal, and other state partners and facilitates coordination between counties. ADHS has long standing, well established relationships with federal, county and tribal public health entities, including health officers, immunization programs, epidemiologists, and preparedness staff, with routine meetings between federal, state and local programs. Under the PHIMS structure and direction of the HEOC, ADHS staff will continue to meet regularly with federal, state, local, tribal, and health care partners to coordinate vaccination program efforts.

Throughout the COVID-19 response, ADHS will continue to host twice weekly meetings with local health officers and once weekly meetings with local response staff responsible for emergency preparedness, epidemiology and vaccine functions. Vaccine Task Force meetings with external partners are held weekly and have been since July 2020.

Following each weekly meeting, minutes, presentations, and follow up materials are sent to Task Force participants. Routine communication, data sharing, and reporting ensure situational awareness between partners is maintained as vaccination planning progresses. The membership of the Vaccine Task Force and its sub-groups will continue to expand and evolve as new information is obtained and new partners are identified and integrated into interdisciplinary

planning efforts. Routine Vaccine Task Force meetings will be used to inform all participants of sub-group activities, upcoming training opportunities, CDC and Operation Warp Speed updates, and planning updates. As the state moves from planning to implementation, daily and weekly vaccine calls will be conducted as needed with key state and local partners to ensure effective communication and coordination across jurisdictions.

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

The Department has well established relationships with the tribal communities in Arizona and maintains IGAs and relationships with tribal partners through multiple program areas including PHEP and AIPO. All 21 tribes are engaged with the Department in a variety of ways. The Department has been working with the tribes throughout the COVID-19 response to coordinate resources for testing, healthcare and outbreak response. To ensure communication for COVID-19 vaccination planning and implementation, HEOC leadership routinely hosts calls with tribal partners and participates in tribal consultation meetings. The Inter Tribal Council of Arizona participates in weekly Vaccine Task Force meetings and has a representative on the VAPAC. Additionally, the ADHS Tribal Health Liaison hosts a monthly call with tribal medical directors. The frequency of this meeting has also increased to meet the communication and coordination needs of the COVID-19 response.

Following the H1N1 response, many 638 facilities expressed a desire for more autonomy in the vaccine distribution process. To address this opportunity, ADHS developed a tool to assess the interest of 638 facilities to be local allocators of COVID-19 vaccine in their communities. In an effort to streamline vaccine distribution and administration to tribal populations, ADHS will maintain communication with tribal entities through the Vaccine Task Force, HEOC, and the Department's Tribal Liaison. See Figure 2 for a graphic representation of the distribution process for tribal communities.

ADHS completed the Tribal and Urban Indian Program Engagement Tool provided by CDC (see Table 1). ADHS implemented a tribal engagement strategy that builds on existing relationships with partners to increase information sharing among federal, state, and tribal partners. The ADHS Tribal Liaison worked directly with the IHS Area Directors and 638 facilities to complete the tool. All tribal jurisdictions have been surveyed to determine if they intend to receive an allocation directly from IHS or if they want to become local allocators.

In addition, ADHS will continue to participate in national, regional, and local meetings with tribal partners. ADHS has executed IGAs with thirteen tribal partners to provide CDC supplemental funding to support influenza and COVID-19 vaccination activities. The Department has also extended invitations to key contacts at tribal facilities to participate in weekly Vaccine Planning Task Force meetings as well as upcoming training opportunities and exercises.

Figure 2 - Arizona Pandemic Vaccine Distribution Plan for Prioritized Target Groups

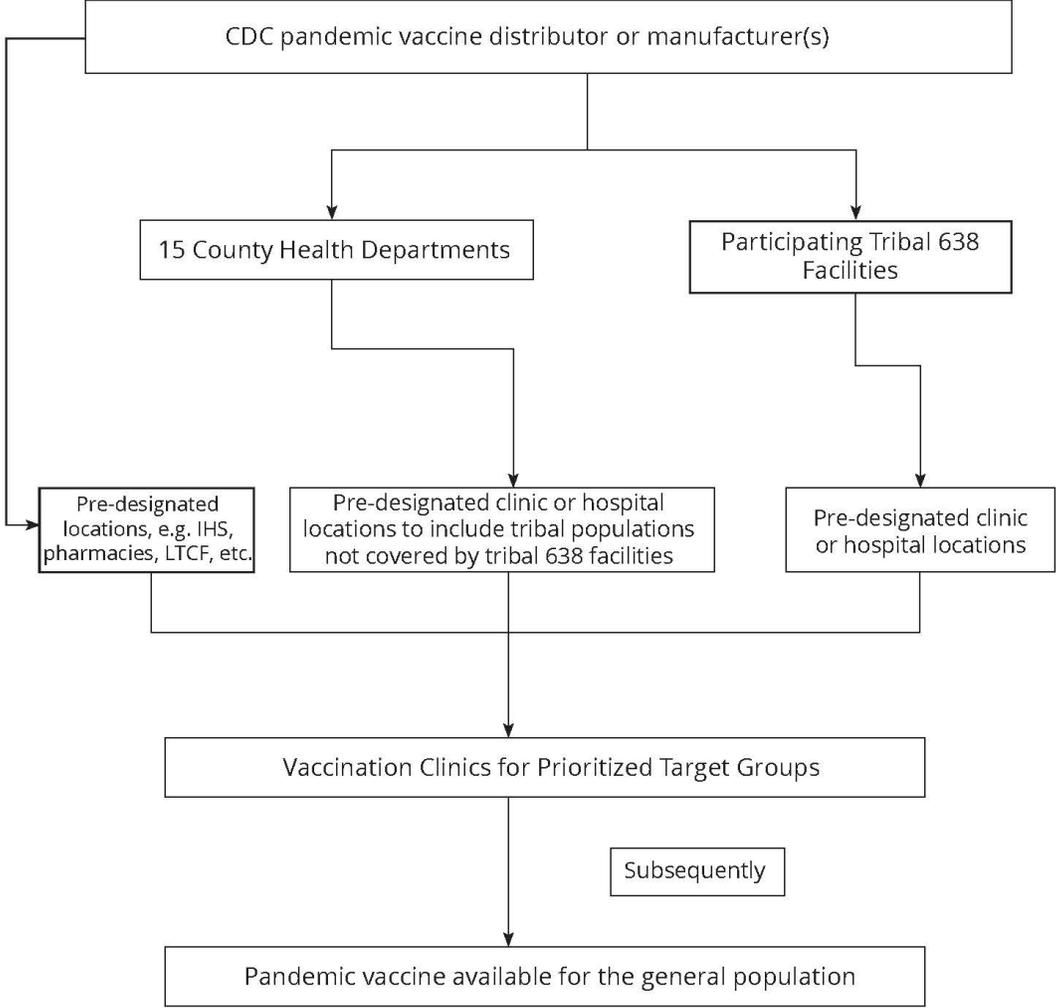


Table 1 - Tribal and Urban Indian Program Engagement Tool

Facility	Affiliation	Tribe Association	Size of Population Served	Distribution Method

G. List key partners for critical populations that you plan to engage and briefly describe how you plan to engage them, including but not limited to: pharmacies, correctional facilities/vendors, homeless shelters, and community-based organizations.

The distribution of vaccine to critical populations is a key consideration in vaccine planning. ADHS will continue coordination with a wide variety of community-based organizations to address access and functional needs (AFN) populations, communities of color and individuals with lesser-English proficiency, Federally Qualified Health Centers (FQHCs), as well as other organizations that work with under-served and high risk populations.

The Task Force has more than doubled in size since its inception in July. It is anticipated that it will continue to grow as additional partners are identified and as planning progresses to address specific issues with each phase of vaccine distribution. The Arizona Pharmacy Association and the Arizona State Board of Pharmacy, in conjunction with county and tribal health departments, will be key resources in reaching out to pharmacies for vaccine administration. Several large pharmacy chains participate in the weekly Vaccine Task Force and have already registered to be onboarded as a vaccine provider.

County and tribal partners will be instrumental in developing tactics for administering vaccine in hard-to-reach populations and congregate settings such as correctional facilities and homeless shelters. The Department has a close working relationship with the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) and has provided testing resources and technical assistance with infection control and outbreaks throughout the response. ADHS will work with county health departments that have state and private prisons to coordinate vaccinating the state prison population. ADHS will also leverage relationships with community-based vaccination organizations (e.g., the Arizona Partnership for Immunizations [TAPI]) to ensure outreach and vaccine administration to critical populations. Based on recommendations from the state, local, and community partners, additional agencies and representatives will be called upon to participate in the Vaccine Task Force to develop strategies for vaccine administration throughout the phases (especially phases 2 and 3).

ADHS will continue to work with local partners to support relationships with community-based organizations, correctional facilities and organizations that support un-housed individuals.

Section 3: Phased COVID-19 Vaccination

A. Describe how your jurisdiction will structure the COVID-19 Vaccination Program around the three phases of vaccine administration:

Phase 1: Potentially Limited Doses Available

The HEOC will continue to review guidance from federal partners regarding vaccine administration and has integrated recommendations from ACIP in addition to previously released NASEM guidance. The VAPAC will continue to use this information to guide decision making when developing state-level vaccine allocation recommendations for the ADHS Director to consider.

VAPAC convened to provide vaccine allocation recommendations while supplies are limited. Updated information and guidance will be provided by CDC/ACIP and additional sub-prioritization will be implemented at the local level. In preparation for Phase 1 vaccines to become available, ADHS utilized the vaccine planning scenarios presented in the CDC Vaccination Program Interim Playbook, which suggested the availability of two vaccine candidates (Pfizer and Moderna) as the likely scenario. As FDA provides emergency use authorization approval of vaccines, vaccination planning and implementation will be updated based on vaccine requirements and availability. During the earliest phase, vaccines will be limited to organizations that have the capacity to quickly vaccinate large numbers of people without the need for extended cold storage or repackaging and redistributing.

Local jurisdictions have conducted advanced planning and ADHS will continue to support their ongoing vaccine allocation efforts. ADHS will offer technical assistance as needed to local jurisdictions providing COVID-19 vaccination services in closed POD settings that allow for social distancing and other infection control procedures. Occupational health settings, temporary vaccination clinics, and other closed PODs may be particularly useful for vaccination of critical infrastructure workers and other select priority populations early in the COVID-19 vaccination response.

ADHS utilized a local allocator process during H1N1 and will do so for the COVID-19 vaccination as well. This will be achieved utilizing 15 Arizona county health departments and 638 facilities that have indicated their interest in allocating for their community. The CDC will inform the State of the number of available doses. The State will take that number of doses and allocate them between the counties and 638 facilities based on VAPAC prioritization recommendations. The counties and 638 facilities will further allocate those vaccines within their communities.

ADHS has an IIS for tracking vaccine allocations with an allocation tool application that will be used to support local partners in allocation planning. A new vaccine management tool has been implemented to automatically integrate data into the State's IIS on a daily basis. These systems will allow allocators to see where doses have been allocated, track doses that have been administered to date, and provide a mechanism for real-time reporting. This is intended to give real-time visibility to allocators as they make their decisions when vaccine supply levels are critically low and must be prioritized for the highest-risk populations.

During Phase 1A when long-term care residents are recommended to receive the vaccine, the CDC has partnered with pharmacies to increase access to vaccine in long-term care facilities (LTCF).

- The CDC's Pharmacy Partnership for LTC Program for COVID-19 Vaccine will provide on-site vaccine clinics for residents of LTCFs and LTCF staff within facilities that opt in to the program. The Pharmacy Partnership for LTC Program provides end-to-end management of the COVID-19 vaccination process, including close coordination with the state, cold chain management, on-site vaccinations, and fulfillment of reporting requirements. The program will facilitate safe and effective vaccination of this prioritized patient population.
 - This program is free of charge to facilities. The pharmacy will:
 - Schedule and coordinate on-site clinic date(s) directly with each facility. Three visits over approximately two months are likely to be needed to administer both doses of vaccine and vaccinate any new residents and staff.
 - Order vaccines and associated supplies (e.g., syringes, needles, personal protective equipment).
 - Ensure cold chain management for vaccine.
 - Provide on-site administration of vaccine.
 - Report required vaccination data within 24 hours of administering each dose.
 - Adhere to all applicable CMS requirements for COVID-19 testing for LTCF staff.
 - By December, over 2,000 LTCFs including assisted living facilities (ALFs), skilled nursing facilities (SNFs), and group homes for individuals with developmental disabilities have signed up for the partnership.
 - Indicating interest in participating is non-binding and facilities may change their selection (opt-out) if needed.
 - CDC will communicate preferences to the pharmacy partners and will attempt to honor facility preferences but may reassign facilities depending on vaccine availability and distribution considerations, and to minimize vaccine wastage.
 - CDC expects the Pharmacy Partnership for LTC Program services to continue on-site at participating facilities for approximately two months.
 - After the initial phase of vaccinations, the facility can choose to continue working with the pharmacy that provided its initial on-site clinics or can choose to work with a pharmacy provider of its choice.
 - ADHS has opted to ACTIVATE this program in Skilled Nursing Facilities beginning December 27, 2020.
 - Activation in all other LTCFs will begin when there are sufficient doses of vaccines allocated to the state to meet the need.

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

ASIIS will be the main repository for vaccination records statewide, including ordering, inventory reconciliation, and administration. ADHS and local partners are implementing a front-

end vaccine management system to interface with ASIIS. ADHS is actively onboarding potential COVID-19 vaccinators into ASIIS to ensure access. Once the initial need for local allocation has ended, all vaccinators will have the ability to log into ASIIS and order vaccines for their facilities.

As indicated by the title of this phase, supply now meets demand. Therefore, ADHS does not anticipate limiting the number of doses that can be ordered. However, regular review of doses ordered versus doses administered and recorded in ASIIS will occur to ensure vaccine is being utilized. Another important tool to aid in decision making during this stage will be GIS mapping to identify areas that have been disproportionately impacted by COVID-19, including socially vulnerable populations and underserved areas. These maps have been developed and are currently being reviewed and tested by Vaccine Task Force members. There may be areas with limited providers, a high social vulnerability index (SVI), vaccine hesitancy or other factors that lead to lower vaccine uptake. In these areas, ADHS plans to work with local partners to develop targeted messaging and mobile POD vaccination strategies to encourage vaccination.

During Phase 2, Arizona will also have the opportunity to participate in the direct allocation to pharmacy partner strategy coordinated by the CDC. Local health officers will be contacted by CDC leadership to opt-in or -out of the program. ADHS meets regularly with the Arizona Local Health Officers Association and will coordinate with county health officials to distribute messaging about the Pharmacy Partnership for LTC Program. It will be critical that states and local health departments receive timely and accurate information about LTCFs that will participate in the pharmacy program in order to coordinate a vaccination program that provides adequate coverage for high-risk populations.

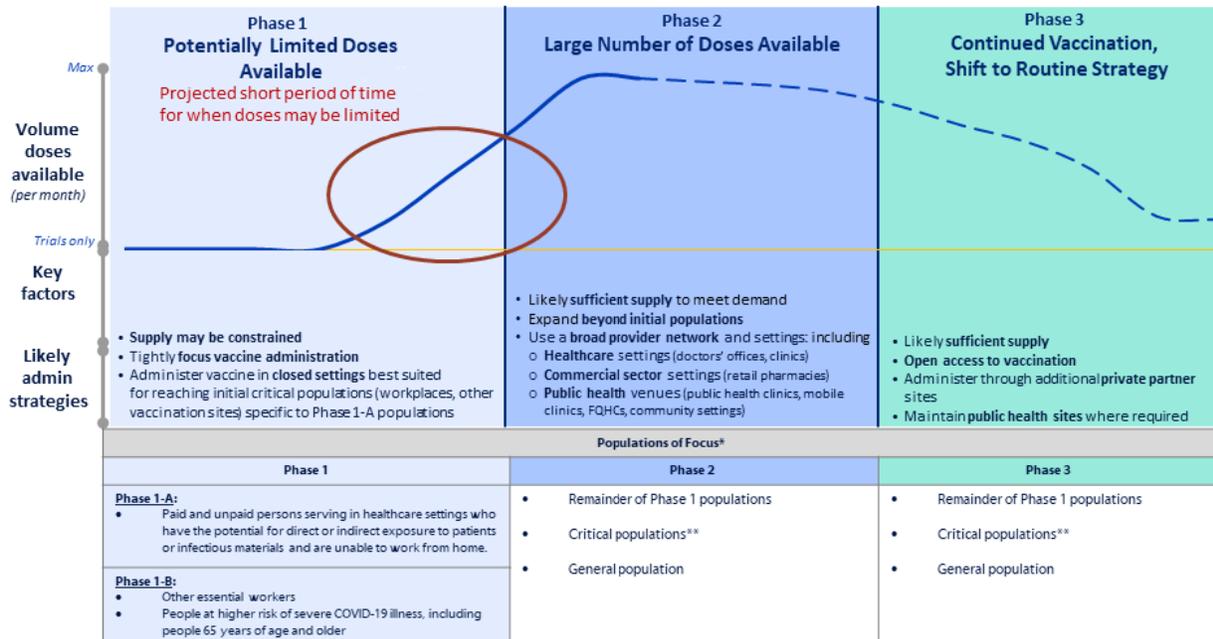
- Vaccine will be allocated and distributed directly to select pharmacy partners from the federal government.
 - Direct allocation opportunities will be provided to retail chain pharmacies and networks of independent and community pharmacies 1 (those with a minimum of 200 stores). All partners must sign a pharmacy provider agreement with the federal government.
 - Once the list of federal partners has been finalized, Arizona will receive the list from CDC.
 - On a daily basis, pharmacy partners must report to CDC, the number of doses of COVID-19 vaccine a) ordered by store location; b) supply on hand in each store reported through VaccineFinder; and c) number of doses of vaccine administered to individuals in each state, locality, and territory.
- Pharmacy providers will be required to report CDC-defined data elements related to vaccine administration daily (i.e., every 24 hours). CDC will provide information on these data elements and methods to report if stores are not able to directly provide data Arizona through ASIIS.
- Arizona will have visibility on number of doses distributed to and administered by each partner store.

Phase 3: Likely Sufficient Supply, Slowing Demand

ADHS will review vaccine inventories as orders are placed to ensure that vaccines are being used in a timely fashion and that new stocks are ordered to match demand. As demand slows,

ADHS will work with local partners to enhance messaging to reinvigorate vaccination efforts and further protect individuals and their communities. GIS data, including SVI, will be considered and ADHS may conduct additional public outreach during this stage to understand slowing trends in vaccine uptake among certain populations. This will mirror lessons learned from similar public outreach done by local communities related to slowing testing demand. Insights from this outreach will be used to develop targeted public messaging campaigns. See Figure 3 for additional information on the phased approach.

Figure 3 - COVID-19 Phased Approach for Vaccine Distribution



Section 4: Critical Populations

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

In order to identify critical populations statewide, ADHS will primarily consider the recommendations from the CDC and ACIP. ACIP released initial recommendation regarding priority populations on December 1, 2020. Other key guidance and sources of information include the framework developed by NASEM and the National Institutes of Health. The VAPAC convened on December 3, 2020 to review federal recommendations and determine populations of focus.

VAPAC is responsible for providing recommendations regarding the prioritization of critical populations to the ADHS Director to develop specific vaccine allocation strategies. In order for VAPAC to provide prioritization recommendations, ADHS provided State and county estimates for the populations of focus identified and shared this information with local health departments and tribal 638 facilities. Arizona's estimates of critical populations are based on CDC guidance

and recommendations of priority groups for COVID-19 vaccination using trusted and reliable data sources including the U.S. Census Bureau, Bureau of Labor and Statistics, and state licensing boards.

As referenced in the *Arizona Pandemic Influenza Response Plan, Supplement 6, Vaccine Distribution and Use*, vaccine allocation decisions are made according to pandemic epidemiology, federal guidance, VAPAC recommendations, vaccine availability, critical infrastructure personnel, people at highest risk of complications, and local needs. CDC has stated that they will provide guidance and recommendations for priority populations, but the decision on when and how to expand the priority groups is a state and local decision. ADHS, county, and tribal partners will make coordinated vaccine prioritization decisions and base vaccine ordering according to local needs. Local jurisdictions will engage in ongoing planning with organizations, employers, and associations that represent the critical population groups.

ADHS has developed a Critical Populations Estimates (see Table 2) based on the CDC’s COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations. While target groups and prioritization tiers may differ somewhat for each local jurisdiction, this worksheet will assist in estimating target groups and reinforcing key planning elements. Data in the worksheet will need to be modified based on updated population, census statistics, and target group prioritization based on federal guidance, VAPAC guidance, and local needs. Revising this information will provide better estimates for groups prioritized for early vaccination.

Table 2 – VAPAC Phased Allocation Recommendation with Critical Population Estimates

Phase	Priority Population	AZ Estimated Population	Resources to vaccinate pop. group (Y/N)?
Health care personnel, including frontline workers at increased risk for COVID-19 and may have underlying medical conditions			
1A	Healthcare practitioners and technical occupations (doctors, nurses, pharmacists, EMTs, paramedics, dentists, etc.)	183,895	
1A	Healthcare support occupations (home health aides, nursing assistants, medical assistants, etc.)	70,166	
Long-term care residents at highest risk for severe disease and death, including staff who interact with vulnerable populations			
1A	Skilled nursing facility residents (all are enrolled in CDC Pharmacy /LTC Program)	32,284	CDC Pharmacy/LTC Program will cover ~146 SNFs, residents and staff
1A	Assisted living, independent living, HUD senior housing (all are enrolled in CDC Pharmacy/LTC Program)	67,416	CDC Pharmacy/LTC Program
1A	Assisted living, independent living, HUD senior living (not enrolled in CDC Pharmacy/LTC program)	18,954	
1A	DES group homes for individuals with developmental disabilities and ICF-IIDs, and staff	3,501	
1B	Adults with high risk medical conditions living in shelters or other congregate living settings	62,565	
Prioritized essential workers			
1B	Education and childcare providers (teachers and staff)	146,305	
1B	Protective service occupations (law enforcement, corrections,	79,410	

	and other emergency response staff)		
Essential workers (based on CISA and EO 2020-12 definitions)			
1B	Power and utility workers	5,692	
1B	Food and agriculture related occupations (packaging and distribution workers, grocery and restaurant workers)	268,800	
1B	Transportation and material moving occupations (public transportation providers, airlines, gas stations, auto shop workers, and other transportation network providers)	227,680	
1B	State and local government workers that provide critical services for continuity of government	TBD by jurisdiction	
1B	Other essential workers (e.g., business and financial services, supply chain for critical goods, funeral services, critical trades, etc.)	TBD by jurisdiction	
People at increased risk for severe COVID-19 disease			
1C	Adults with underlying medical conditions (obesity, COPD, heart disease, diabetes, chronic kidney disease)	2,278,870	
1C	Adults 65+ years and older	1,264,218	
1C	Adults living in congregate settings	TBD by jurisdiction	

Note: These numbers are intended estimates that provide insight into the order of magnitude of each population group and do not represent exact numbers, nor are the categories mutually exclusive. Data are sourced from multiple national and state data sources (e.g., Bureau of Labor Statistics, state licensing boards)

Table 2S lists populations that may be at increased risk for acquiring and transmitting COVID-19 disease. These populations may be more socially vulnerable per the CDC Social Vulnerability Index, and should be considered for sub-prioritization throughout all phases. These criteria have been provided as a proposed framework to ensure that all populations have equitable access to COVID-19 vaccination.

Table 2S – Sub-Populations at Increased Risk for Acquiring or Transmitting COVID-19

Sub-Priority Population	AZ Estimated Population
Adults from racial and ethnic minority groups	3,207,971
Adults from tribal communities	299,123
Adults who are in correctional facilities/incarcerated	60,485
Adults experiencing homelessness/living in shelters	62,565
Adults attending colleges/universities	327,385
Adults living and working in other congregate settings	54,598
Adults living in rural communities	1,091,343
Adults with disabilities	946,481
Adults who are uninsured or under-insured	808,643
Adults who are non-English speaking	96,696
Adults with Medicaid (AHCCCS)	1,820,262
Pregnant women (<i>ACIP recommendations pending</i>)	72,500
Children age 17 and under (<i>ACIP recommendations pending</i>)	1,646,177

Information on critical populations will be provided by ADHS in partnership with other state agencies, county health departments, professional boards and associations. If additional data is needed, particularly related to priority groups defined by CDC, ADHS will utilize existing resources such as the Arizona State Health Assessment and our Public Health Statistics team and can partner with local and tribal health departments to develop and disseminate additional survey tools.

ADHS worked with local and tribal health departments to develop and implement a vaccine prioritization and allocation survey to assess local and tribal health departments' current capacity to reach and engage critical population groups in their jurisdiction. This has assisted local and tribal partners to identify established POD sites that will meet the needs of prioritized populations and address challenges they are facing with regards to engaging and reaching specific priority populations in their jurisdictions. ADHS is hosting on-going weekly regional vaccine coordination calls with counties and tribal PHEP grant recipients to promote engagement and ensure the timely exchange of information related to the distribution and administration of COVID vaccines.

GIS mapping is used to support local jurisdictions and tribal 638 facilities in gathering information on reaching priority populations. The ADHS GIS team will continue to enhance the Pandemic Vaccine Planning Priority Populations Dashboard (see Figure 4) by adding groups of priority populations as more vaccines become available. The current capability of this dashboard includes the numbers and locations of the following populations:

- Healthcare Practitioners
- Healthcare Support Practitioners
- Protective Service Workers including first responders
- Essential Workers (to be developed in alignment with CDC recommendations) and local and tribal jurisdictions
- People with underlying medical conditions
- People over age 65

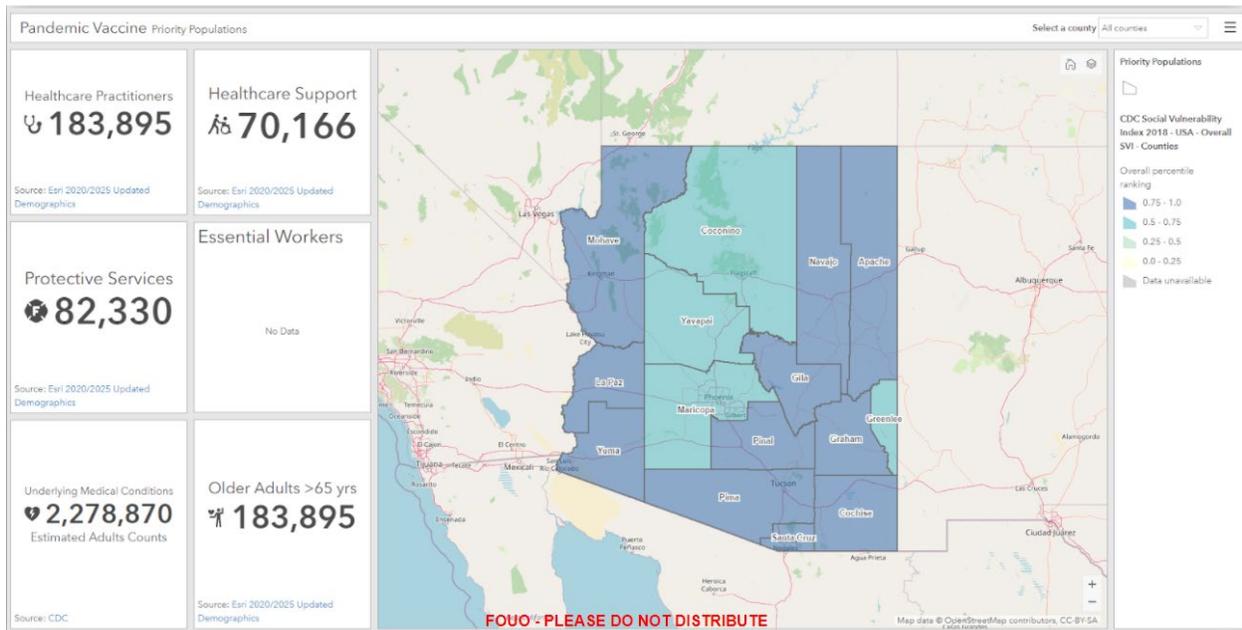
The dashboard includes a map layer that represents the SVI, which was developed to identify communities that will need support before, during, and after public health emergencies. This tool is considered a measure of social determinants of health and uses US Census data to track locations that have especially high SVI scores. The scores come from ranking each county and census tract on 15 social vulnerability factors, grouped into four related themes: socioeconomic, housing composition and disability, racial and ethnic minority groups, and housing and transportation. County health departments will utilize this map layer to identify communities that may have groups of socially vulnerable populations and need additional outreach and services.

In addition, the Department worked with partners at Arizona State University (ASU) to identify priority areas with individuals at high risk for COVID-19 complications using two different assessments of risk - one utilizing Hospital Discharge histories and 20 diagnosis codes that are well documented in the scientific literature as associated with elevated risk of poor COVID outcomes. The second approach was conducted using a COVID vulnerability index developed by ASU. It looks at many factors, such things as poverty, ethnicity, that has been shown to be

statistically associated with elevated COVID death, diagnosis, or hospitalization. This analysis identified 31 high risk Primary Care Areas (PCAs) that contain an estimated 54% of all persons in Arizona who would be at elevated risk of poorer COVID-19 outcomes. These areas have been prioritized throughout the response for targeted communications, social media listening, increased testing and vaccine resources.

Additional layers identify where populations of healthcare practitioners and support workers, as well as protective service (first responders) workers, are geographically located. These populations are mapped by total numbers at the census block group level.

Figure 4 - Screenshot from Priority Populations Dashboard



In addition to the Priority Populations Dashboard (see Figure 4), The ADHS GIS team has also developed a provider dashboard that shows potential vaccination sites (healthcare facilities, pharmacies, established POD sites, and other non-traditional vaccinator sites) as well as established sites. By looking at the geographic areas with higher SVI scores, identified target PCAs, and the availability of vaccination sites in the area, public health staff can identify gaps in services to vulnerable populations.

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

ADHS will utilize Arizona Governor’s Executive Order 2020-12: Prohibiting the Closure of Essential Services (https://azgovernor.gov/sites/default/files/eo_2021_0_sw.pdf) and the Cybersecurity and Infrastructure Security Agency’s (CISA) Guidance on the Essential Critical Infrastructure Workforce, Version 4 (<https://www.cisa.gov/publication/guidance-essential->

critical-infrastructure-workforce) to define critical infrastructure workforce including those in the following sectors:

- Healthcare/Public Health
- Law enforcement, public safety, and other first responders
- Education
- Food and agriculture
- Energy
- Water and wastewater
- Public works and infrastructure support services
- Other community or government-based and essential functions

Multiple state data sources will be used to estimate the workforce within these specific sectors. In addition, local health departments will engage organizations, businesses, and associations that represent these sectors in their jurisdictions. As mentioned previously, VAPAC will play an important role in reviewing the critical population estimates provided by state and local partners and making recommendations on vaccine allocation. It will be essential to have reliable population estimates available early on for ADHS and VAPAC to determine a fair and equitable allocation by jurisdiction.

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

ADHS will continue to evaluate updated information regarding critical workforce sectors that are at increased risk for COVID-19 to inform planning and prioritization of initial vaccine. Ultimately, VAPAC will use data and information about population subsets by jurisdiction to recommend a vaccine allocation for Arizona. For subset groups of essential workers, ADHS will utilize CDC and CISA guidance, as well Executive Order 2020-12, to create a risk categorization methodology that guides the allocation of scarce resources for workers, including personal protective equipment (PPE), access to medical evaluation, testing, and vaccines. Each sector will identify the types of workers that are most at risk within these sectors. This will require the engagement of the essential worker community (employers) to answer specific questions about their workers including questions about setting, proximity, type of contact with the public, duration of contact, number of different contacts, employee risk factors, and others.

ADHS will collaborate with local and tribal stakeholders and engage the respective Emergency Support Functions (ESFs) through DEMA to develop and disseminate survey tools as needed to assess key information about essential workers. This information will assist local jurisdictions with prioritizing subgroups of essential workers for vaccine allocation. The Department also recognizes that additional survey tools may be developed and distributed by employers in coordination with local stakeholders. ADHS is prepared to support the essential worker community and local partners in these efforts.

ADHS will utilize the SVI to identify communities that may need enhanced support before, during and after disasters. The index shows the locations of socially vulnerable populations who are especially at risk during public health emergencies. Since the SVI score for a geographic area (census tracts) takes into account 15 social factors, this method, as well as previous

mapping efforts completed by ADHS based on hospital discharge data and other chronic disease data sources, will help to identify populations that have multiple risk factors making them more vulnerable to suffering adverse events from COVID-19.

Commonly used methods of risk communication may not reach or have little impact among socially vulnerable persons and therefore more creative measures are needed to estimate numbers and to reach members of these populations. ADHS will continue to partner with community organizations, such as the Arizona Statewide Independent Living Council (AZSILC), to ensure these populations are included in the statewide vaccine allocation and distribution process.

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

The 2019 *Arizona Pandemic Influenza Response Plan* includes a list of state, county, tribal, local, and private sector supporting agencies that will work with ADHS during the mass vaccination response process. Points of contact for these agencies are established and will be utilized within the PHIMS structure to maintain communication during the vaccine allocation and distribution process. Some of these organizations include:

- Arizona State Board of Pharmacy (ASBP)
- Arizona Department of Environmental Quality (DEQ)
- Arizona Department of Public Safety (DPS)
- Attorney General's Office (AGO)
- Arizona Department of Agriculture (ADA)
- Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR)
- Arizona Department of Economic Security (DES)
- Arizona Department of Administration (ADOA)
- (Arizona) Division of Emergency Management (DEMA)
- Arizona Health Care Cost Containment System (AHCCCS)
- Arizona Department of Transportation (ADOT)
- Arizona Department of Education (ADE)
- Arizona Poison and Drug Information Center
- County and Tribal Health Departments
- Emergency Management Departments
- Medical Examiners (OME)
- Metropolitan Medical Response Systems (MMRS)
- Other private sector associations and organizations

ADHS will work with county and tribal health departments, TAPI, and other community organizations to establish lines of communication with organizations and employers that represent priority populations. Outreach in each county or tribe will be customized to meet the needs of each jurisdiction. The HEOC will work with the Communications team to develop messaging for the previously mentioned priority populations for dissemination at the local level. Where possible, ADHS will leverage statewide partnerships with entities like the Arizona

Coalition for Healthcare Emergency Response (AzCHER), AZSILC, TAPI, healthcare associations, and others to deliver these messages from the State to community members.

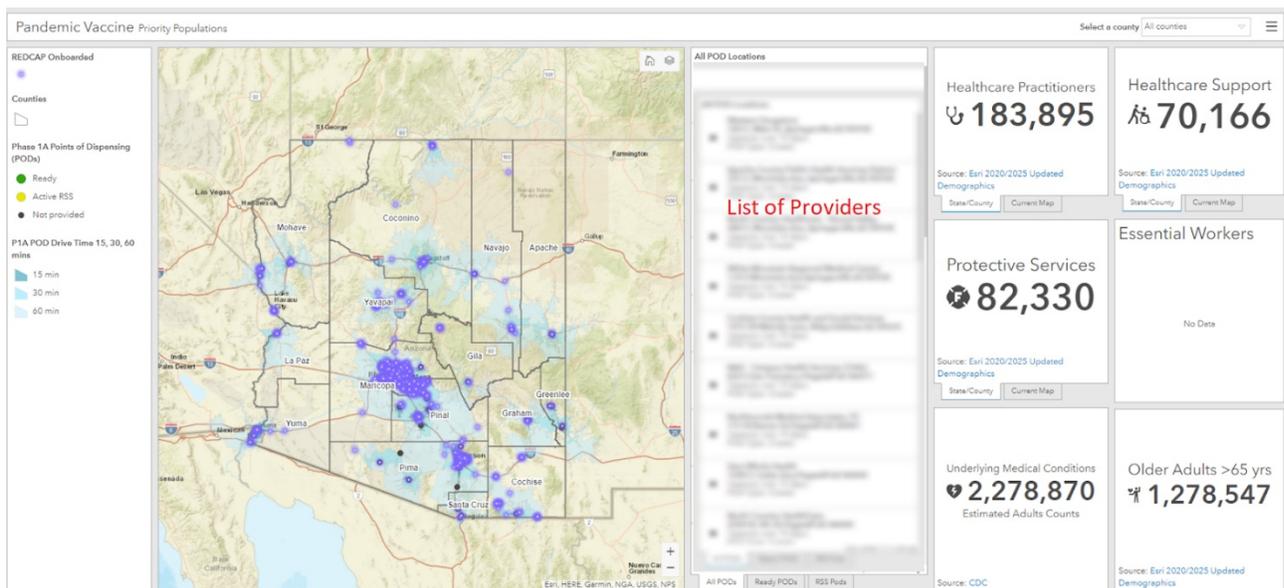
Section 5: COVID-19 Provider Recruitment and Enrollment

A. Describe how your jurisdiction is currently recruiting or will recruit and enroll COVID-19 vaccination providers and the types of settings to be utilized in the COVID-19 Vaccination Program for each of the previously described phases of vaccine availability, including the process to verify that providers are credentialed with active, valid licenses to possess and administer vaccine.

ADHS is utilizing a vaccine provider onboarding tool developed in the REDCap system. The tool is based on the previous CDC Provider Agreement used during the H1N1 vaccination campaign, and has been adapted to accommodate the required CDC data elements and agreements. The system will be used to collect the required data, including provider information, facility type, facility target populations, facility capacity, cold storage capacity, ASIIS status (user or not), and training completed versus needed.

The tool launched September 4, 2020 and onboarded over 250 providers in the first two weeks following the launch. ADHS sent an email to key stakeholders and partners explaining the purpose of the tool and how to complete the onboarding process. The tool will be updated to ensure all current provider agreement parts are accurately captured. In order for an entity to receive an allocation of COVID-19 vaccine from the state, they must complete all required steps within the onboarding tool. See Figure 5 for a map of providers that have completed the onboarding process as of December 2020. Figure 5 displays a map of providers that have completed the onboarding process thus far. Over 1,200 providers across all of Arizona’s 15 counties have begun the onboarding process and over 500 providers are ready to receive vaccine.

Figure 5 - Screenshot from COVID-19 Vaccine Provider Dashboard



B. Describe how your jurisdiction will determine the provider types and settings that will administer the first available COVID-19 vaccine doses to the critical population groups listed in Section 4.

Decisions regarding provider types and settings will be made once the priority groups are defined by ACIP and further prioritized by VAPAC and ADHS leadership. Additionally, the extreme shipping and storage requirements for the first anticipated vaccine (Scenario A) will drive decision making when determining provider types and settings. The Department has also developed a GIS dashboard that shows where providers are located in relation to areas highly impacted by COVID-19; the dashboard includes vaccine administration capacity collected from the REDCap provider onboarding tool to help ADHS and local allocators determine providers that have capacity to manage initial shipments of vaccine and vaccinate critical populations.

C. Describe how provider enrollment data will be collected and compiled to be reported electronically to CDC twice weekly, using a CDC-provided Comma Separated Values (CSV) or JavaScript (JSON) template via a SAMS-authenticated mechanism.

Provider enrollment data will be exported directly from the REDCap onboarding tool. A comma separated value (CSV) or JavaScript (JSON) report will be provided electronically to the CDC twice weekly or as requested.

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

All providers must use the REDCap onboarding tool. The tool requires each provider to submit valid credentials. The AIPO team reviews each provider's submission for accuracy and completeness. This includes checking license numbers for each provider listed. Providers without active licenses or on the Office of the Inspector General (OIG) list for fraud are not allowed to continue their enrollment process. Additional contracted staff may be enlisted to assist with the provider onboarding process as needed.

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

AIPO hosts a Learning Management System (LMS) called AIPO TRAIN (<https://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#provider-training>) initially designed to provide training for Vaccine for Children (VFC) providers. Training materials have been updated or modified for non-traditional vaccinators. Completed training will be tracked in the LMS and include a quiz to measure knowledge of the subject matter presented. Trainees must obtain 80% or higher to pass and receive a certificate of completion for each training. Training topics include: cold storage and handling of vaccines, vaccine ordering, inventory, reporting, accountability, and

digital data logger training. The training also includes information on how to use ASIIS for all vaccine reporting including administration, reporting, and reminder recall. In an effort to expedite the onboarding process for providers that will be engaged in the initial stages of COVID-19 vaccination, providers that have previously completed VFC trainings will not be required to retrain on program requirements. ADHS is prepared to develop additional training for specific COVID-19 vaccine program elements or to expedite provider onboarding as needed.

F. Describe how your jurisdiction will approve planned redistribution of COVID-19 vaccine (e.g., health systems or commercial partners with depots, smaller vaccination providers needing less than the minimum order requirement).

AIPO intends to utilize the vaccine redistribution form provided by the CDC when redistribution is needed. It is anticipated that only the county health departments and 638 facilities will have the capacity to redistribute vaccine. The CDC has indicated that redistribution of vaccine is allowable for refrigerated vaccines only. Based on the packaging and storage requirements of Vaccine Scenario A listed in the CDC Interim Playbook, local partners in Arizona have expressed concerns regarding the ability to administer the minimum requirement of 1,000-5,000 doses to critical populations in one location. Smaller clinics, especially in rural communities in Arizona, have requested the ability to redistribute vaccine in increments less than 1,000 doses in order to vaccinate critical workforce and avoid any potential wasted vaccine. Re-packaging and redistributing in 100-200 dose increments would enable Arizona to meet the demand of health care personnel in smaller communities during the initial phase of vaccination.

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

ADHS, county health departments, and 638 facilities will ensure that vaccine is distributed equitably throughout Arizona. The use of the Department's allocation application tool will provide visibility to where the doses are distributed and available throughout the State. As detailed previously, during the different phases of vaccination ADHS will be monitoring areas with high SVI and lower access to vaccination and working collaboratively with local partners to develop strategies to increase vaccine availability and uptake in these areas.

H. Describe how your jurisdiction plans to recruit and enroll pharmacies not served directly by CDC and their role in your COVID-19 Vaccination Program plans.

The Arizona Pharmacy Association (AzPA) and the Arizona State Board of Pharmacy are represented on the Vaccine Task Force, which convenes on a weekly basis. The Department will work with AzPA and the State Pharmacy Board to reach out to small rural pharmacies to participate in the ADHS onboarding process. Individual pharmacy leads for all large chains across Arizona have all been provided with the email and link for Arizona's COVID-19 provider onboarding tool to begin the process for each of their sites that wish to participate and receive a state vaccine allocation.

In recent weeks, the Department learned that CDC plans to engage large retail pharmacies in Phase 1 to provide vaccination for LTCFs. CDC provided instructions to LTCFs to sign up for

participation in this program. Once enrolled in the program the pharmacy chains will coordinate with the LTCFs for vaccination services. Pharmacies will then receive an allocation of the vaccine from the State's allotment. The CDC Retail Pharmacy Partnership will include additional large retailers and may be activated at the end of Phase 1 or 2 when more vaccine is more widely available.

ADHS activated the CDC Pharmacy Partnership in December beginning with SNFs. It will then expand to other LTCFs as vaccine supplies become available. The State will continue to support federal efforts to engage pharmacies and ensure that LTCFs are covered. ADHS will work with pharmacies and LTCFs to complete the Arizona COVID-19 provider onboarding tool in order to receive a state allocation separately from the federal allocation.

Section 6: COVID-19 Vaccine Administration Capacity

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

Arizona launched a COVID-19 Vaccine Provider Onboarding Tool in early September 2020. The Department has used the online platform REDCap to encourage providers to begin the onboarding process which includes determining their vaccine administration capacity based on the estimated number of persons the practice could vaccinate on a weekly basis, age groups served, and populations the practice will focus immunization efforts on. Using the information captured in the ADHS provider onboarding tool on the number of vaccinations providers have the ability to administer, ADHS has developed an internal dashboard to measure vaccine administration capacity of providers that have completed the onboarding process.

Arizona has demonstrated an advanced ability to develop the provider onboarding process to collect and assess information about vaccine administration capacity. However, it is important to note that, based on information reported by onboarded providers, most do not have the ability to administer 1,000 doses or more of vaccine per week. If the only vaccine available in Phase 1 is based on Scenario A, which requires the ability to administer 1,000 doses or more of vaccine per week, then that will limit the number of providers that can administer vaccine during Phase 1. Ultimately, if early vaccine has requirements consistent with details shared in Scenario A, this may lead to exclusion of some tribal partners and rural communities that do not have a high vaccine administration capacity. In order to ensure a fair and equitable allocation of vaccine, alternative packaging of vaccine is critical to allow smaller rural sites with lower vaccine administration capacity to have an opportunity to vaccinate critical populations. ADHS is also working with partners to discuss opportunities for redistribution as described in Section 5F.

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

The Department will continue to utilize GIS technology to monitor provider onboarding by geographic location to determine which areas may have gaps and require additional provider recruitment. The agency has access to GIS information on licensed health care facilities as well as pharmacies, fire stations, large scale COVID-19 testing sites, and other potential vaccination sites. This will enable staff to reference and compare providers that have completed the

onboarding process. This information will be used to inform planning and outreach efforts moving forward.

If there are a lower number of providers completing the onboarding process than required to cover priority health care populations during the initial stages of vaccination, the Department will engage health care systems, pharmacy association, and local public health partners to capture additional data to inform provider recruitment and allocation planning and conduct targeted outreach to providers. This has been successful previously in Arizona's COVID-19 response as ADHS worked with the Arizona Association of Community Health Centers, the Arizona Medical Association, and emergency medical services partners to expand testing sites across the state. The participation of these stakeholders on the Vaccine Task Force will support rapid action when gaps in coverage are identified.

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

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

The VAPAC convened to develop guidance for vaccine allocation for Phases 1A - 1C. ADHS will continue to utilize VAPAC guidance to determine who will be eligible to receive vaccines and at what point in the distribution cycle. The CDC will identify how many doses are allocated to the State. The State will allocate to all 15 county health departments and 638 facilities that have elected to be local allocators. The Department will inform local allocators of the number of vaccines allotted to them. The local allocators will then be responsible for allocating those vaccines, based on VAPAC guidance, to enrolled vaccinators in their communities. Local allocators will have lists of enrolled vaccinators in their community pulled from the onboarding tool. This will help allocators better understand the population each site can vaccinate as well as vaccination capacity. ADHS expects the local allocations to be pro rata based on the population of priority groups.

At this stage, it will also be important for the state to have situational awareness from federal partners on sites that have received direct allocations from CDC (e.g., IHS, pharmacies, LTCF, DOD, etc.) in order to develop a fair and equitable vaccine allocation plan. Without this information, it will be challenging to develop a state allocation plan for many tribal partners that have both IHS and 638 facilities, as well as LTCF and pharmacies that plan to work directly with CDC and will receive a federal allocation.

B. Describe your jurisdiction's plan for assessing the cold chain capability of individual providers and how you will incorporate the results of these assessments into your plans for allocating/assigning allotments of COVID-19 vaccine and approving orders.

The onboarding tool asks providers to input data for cold storage capacity including make, model, and photograph of the unit(s). The tool also asks about the availability of Digital Data Logs (DDLs). No vaccinator site will be allowed to onboard without providing proof of cold storage capacity and ensuring DDLs are available for monitoring vaccine 24 hours a day. ADHS will provide DDLs as needed to any enrollee that requests them. The onboarding tool states the requirements for 24/7 temperature monitoring and maintenance of DDL temperature reports for randomized review by AIPO staff. Additional training is available through the AIPO TRAIN platform and expedited training can be developed and delivered as needed for alternative or non-traditional vaccinators to complete prior to receiving vaccine.

C. Describe your jurisdiction's procedures for ordering COVID-19 vaccine, including entering/updating provider information in VTrckS and any other jurisdictional systems (e.g., IIS) used for provider ordering. Describe how you will incorporate the allocation process described in step A in provider order approval.

The onboarding tool will be required for any agency, site, or group wishing to be a COVID-19 vaccinator. Once the tool is completed and submitted to the state, staff will review the submission. They will ensure all needed information is provided and accurate. Once a provider is approved to be a COVID-19 vaccinator, VFC/Vaccine for Adults (VFA) partners will be allowed to participate and their order set(s) will be updated. New providers will be added to ASIIS and given login information and further instructions for submitting vaccine orders.

In the earliest phases, when vaccine will be limited, the county health department and 638 local allocators will utilize an electronic allocator tool to indicate who is to receive doses from each day's allocation. The information in the allocation tool will be used to create vaccine orders in ASIIS and subsequently in VTrckS. The vaccination site will be notified that vaccines have been allocated to them and to prepare for arrival. This process will require close coordination among federal, state, local, tribal, and health care partners to ensure sites are notified of vaccine allocation and shipment information in order to be prepared to receive and administer vaccine immediately.

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

ADHS will continue to work with CDC and vaccinators to understand requirements and implement possible strategies for the redistribution of vaccine. Arizona VFC/VFA providers are aware that transfer paperwork must be submitted and program approval received prior to moving vaccine between facilities. This will be reinforced for all providers that receive COVID-19 vaccines. ADHS will routinely monitor vaccine ordering and communicate with county health departments and 638 allocators. Training materials include information on limitations of moving vaccine (i.e., program approval is required). It is understood that the CDC Vaccine Redistribution Agreement can be implemented for refrigerated vaccine only. Additional exercises and resources will be shared to provide training to partners on allowable vaccine distribution strategies including mobile POD planning requirements when applicable.

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

AIPO will follow the same process that is utilized for the VFC/VFA programs. Programs have a wastage form that must be completed and submitted. Staff will review all reasons for vaccine wastage and provide training to provider staff as needed. Once additional guidance is available, further processes on vaccine disposal or return will be developed and guidance forms and training materials will be updated.

Section 8: COVID-19 Vaccine Storage and Handling

A. Describe how your jurisdiction plans to ensure adherence to COVID-19 vaccine storage and handling requirements, including cold and ultracold chain requirements, at all levels.

AIPO provides LMS trainings to educate partners on the requirements for vaccine storage and handling, traditional cold storage units, and DDL requirements. These trainings are required for all COVID-19 vaccinators. Additionally, training is provided for non-traditional vaccination sites. This includes the use of DDLs and the requirement for hourly temperature checks to ensure the vaccine is being properly maintained at the appropriate temperature. More information has been provided in previous sections regarding the capabilities of the LMS platform AIPO TRAIN. Additional information and resources will be distributed through local partners and provider networks, including training offered by TAPI. Proactive training and resources will be developed to reinforce storage and handling requirements based on provider needs during the different stages of vaccination.

AIPO has clearly defined expectations related to transfer of vaccines for VFC/VFA programs. This guidance will also apply to the COVID-19 vaccine. Refrigerated vaccines can only be transferred after proper paperwork has been submitted and approved by the program. Unplanned repositioning will result in loss of ordering privileges until the site comes into full compliance with the requirements.

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

The onboarding tool assesses providers' cold storage and DDL capacity. Vaccinators must have the proper equipment and complete storage and handling training. All vaccinators will be required to maintain 24/7 temperature monitoring utilizing DDLs. While DDL reports will not be regularly reviewed, the program does intend to spot check them and providers will be required to make them available upon request. DDLs will be required for permanent and temporary cold storage units. Transported and redistributed vaccines must also have DDL tracking.

It is anticipated that the redistribution will most likely originate at the county health department or 638 local approver level. AIPO will support these groups to promote successful redistribution of vaccine. This process will necessitate a complete and approved redistribution form as provided by the CDC.

Section 9: COVID-19 Vaccine Administration Documentation and Reporting

A. Describe the system your jurisdiction will use to collect COVID-19 vaccine doses administered data from providers.

ASIIS is an immunization registry designed to capture immunization data on individuals within the State. The registry serves as a receptacle for accommodating these reported data. Providers are encouraged to enter data on adult vaccinations to provide life-long data. In this capacity, the registry then provides a valuable tool for the management and reporting of immunization information to public health professionals, private and public healthcare providers, parents, guardians, and school and child care personnel. ASIIS will be utilized for all aspects of COVID-19 vaccine reporting including ordering, administration, and reconciliation. ASIIS has additional features including vaccine forecasting and patient reminder/recall, which make it an ideal tool for providers to track 2-dose vaccination series when data entry is real-time or up-to-date

Under Arizona Administrative Code (A.A.C.) R9-6-706 and 707, children 18 years of age and younger are required to receive certain vaccines to enter childcare facilities and/or schools. Providers are mandated under Arizona Revised Statute (A.R.S.) § 36-135 to report all immunizations administered to children 18 years of age and younger to the state's health department. Executive Order 2020-57 outlines additional vaccine administration requirements:

Pursuant to the Enhanced Surveillance Advisory and §§A.R.S. 36-782(b)(1) and (4), 36-783(a), (D) and (F) and 36-787(A), an individual or local health agency who administers COVID-19 vaccine shall report the following through a department required format to the Arizona Department of Health Services every twenty-four hours:

- a. The individual's name, date of birth, gender, race/ethnicity, residential address, phone number, and vaccine priority group;
- b. The vaccine product information, including CVX, dose number, lot number, manufacturer, and expiration date;
- c. The route of administration and administration site on the patient's body;
- d. The month, day, and year of each immunization;
- e. The facility administration site details including facility name, type, and address; and
- f. Attest to providing the individual with follow up information if a second dose is required.

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

The Department completed a review of regulatory issues regarding the implementation of the IZ Gateway. The data sharing agreement was approved. This enables ADHS to connect ASIIS directly to the gateway for data transmission. ADHS has worked with an IIS vendor to ensure the Department is successful in sharing data. Additionally, the Department has connected to the CDC data lake and data clearinghouse. COVID-19 vaccination data will be shared through these

platforms. No personally identifiable information (PII) is transmitted. To date, the Immunization Gateway is not yet operational.

C. Describe how your jurisdiction will ensure each COVID-19 vaccination provider is ready and able (e.g., staff is trained, internet connection and equipment are adequate) to report the required COVID-19 vaccine administration data elements to the IIS or other external system every 24 hours.

The onboarding tool asks questions about equipment and describes expectations and requirements for vaccine administration reporting. The tool includes multiple modules to ensure that providers are aware of cold storage, handling, and ASIIS requirements. Providers also have to agree to the CDC provider agreement and conditions of participation. The information submitted will allow the State to assess site readiness and the ability to administer COVID-19 vaccine.

The allocation tool will pull real-time data from ASIIS and identify who is not reporting. Subsequent orders will not be approved if data indicate vaccine was not administered. Vaccination administration will be reported into ASIIS. Many large hospital systems and health care providers are already electronically connected to ASIIS via their Electronic Health Record (EHR) systems, which will be especially advantageous during the early stages of vaccination.

D. Describe the steps your jurisdiction will take to ensure real-time documentation and reporting of COVID-19 vaccine administration data from satellite, temporary, or off-site clinic settings.

The onboarding tool makes it clear that real-time reporting is a requirement for COVID-19 vaccination program participation. Smaller, more rural communities will be asked to address potential connectivity challenges in advance of vaccine distribution. The National Guard is preparing to support internet connectivity in rural communities. In addition, ADHS has amended current IGAs with county and tribal health departments to include CDC supplemental funding to support data entry personnel to make sure documentation and reporting are as close to real-time as possible.

E. Describe how your jurisdiction will monitor provider-level data to ensure each dose of COVID-19 vaccine administered is fully documented and reported every 24 hours as well as steps to be taken when providers do not comply with documentation and reporting requirements.

The review process will happen within ASIIS and the allocation tool. Providers must demonstrate that all vaccine received has been administered to be eligible for additional vaccine through ASIIS. The system is set up to reject requests that are incomplete. Additional reports from ASIIS will also be developed if needed to ensure proper data reporting requirements are being met.

ADHS will assign personnel to conduct daily reviews of ASIIS data to compare who has been allocated doses with who has reported doses administered. This will allow staff to quickly identify gaps and enable them to reach out to providers and rectify the situation.

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

ADHS will use coverage reports along with reminder recall to help ensure both doses are administered. Coverage reports will indicate if people have received one or two doses and the reminder recall will allow programs to recall people for their second dose if missing. It is critical to know who got which vaccine presentation and when. The COVID-19 vaccines are not interchangeable, so knowing which presentation is an important piece of data for the second required vaccination. This data will help the Department to better understand who is protected within individual communities and help focus immunization efforts in areas of greatest need or gaps.

The Department will develop and monitor coverage reports utilizing ASIIS. In addition, ADHS has developed GIS planning tools to look at broader population-based coverage. All local allocators from the counties and tribal jurisdictions will have access to ASIIS and a secure GIS portal. The information will be used to identify gaps and promote coverage for targeted populations. ADHS will utilize task force meetings and other meetings to review the information with stakeholders and identify opportunities to improve vaccine uptake. In areas with lower coverage or uptake, ADHS will work with local partners to develop targeted messaging and other strategies.

Section 10: COVID-19 Vaccination Second-Dose Reminders

A. Describe all methods your jurisdiction will use to remind COVID-19 vaccine recipients of the need for a second dose, including planned redundancy of reminder methods.

ASIIS will be utilized for all vaccine activities including ordering, inventory, administration, and reminder recall. Onboarded providers can learn how to use ASIIS reminder recall features by completing a training in the AIPO TRAIN platform.

The program will utilize the vaccination cards that will be included in the ancillary kits for tracking vaccination details and scheduling second dose appointments before leaving the site of the first vaccination and is exploring additional electronic mechanisms to support this function. ADHS is developing a vaccine management tool, which will provide the ability to monitor a two-dose vaccination series.

Many providers will be using EHRs for all vaccination reporting. Some EHR systems have reminder recall as well. Other providers will utilize the same systems they use in their day-to-day reminder activities or platforms provided by pharmaceutical companies. Since many patients will be captured within both ASIIS and EHR systems, some redundancy in reminder recall contact methods is expected.

In addition, when vaccine is more widely available for the general public, social marketing campaigns and web-based information will remind the public of the need for two doses of vaccine.

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

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

Per Executive Order 2020-57, real-time reporting is required. ADHS has asked providers that have onboarded to make preparations and ensure that they have the connectivity and staff to report at the vaccination site. If data entry cannot occur at the site utilizing the approved vaccine management tool, it must occur within ASIIS within 24 hours of administration via transmission from an approved electronic health record system or other approved method. ADHS will utilize the Mass Vax Module in ASIIS for quick and easy data upload. If real-time direct data entry is not feasible for a site, the Program will utilize a spreadsheet that will capture all the required data elements. The provider will send the spreadsheet to AIPO staff who will convert it into HL7 and upload it into ASIIS. This option will be discussed and made available to providers if warranted. The National Guard has indicated that they may have the capacity to boost connectivity in the more rural communities within the State. Additional options are also being reviewed at this time to account for network outages or other access issues as well as additional vaccine management modules that will interface with ASIIS.

B. List the variables your jurisdiction's IIS or other system will be able to capture for persons who will receive COVID-19 vaccine, including but not limited to age, race/ethnicity, chronic medical conditions, occupation, membership in other critical population groups.

ASIIS is able to record and display the age (date of birth) of people within the system. The system is also capable of capturing race and ethnicity, but these are not required fields during data entry. Some of the data elements are only gathered when providers are reporting via HL7 and not when reporting manually (Vaccination Complete). Some data elements are not required by the Inspector General and are not collected via HL7 (IIS Vaccination Event ID or Filler Order Number, Vaccine Administering Provider Suffix, Dose Number). EHRs are only sending an administered dose and the IIS is doing the evaluation of the dose number.

ADHS in conjunction with the local jurisdictions will also be utilizing a vaccine management system which will assist in scheduling appointments, creating and managing PODS, and submit data to ASIIS. The tool will be able to collect the following:

- Patient name, DOB, gender, race/ethnicity, residential address, phone number, email, and vaccine priority group
- Vaccine product information
- Route of administration and administration site on the patient's body
- Date of immunization
- Facility that administered the vaccine

The vaccine management system will interface with ASIIS and ensure that all required data points are transmitted and logged in ASIIS.

ADHS recognizes the limitations in the current ASIIS platform and will leverage other data sources to obtain identifying information for critical populations (e.g., occupation, medical conditions).

C. Describe your jurisdiction's current capacity for data exchange, storage, and reporting as well as any planned improvements (including timelines) to accommodate the COVID-19 Vaccination Program.

ASIIS is a cloud-hosted platform with extensive storage capacity and the ability to provide reporting in real time. The system is bi-directional capable, but has not been thoroughly tested. 70% of the State's VFC/VFA providers are connected to ASIIS via HL7 and their EHRs. The Department intends to use the Mass Vax Module for real-time, 24-hour data entry. Providers are actively enrolling as vaccinators now and being onboarded into ASIIS.

D. Describe plans to rapidly enroll and onboard to the IIS those vaccination provider facilities and settings expected to serve healthcare personnel (e.g., paid and unpaid personnel working in healthcare settings, including vaccinators, pharmacy staff, and ancillary staff) and other essential workers.

ADHS is currently onboarding all provider types including facilities and settings that serve healthcare personnel (e.g., paid and unpaid personnel working in healthcare settings, including vaccinators, pharmacy staff, and ancillary staff). This is being done now to ensure cold storage capacity and to provide sufficient time for staff to be fully trained in all areas of COVID-19 vaccination activities. The provider onboarding process has been expedited and each vaccinator will be reviewed, approved, and onboarded in both IIS and VTrckS, as soon as is possible and can be completed in less than 30 minutes if needed.

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

ADHS is able to CONNECT and will review SHARE options when they become available.

In the meantime, ADHS is working with the state's IIS vendor to ensure that all of the pieces are in place to make the connection to the Immunization Gateway once it is deemed permissible. The data sharing agreement has been fully signed and returned to the CDC.

F. Describe the status of establishing:

- a. Data use agreement with the Association of Public Health Laboratories to participate in the IZ Gateway*
- b. Data use agreement with CDC for national coverage analyses*
- c. Memorandum of Understanding to share data with other jurisdictions via the IZ Gateway Share component*

The CDC data sharing agreement, allowing the Program to provide vaccination administration data, without PII, to the CDC has been signed and returned to the CDC.

The Memorandum of Understanding remains pending as the CDC finalizes the functionality of the Immunization Gateway.

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

ADHS staff have developed a spreadsheet that includes all required data elements. Once completed, that spreadsheet would be submitted by the provider to AIPO. AIPO staff would then convert the data into a HL7 message and upload it into ASIIS. This is considered a last resort as the expectation is clear that real-time direct data entry is essential and required.

H. Describe how your jurisdiction will monitor data quality and the steps to be taken to ensure data are available, complete, timely, valid, accurate, consistent, and unique.

ADHS has informed and will continue to remind providers of the requirements to report administered vaccinations within the required timeframe. Arizona currently has around 3,500 provider sites that are interfaced and regularly reporting vaccinations. ADHS has established procedures for deduplication of patient and vaccination data. One of the quickest and easiest ways to ensure accurate data reporting is to require dose accountability from COVID-19 providers. The Department is already using the same strategies with provider sites participating in the VFC program. With dose accountability, ADHS will ensure provider sites are submitting the required data fields for each vaccination record. AIPO staff will monitor the vaccine utilization rate by providers and will send specialized COVID-19 Dose Accountability Report Cards. The providers will use the report cards to identify which administered vaccines did not decrement from their inventory and can correct the inconsistencies of the submitted data to properly reflect which vaccine (vaccine product, lot number, etc.) was administered to which patient and improve the data quality in the system. The Department will assign staff to monitor and review the dose accountability report card and provide rapid training to providers that experience challenges.

Section 12: COVID-19 Vaccination Program Communication

A. Describe your jurisdiction's COVID-19 vaccination communication plan, including key audiences, communication channels, and partner activation for each of the three phases of the COVID-19 Vaccination Program.

Arizona's COVID-19 vaccination communication plan is guided by the *ADHS Crisis and Emergency Risk Communication (CERC) Plan* and the *Arizona Pandemic Influenza Response Plan*. ADHS will work collaboratively with state, local, tribal, and health care partners to develop coordinated community engagement and a public messaging strategy. The Communications team has experience working with professional communication agencies to conduct formative research, including surveys, community listening, and focus groups, to collect feedback to inform messaging development and dissemination. The initial work will be very targeted and will focus on health care personnel identified for vaccination during Phase 1A. Subsequent work will focus on issues especially relevant to Phases 2 and 3, such as vaccine hesitancy. During Phases 2 and 3, additional community partners will be engaged to assess communication needs and develop targeted social marketing activities for identified audiences.

The initial target audiences include priority populations such as LTCF residents, health care personnel, and emergency medical service providers, but the overall community engagement strategy will be inclusive of all population demographics and sub-priority groups throughout Arizona's diverse communities.

Local allocators, including county and tribal health departments, will play an important role in identifying partners to help further disseminate messaging to communicate vaccine safety, efficacy, and importance. By establishing communication channels with local experts, the Department will be able to better target messages across the state to a diverse set of audiences. The following phased approach may be used to structure communication and outreach efforts:

- Phase 1: Potentially Limited Doses Available. Messaging will be targeted at priority groups utilizing GIS tools with data layers, best practices established in local jurisdictions, and available messaging from federal partners.
- Phase 2: Large Number of Doses Available, Supply Likely to Meet Demand. Additional messaging will be implemented to target additional priority groups that may have been disproportionately impacted by COVID-19 and live in underserved areas with lower vaccine uptake.
- Phase 3: Likely Sufficient Supply, Slowing Demand. Messaging may focus on the social responsibility of protecting loved ones, essential workers, and other vulnerable community members.

B. Describe your jurisdiction's expedited procedures for risk/crisis/emergency communication, including timely message development as well as delivery methods as new information becomes available.

Strategies and tactics outlined in the Department's CERC Plan will be used to guide message development, content approval, and message delivery methods. ADHS Communications staff

will support local risk communication efforts as requested by county and tribal health departments. In conjunction with the Governor's Office, Communications staff will also coordinate state-level communications including the Arizona Health Alert Network (AzHAN) messages, media releases, press conferences, blog posts from the ADHS Director, and social media messaging.

Messaging needs are typically identified by stakeholders (e.g., county, tribal, health care system stakeholders, or vaccination partners), HEOC leadership staff, Department leadership, or Communications staff. Content development for the vaccination campaign will be the primary responsibility of SMEs within the HEOC Operations Section and AIPO. The process for urgent message development, approval, and dissemination has been exercised and utilized frequently during the COVID-19 response and can be implemented within 24 hours as necessary.

Section 13: Regulatory Considerations for COVID-19 Vaccination

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

All COVID-19 vaccine providers will be onboarded in the REDCap tool and ASIIS. This will ensure the program has contact information for all vaccinators. The Department utilizes a mass blast email system and the AzHAN. Both will be utilized to share specifics with provider contacts about Emergency Use Authorizations (EUAs) and Vaccine Information Statements (VISs). This information and the expectation for sharing are defined in the onboarding tool as well. When more CDC guidance documents are available for distribution, the Department expects some of this information will be distributed to providers in hardcopy format in the vaccine or ancillary kits, but the Department also has the ability to distribute digital copies widely via multiple provider networks and secure platforms.

ADHS will utilize provider networks and the AzHAN system to provide important messaging on vaccine fact sheets, VIS, EUA, biologics license applications (BLA), and other CDC guidance and recommendations when available. Information may also be posted on the ADHS website as well as the ASIIS, AIPO TRAIN, and mobile applications such as the ADHS Infectious Disease Arizona (IDAZ) app. The Department will also work with members of the Vaccine Task Force to distribute information through their networks and contact lists. More information about EUA and BLA are available on the Food and Drug Administration (FDA) website. VIS and fact sheets are provided when vaccine receives FDA approval.

B. Describe how your jurisdiction will instruct enrolled COVID-19 vaccination providers to provide Emergency Use Authorization (EUA) fact sheets or vaccine information statements (VISs), as applicable, to each vaccine recipient prior to vaccine administration.

AIPO will develop a training module in the LMS, AIPO TRAIN, that will include all the information vaccinators need to understand, locate, and share with vaccine recipients prior to vaccine administration as required. This information will be reinforced through pop-ups on the ASIIS website and resources posted on the ADHS website and distributed through ADHS and partner email lists.

Section 14: COVID-19 Vaccine Safety Monitoring

A. Describe how your jurisdiction will ensure enrolled COVID-19 vaccination providers understand the requirement and process for reporting adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

The provider onboarding tool addresses the requirement to utilize the Vaccine Adverse Event Reporting System (VAERS). The Program will address the need for VAERS in AIPO TRAIN. AIPO will utilize the online platform to deliver training to providers, including VAERS and other vaccine safety requirements. Training and other materials may be updated with new content as we learn more about the situation and expectations related to safety monitoring, reporting, and VAERS during the different phases of vaccination.

Additionally, the Vaccine Task Force will create a Vaccine Safety, Monitoring and Messaging work group to further identify needs and messaging. We have heard that there may be a mobile application or other system used to promote safety monitoring and VAERS reporting among populations that receive vaccination under a FDA EUA. As the Department learns more about the situation and expectations, the Vaccine Safety Monitoring and Messaging sub-committee will play an important role in helping to develop targeted messaging for health care workers and other priority populations that may receive COVID-19 vaccine during an initial phase of vaccination. A key member of this committee, Arizona's Poison and Drug Information Centers, which currently oversees the Arizona COVID-19 hotline, will be critical messengers of this information as they are often a primary point of contact for healthcare providers and members of the public.

Section 15: COVID-19 Vaccination Program Monitoring

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

- *Provider Enrollment*

All enrollment activities are completed in the onboarding tool. The tool will be reviewed daily. Regular reports will be generated by ADHS by jurisdiction and shared with the county and tribal health departments. The key data elements and information collected by the provider onboarding tool will help local communities to determine how many vaccinators have completed the onboarding process, cold storage capabilities, and overall vaccine administration capacity to develop local mass vaccination plans. The

report information coupled with additional GIS data will also help communities identify any gaps in vaccine provider coverage in areas that have been impacted by COVID-19, and develop plans to conduct outreach and recruitment to onboard additional vaccine providers. The State with the county health departments will work collaboratively to recruit additional vaccinators as needed based on the county and tribal reports.

- *Access to COVID-19 vaccination services by population in all phases of implementation*

The onboarding tool will identify where vaccinators are located and the allocation tool will identify where the vaccines have been allocated and administered. Local county health departments and allocating 638 facilities will have access to the allocation tool to assist with their review and subsequent allocation of vaccine as needed. A GIS dashboard can be used to determine which populations are covered or underserved by COVID-19 vaccination throughout the phases of implementation.

- *IIS or other designated system performance*

The IIS utilized by AIPO is cloud-hosted with redundancy built into the contract with the vendor. The Program and vendor will regularly monitor system performance and will make adjustments as needed to ensure that the system is accessible.

- *Data reporting to CDC*

The Department will report to the CDC through the IZ Gateway once permission is obtained by the legal team. CDC guidelines will gauge what data elements are reported and the frequency of these reports. The Program will build tasks that meet the requirements in a timely manner.

- *Provider-level data reporting*

Providers have access to their data in ASIIS at all times. Additionally, the Program can access individual data as needed as well. County and tribal health departments will receive weekly reports on providers that completed the onboarding tool, and will have the ability to monitor data at the provider-level and local-level. ADHS will assign staff to monitor and review reports and provide rapid training to providers facing challenges with data reporting.

- *Vaccine ordering and distribution*

In the earliest phases, vaccine ordering and distribution will take place in ASIIS and the allocation tool. In the later phases, ordering and distribution will take place only in ASIIS. Personnel will be assigned to provide quality assurance and identify any gaps during the ordering and distribution processes to allow ADHS staff and members of the Vaccine Task Force to implement real time solutions.

- *1- and 2-dose COVID-19 vaccination coverage*

Coverage will be assessed through reports from ASIIS and the vaccine management tool. AIPO will utilize the reminder cards in the ancillary kits and ASIIS reminder recall abilities to record first and second doses and to set appointments. Providers will utilize external reminder recall systems as they choose. Many of the providers have reminder capabilities within their EHRs. It is expected that all information is to be entered into ASIIS within 24 hours as a condition of participation. This will allow state and local partners to assess first and second dose vaccination coverage. ASIIS also has a module for reminder recall. For patients that miss their window for receiving their second dose within the specified timeframe, ASIIS has the ability to provide a report of patients, including contact information for providers. ADHS can monitor first and second dose vaccination coverage by facility. State and local allocators will monitor this information to ensure that two-dose series are administered appropriately and within the recommended timeframe.

Reports will be developed to identify the proportion of individuals missing their second dose to allow state and local partners to develop high-level strategies to address contributing factors to these vaccination gaps. In addition, ADHS will build reports for use by state and local partners to compare population estimates for prioritized groups with the actual number of individuals in these groups who have been vaccinated. This will drive targeted outreach to priority populations who may be under-vaccinated.

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

- *Budget*

Statewide vaccine operational and logistical planning support is being provided by the ADHS Health Emergency Operations Center (HEOC). The HEOC will be responsible for monitoring the budget and expenditures required to implement the COVID-19 vaccination program. The primary funding that currently supports the immunization program is from CDC, which has also been distributed to county and tribal health departments to support the COVID-19 vaccination program and expenditures are also tracked on a monthly basis. ADHS anticipates additional currently unfunded needs that will require additional supplemental funding to support the COVID-19 vaccination program for activities including community engagement, public messaging, and robust data management tools. Although there is an opportunity for providers to seek reimbursement for a vaccine administration fee, state and local partners have estimated that non-reimbursable operational costs of vaccine distribution and administration will exceed existing available grant funds for the Phase 1 vaccination campaign, including vaccine distribution and public messaging while vaccine supplies are limited and that there will be additional supplemental funding needs for calendar year 2021.

- *Staffing*

The HEOC will continue to monitor staffing requests and needs related to vaccination program statewide. State and local partners will utilize a web-based platform (WebEOC) to monitor resource requests for staffing that cannot be filled locally. Unfilled staffing

needs may be addressed through the use of ESAR-VHP, Medical Reserve Corps, and Arizona National Guard as resources allow. Additional staffing may be procured via contracts with health care staffing agencies or MOUs with universities or schools with health care training programs. As the state moves from Phase 1A to 1B of vaccination, staffing support is expected to shift to additional provider sites and vendors that have completed the ADHS provider onboarding process and have been approved to receive and administer COVID-19 vaccine. As more vaccines become available, state and local partners will contract with vendors that typically provide employee flu shots to ensure that critical workforce receive vaccinations. If additional staffing is required to fill a critical shortage, urgent requests must be submitted to the HEOC to fulfill the need with contracted positions. This mechanism has been utilized successfully to support other elements of the State's COVID-19 response.

- *Supplies*

The AIPO Finance and Program Managers review supply needs as identified by staff during regular monthly meetings. As part of HEOC operations, the Department also maintains a state warehouse and inventory system for personal protective equipment, testing supplies, and other critical resources that can be used to support vaccination. The HEOC maintains close communication and coordination with local partners to identify critical supply needs and monitor resource requests. Counties and tribes submit resource requests to the state on behalf of local and health care partners, and the state distributes supplies to partners based on critical needs and population when available.

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

- *Message delivery*

ADHS utilizes a myriad of communication tools and resources including the Department's Communications team informed by programmatic SMEs. In addition, the Vaccine Task Force also hosts a Communication Workgroup. All are engaged in COVID vaccine messaging and coordinate routinely to review available materials and develop materials as needed. In alignment with the ADHS CERC Plan, messaging will be developed and routed through SMEs in the Operations Section, PIO staff, and the HEOC Manager before receiving final approval from the Director's Office as required.

In order to better gauge public opinion, the Department will conduct community engagement activities with a vendor to assess perceptions and attitudes of the community towards the COVID-19 vaccine. This assessment will help define how the Department and programs further develop and target messaging.

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

In accordance with the Department's CERC Plan, ADHS staff will conduct media monitoring to stay abreast of how messages are being received and to stay on top of misinformation across the state. ADHS will work with county, tribal, and health care system PIO partners to address specific media monitoring concerns and develop additional messaging to counter misinformation as necessary.

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

At this stage in planning, ADHS has convened a multi-jurisdictional Vaccine Planning Task Force that includes county and tribal partners. The Vaccine Task Force is used to evaluate vaccine updates from CDC and federal partners, as well as routinely monitor local-level situational awareness. During regular meetings with local partners, the Department is able to receive feedback regarding vaccination strategies, activities, barriers, and challenges. Throughout the different phases of vaccination, ADHS will continue to conduct Vaccine Task Force meetings and engage other partners such as AzCHER. The jurisdiction will use regular task force meetings, exercises, and surveys to collect additional feedback to monitor vaccine-related needs and progress in certain areas.

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

ADHS will review total vaccinator enrollment, vaccines received in Arizona, vaccine ordered by vaccinators, vaccine administered, and vaccination coverage. The parameters of this coverage will continue to be defined as additional data becomes available. GIS mapping will be used to identify where vaccinators are throughout the State as well as high risk populations and other components. These maps will be shared through a secure portal with local health department staff. The program will utilize the Vaccine Finder tool to provide information about where Arizonans can go to be vaccinated as vaccine becomes more widely available to the general public. That tool, as well as high-level vaccination metrics will be posted to the ADHS COVID-19 webpage (<http://www.azhealth.gov/COVID-19>).

Appendix A: VAPAC Roster

Agency	Title
ADHS	Director and SMEs
Arizona's Governor's Office	Governor's Office Representative
Arizona Pharmacy Association	Executive Director
Arizona Medical Association	Executive Director
Arizona Nurses Association	Executive Director
Arizona Alliance for Community Health Centers	Chief Executive Director
Arizona American Academy of Pediatrics	Executive Director
Arizona Tribal Emergency Council	Chair
Intertribal Council of Arizona	Executive Director
Indian Health Services	Phoenix Area Director
Navajo Nation	Health Director
Arizona Hospital and Healthcare Association	Executive Director
Health System Alliance of Arizona	Executive Director
Arizona Health Care Association	Executive Director
County Health Officer Collaborative Team	County Health Officers
Subject Matter Experts	Hospital Executives

Appendix B: Plan References

- ADHS. (2019, May). Arizona Pandemic Influenza Response Plan. Version 2.
- ADHS. (2019, August). Crisis and Emergency Risk Communication Plan.
- ADHS (2020). Arizona Crisis Standards of Care Plan. 3rd Edition.
- ADHS. (2019, June). Medical Countermeasures Operational Plan.
- CDC. (2020, September). COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations. Version 1.
- CISA. (2020, August). Guidance on the Essential Critical Infrastructure Workforce. Version 4.
- Executive Order 2020-12. (2020). Prohibiting the Closure of Essential Services.
https://azgovernor.gov/sites/default/files/eo_2021_0_sw.pdf
- Maricopa County Department of Public Health. (n.d.). Closed Point of Dispensing Site Guide.
- Maricopa County Department of Public Health. (n.d.). *Partners in Public Health Preparedness*. Retrieved from Maricopa County:
<https://www.maricopa.gov/4549/Partners-in-Public-Health-Preparedness>

Appendix C: Definition & Acronym List

Acronym	Description
AAR	After Action Report
ACIP	Advisory Committee on Immunization Practices
ADHS	Arizona Department of Health Services
ADOA	Arizona Department of Administration
ADOH	Arizona Department of Housing
AGO	Arizona Attorney General's Office
AHCCCS	Arizona Health Care Cost Containment System
AIPO	Arizona Immunization Program Office
ALF	Assisted Living Facility
ASBP	Arizona State Board of Pharmacy
ASIIS	Arizona State Immunization Information System
ASPR	Office of the Assistant Secretary for Preparedness and Response
AzCHER	Arizona Coalition for Healthcare Emergency Response
AZDA	Arizona Department of Agriculture
AzHAN	Arizona Health Alert Network
AZSILC	Arizona Statewide Independent Living Council
AzTEC	Arizona Tribal Emergency Committee
BLA	Biologics License Applications
CDC	Centers for Disease Control and Prevention
CERC	Crisis and Emergency Risk Communication
CISA	Cybersecurity & Infrastructure Security Agency
CSV	Comma Separated Value
DDL	Digital Data Logger
DEMA	Department of Emergency and Military Affairs

DEQ	Arizona Department of Environmental Quality
DES	Arizona Department of Economic Security
DOC	Arizona Department of Corrections
DPS	Arizona Department of Public Safety
EHR	Electronic Health Record
ESF	Emergency Support Function
EUA	Emergency Use Authorization
FEMA	Federal Emergency Management Agency
FDA	Food and Drug Administration
GIS	Geographic Information Systems
HEOC	Health Emergency Operations Center
HIE	Health Information Exchange
IDAZ	Infectious Disease Arizona
ICS	Incident Command Structure
IGA	Intergovernmental Agreement
IHS	Indian Health Services
IIS	Immunization Information System
IP	Improvement Plan
ITCA	Inter Tribal Council of Arizona
JIS	Joint Information System
JSON	JavaScript Object Notation
LMS	Learning Management System
LTCF	Long-Term Care Facility
MMRS	Metropolitan Medical Response Systems
NASEM	National Academies of Sciences, Engineering, and Medicine
OIG	Office of the Inspector General
OME	Office of the Medical Examiner

PHEP	Public Health Emergency Preparedness
PHIMS	Public Health Incident Management System
PII	Personally Identifiable Information
PIO	Public Information Officer
POC	Point of Contact
POD	Points of Dispensing
PPE	Personal Protective Equipment
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SVI	Social Vulnerability Index
TAPI	The Arizona Partnership for Immunizations
TTX	Tabletop Exercise
VAERS	Vaccine Adverse Event Reporting System
VAPAC	Vaccine and Antiviral Prioritization Advisory Committee
VFA	Vaccine for Adults
VFC	Vaccine for Children
VIS	Vaccine Information Statement
VPD	Vaccine Preventable Disease