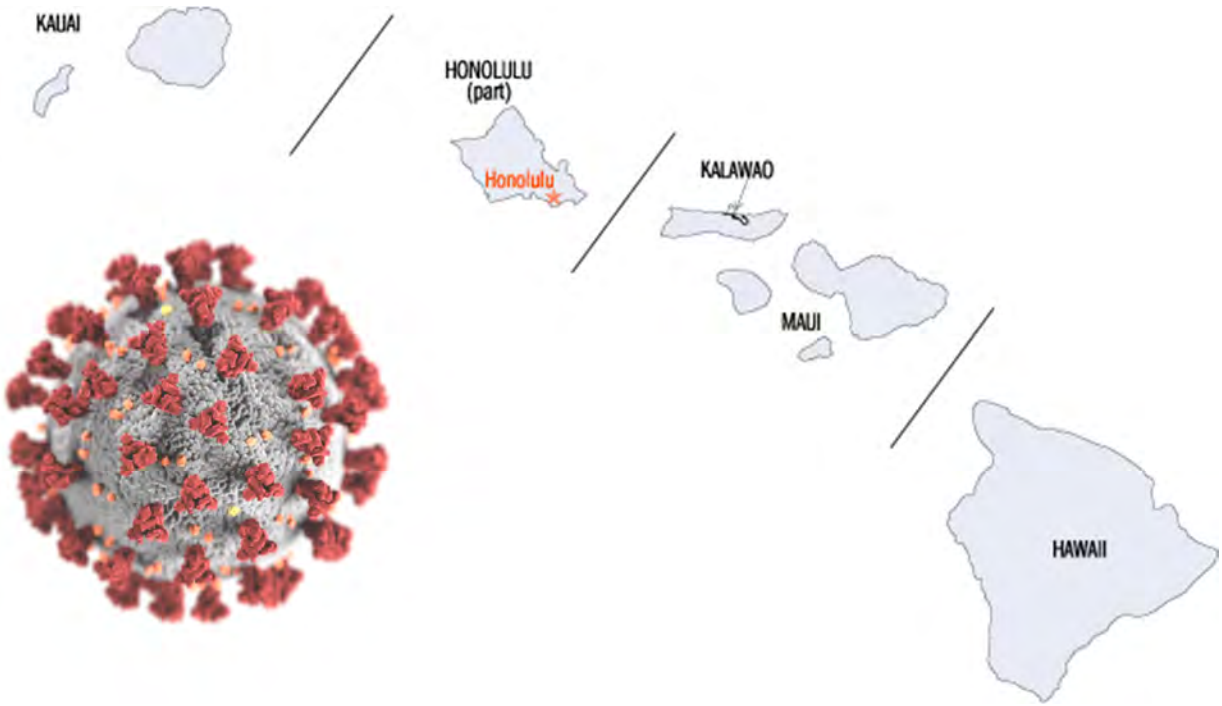

COVID-19 Vaccination Plan

DRAFT

Hawaii Department of Health
OCTOBER 16, 2020 | DRAFT VERSION 1.0

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Record of Change

Date Reviewed	Change Number	Date of Change	Description of Change	Name of Author

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Promulgation Statement

This COVID-19 Vaccination Plan is hereby accepted for implementation and supersedes all previous editions.

_____ _____

Elizabeth “Libby” Char, M.D. DATE
Hawaii Department of Health
Director

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Contents

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Executive Summary

"The emergence of the COVID-19 pandemic has created unprecedented public health challenges and spurred a global race to develop and distribute one or more viable vaccines. The challenge of vaccine development is matched by the challenge of vaccine distribution; once discovered and produced, it must be delivered and dispensed to the population writ large. Although a vaccine is not yet available, lessons learned from the acquisition and distribution of COVID-19 diagnostics and therapeutics suggest that States begin addressing the challenges of mass distribution before its arrival. Immunizing the U.S. population against COVID-19 will likely require the single largest vaccination campaign ever undertaken and require leaders from state public health, immunization, and emergency management systems to design and execute the vaccination operation. As with many COVID-19 activities, a "whole of government" response, with broad participation by health and human services, economic development, education, and public safety agencies, as well as private sector partners and the public, is crucial to success."[1]

On September 16, 2020 the Centers for Disease Control and Prevention (CDC) released the *COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations*[2] and directed jurisdictions to prepare and submit their COVID-19 vaccination response plans for CDC review no later than October 16, 2020 in support of Operation Warp Speed, which has a mission to delivery 300 million doses of safe and effective vaccine by 1 January 2021.[3]

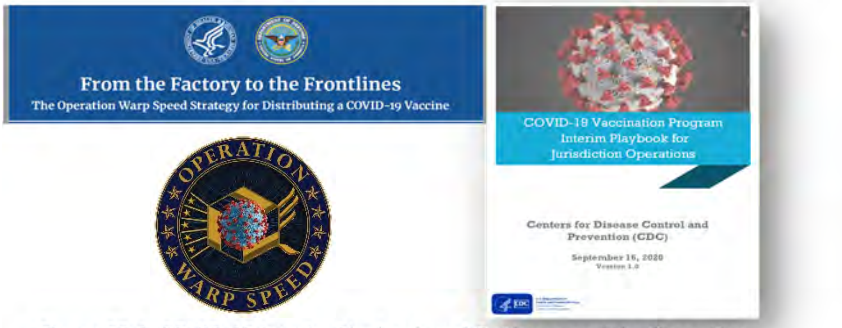

Figure ES-1: COVID-19 Interim Playbook and Guidance and the Operation Warp Speed Strategy for Distributing a COVID-19 Vaccine

The Hawaii Department of Health (HDOH), as the lead state health agency and lead state agency for State Emergency Support Function 8 (SESF #8) Public Health and Medical Services, formed a Core Planning Team with representatives from local, state, and federal levels as well as private sector partners under the leadership of the Disease Outbreak Control Division (DOCD) Immunization Branch (IMB) to develop the state's COVID-19 Vaccination Plan.

The purpose of the HDOH COVID-19 Vaccination Plan is to provide an operational plan that will support the state's efforts to implement a comprehensive vaccination program to reduce COVID-19-related illnesses, hospitalizations, and deaths, and to help restore societal functioning. This plan provides operational and logistical guidance for planning and coordinating a statewide COVID-19 vaccination effort to effectively request, secure, receive, store, stage, distribute, dispense, and recover vaccine assets. It describes the concept of operations and identifies anticipated roles and responsibilities of organizations supporting this effort.

HDOH organized the overall concept of operations for the vaccination effort driven by three overarching Operational Priorities supported by nine Operational Objectives to achieve the desired end state of maximizing societal benefit by reducing morbidity and mortality caused by transmission of the novel coronavirus **(see Figure ES-2)**.

[1] Preparing For The COVID-19 Vaccine And Considerations For Mass Distribution, https://www.nga.org/memos/covid-19-vaccine-considerations-mass-distribution/ accessed September 28, 2020.
[2] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.
[3] https://www.defense.gov/Explore/Spotlight/Coronavirus/Operation-Warp-Speed/Operation-Warp-Speed-Timeline/

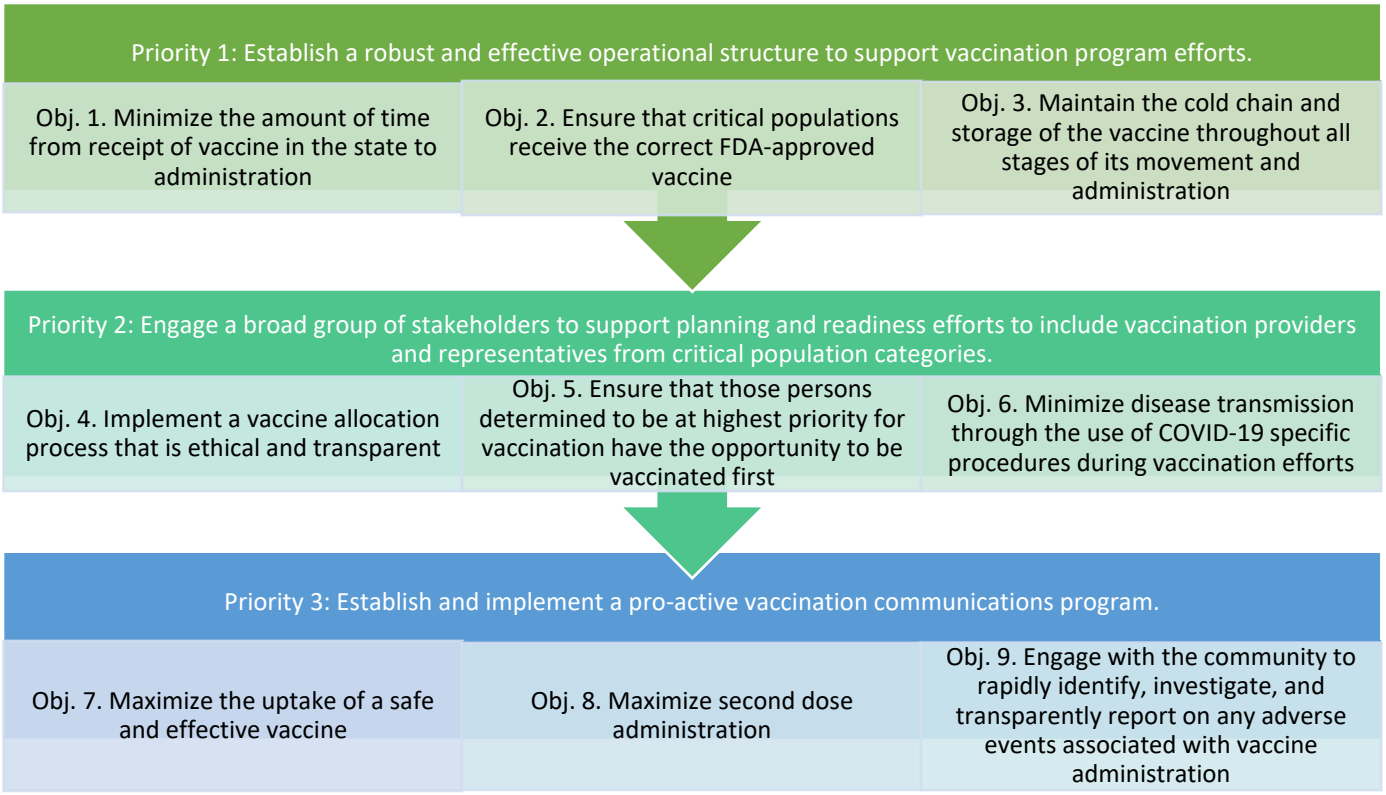

Figure ES-2: COVID-19 Priorities and Objectives

HDOH will use two primary coordinating bodies, a Vaccination Core Planning Team and a Vaccination Program Implementation Committee, as well as standing and ad hoc working groups to support the COVID-19 vaccination program **(See Appendix A: Task Organization)**.

HDOH selected stakeholders from organizations throughout Hawaii to support each of these two coordinating bodies based on four recommended categories for critical population groups identified in CDC's *Interim Updated Planning Guidance on Allocating and Targeting Pandemic Influenza Vaccine during an Influenza Pandemic*[4] **(see Figure ES-3)**.

> "Guidance for allocating and targeting initial vaccination of certain groups includes a structure… that defines population groups in four broad categories that correspond with the objectives of a pandemic vaccination program – to protect people who
> 1) maintain homeland and national security,
> 2) provide health care and community support services,
> 3) maintain critical infrastructure, and
> 4) are in the general population."

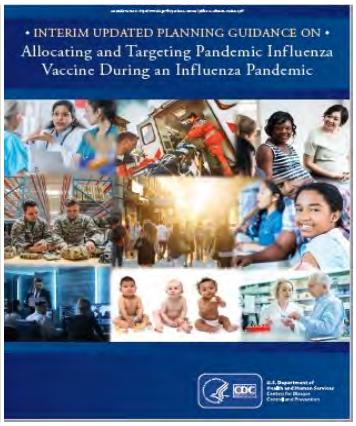

Figure ES-3: Four Categories for Critical Population Groups

The CDC's *COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations* identifies three phases of operation for the availability of COVID-19 vaccine as described below in **Figure ES-4.** NOTE: We are currently in "Phase 0" before the arrival of COVID-19 vaccine.

[4] https://www.cdc.gov/flu/pandemic-resources/pdf/2018-Influenza-Guidance.pdf

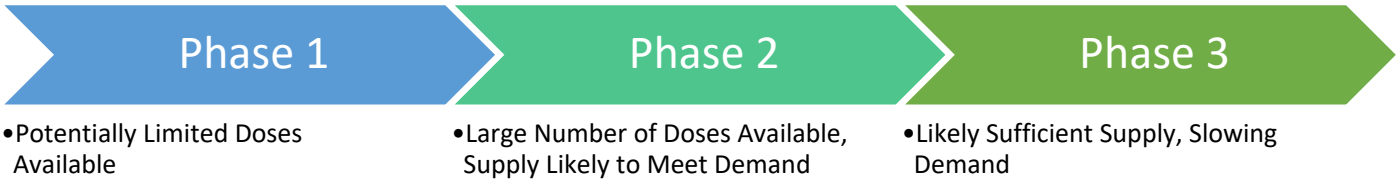

Figure ES-5: Operational Phases

A key point to consider is that vaccine supply will be limited in Phase 1, so the allocation of doses will focus on vaccination providers[5] and settings for vaccination that will be able to target limited critical populations throughout the state. HDOH will need to rapidly enroll COVID-19 vaccination providers in each county into the Hawaii Immunization Registry (HIR) system[6] so that they can identify and order the number of doses they require to reach those critical populations. The vaccine supply will increase in Phases 2 and 3, allowing vaccination efforts to be expanded to additional critical populations including the general public. It is important to note that recommendations on the various population groups to receive initial doses of vaccine could change after vaccine(s) are available, depending on each vaccine's characteristics, vaccine supply, disease epidemiology, and local community factors.[7] And, the duration of each phase is uncertain. HDOH will convene a Vaccine Prioritization/Allocation Working Group that will consider these factors during their working sessions as they recommend modifications and adjustments to allocation decisions for each phase of operations **(See Figure ES-5: Vaccine Allocation Process)**.

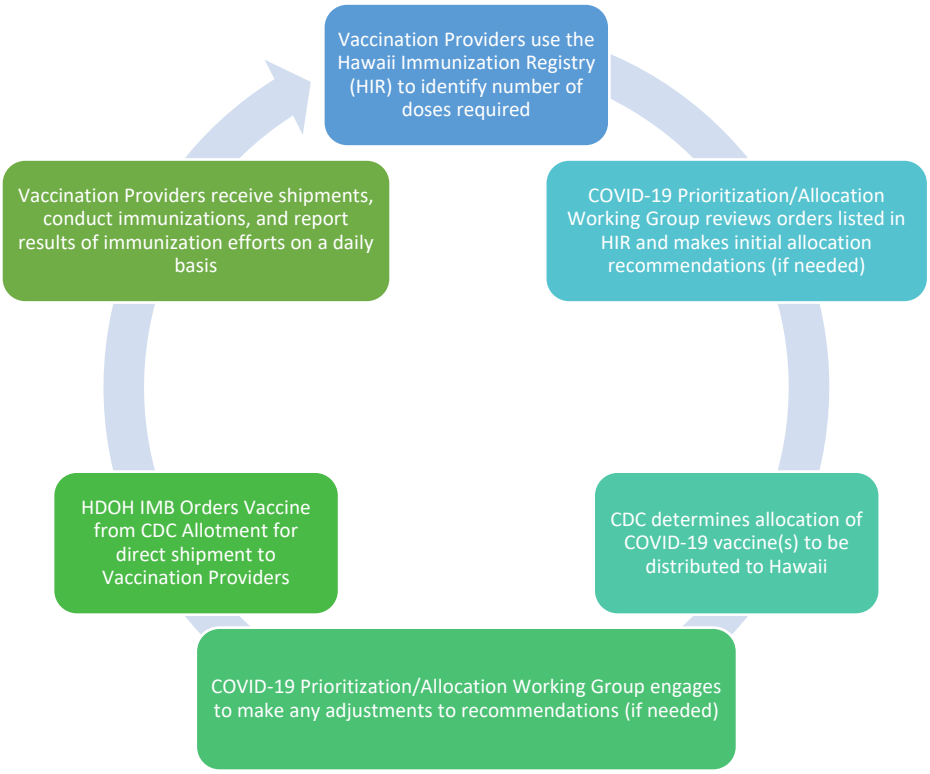

Figure ES-4: Vaccine Allocation Process

[5] For the purposes of this document, "vaccination provider" refers to any facility, organization, or healthcare provider licensed to possess/administer vaccine or provide vaccination service (to include HDOH), while a "COVID-19 vaccination provider" is any vaccination provider that HDOH enrolled in the COVID-19 Vaccination Program.

[6] https://health.hawaii.gov/docd/about-us/programs/hawaii-immunization-registry-hir/

[7] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

On October 2, 2020, the National Academies of Sciences, Engineering, and Medicine (NASEM) published the "*Framework for Equitable Allocation of COVID-19 Vaccine*".[8] The HDOH COVID-19 Vaccination Plan uses that framework to identify the composition of the critical populations groups to receive vaccinations **(See Appendix C: Critical Populations)**. As note previously, the Vaccine Prioritization/Allocation Working Group will need to consider factors such as the risk of critical populations acquiring infection, severe morbidity and mortality, negative societal impact, and transmitting infection to others in making allocation decisions.

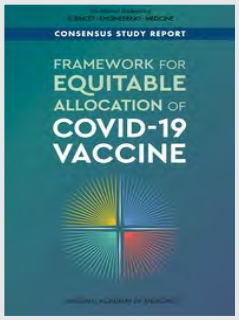

Figure ES-6: Framework

The Framework describes the use of four allocation stages[9] to target population groups starting with Allocation Stage 1a and progressing until the entire population desiring to get vaccinated is able to receive the COVID-19 vaccine.

Table ES-1: Population Groups

Allocation Stage	Population Group
Stage 1a	High-risk health workers (e.g., in hospitals or nursing homes, or providing home care)—these health professionals are involved in direct patient care. Also included are workers who provide transportation, environmental services, and other health care facility services and who risk exposure to bodily fluids or aerosols.
	First responders whose jobs put them at high risk of exposure to COVID-19
Stage 1b	People of all ages with comorbid and underlying conditions that put them at significantly higher risk
	Adults aged 65 and older living in congregate or overcrowded settings
Stage 2	K-12 teachers and school staff
	Critical risk workers in high-risk settings - workers who are both in industries essential to the functioning of society and at substantially high risk of exposure
	People of all ages with comorbid and underlying conditions that put them at moderately higher risk
	People in homeless shelters or group homes for individuals with physical or mental disabilities or in recovery and staff who work in those facilities
	People in prisons, jails, detention centers, and similar facilities, and staff who work in such settings
	Adults aged 65 and older not included in Allocation Stage 1
Stage 3	Young Adults (18-22)
	Children (0-17)
	Workers in industries and occupations important to the functioning of society and at increased risk of exposure not included in Allocation Stages 1 or 2
Stage 4	Everyone residing in Hawaii who did not have access to the vaccine in previous allocation stages

This plan provides stakeholders from the whole community with the operational information needed to prepare their organizations to support the HDOH COVID-19 Vaccination Program. The HDOH COVID-19 Vaccination Core Planning Team recommends that stakeholders develop/update standard operating procedures (SOPs), as well as supporting plans and procedures, as the state prepares to enter Phase 1, and begins outreach efforts throughout Hawaii to prepare the public for the COVID-19 Vaccination Program as vaccines become available.

[8] https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus

[9] **NOTE:** The *Framework for Equitable Allocation of COVID-19 Vaccine* uses the term "phases" (not "stages") suggesting successive deployments of vaccine to critical populations groups instead of another term "tiers" which had been used previously by the CDC (i.e. – Phases 1a, 1b, 2, 3 and 4 instead of Tier 1, Tier 2, or Stage 1, Stage 2, etc.). The authors stated that they wanted to eliminate the suggestion of any population group having greater importance than another, and that within each phase, all groups should have equal priority for vaccine. Also, that when individuals within a group fall into multiple phases ("stages"), the higher phase ("stage") should take precedent. For the purposes of the HDOH COVID-19 Vaccination Plan, planners use the term "stages" instead of "phases" to avoid confusion with the three phases of this plan.

1 Situation

1.1 Purpose

The purpose of the Hawaii Department of Health (HDOH) COVID-19 Vaccination Plan is to provide an operational plan that will support the state's efforts to implement a comprehensive vaccination program to reduce COVID-19-related illnesses, hospitalizations, and deaths, and to help restore societal functioning.

1.2 Scope

This plan provides operational and logistical guidance for planning and coordinating a statewide COVID-19 vaccination effort to effectively request, secure, receive, store, stage, distribute, dispense, and recover vaccine assets. It describes the concept of operations for this effort and identifies anticipated roles and responsibilities of each organization. Regulatory requirements may necessitate the use of additional detailed standard operating procedures and/or field operations guides for the successful completion of vaccination operations. This plan has been designed to complement the use of those detailed plans and procedures, however it does not contain that level of detail such as job action sheets for individual positions.

HDOH organized the overall concept of operations for the vaccination effort driven by three overarching Operational Priorities supported by nine Operational Objectives to achieve the desired end state of maximizing societal benefit by reducing morbidity and mortality caused by transmission of the novel coronavirus **(See Figure 1-1)**.

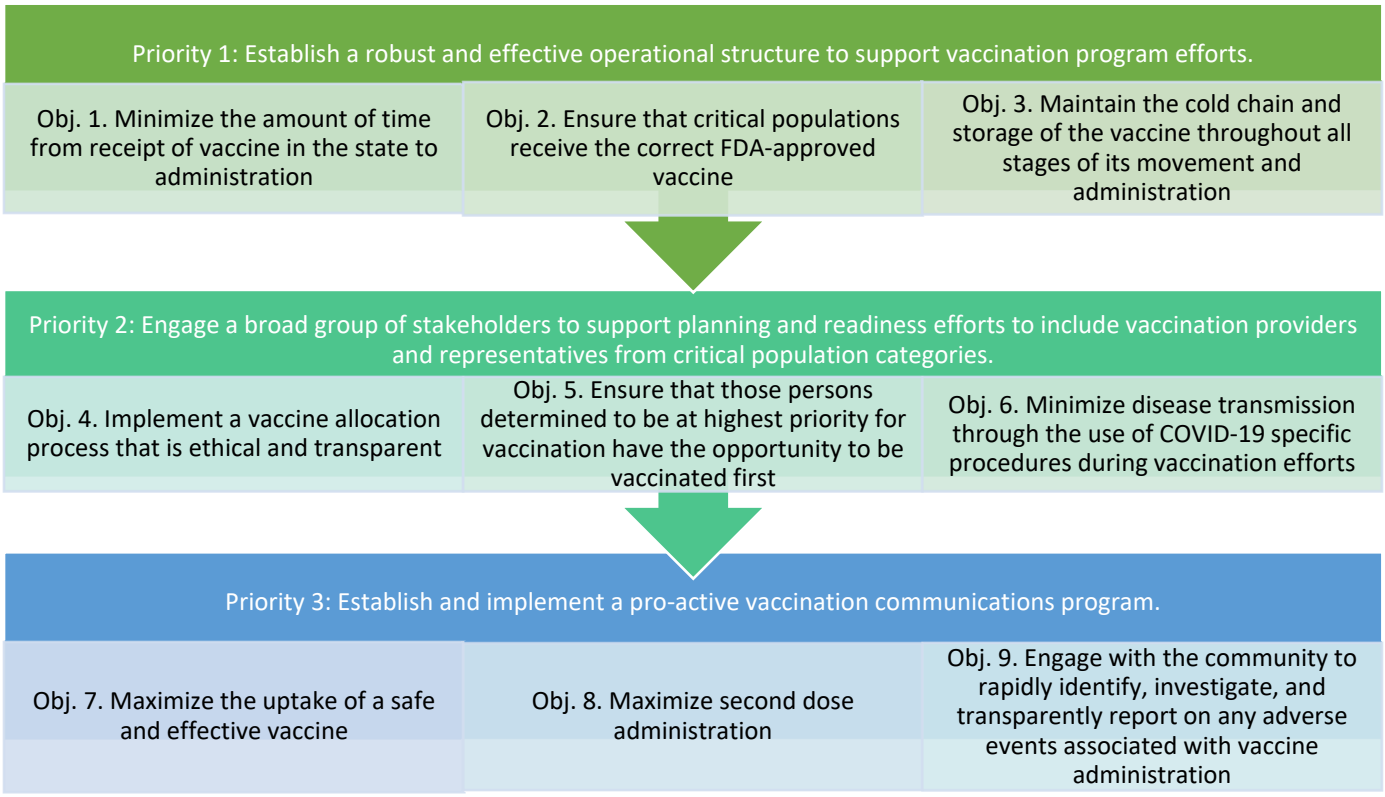

Figure 1-1: COVID-19 Priorities and Objectives

Relationship to Other Plans

The Hawaii COVID-19 Vaccination Plan provides context in light of other existing plans (i.e. Hawaii Department of Health Pandemic Influenza Plan (2008), Hawaii Strategic National Stockpile Plan (2019), Hawaii State Emergency Operations Plan (EOP) (2019), etc.) and guidance from the Centers for Disease Control and Prevention (CDC). This plan also recognizes that District Health Offices (DHOs), as well as other stakeholders have existing vaccination plans and procedures, and may need to update their plans and procedures based on COVID-19 specific vaccination requirements.

1.3 Situation Overview

> *"The emergence of the COVID-19 pandemic has created unprecedented public health challenges and spurred a global race to develop and distribute one or more viable vaccines. The challenge of vaccine development is matched by the challenge of vaccine distribution; once discovered and produced, it must be delivered and dispensed to the population writ large. Although a vaccine is not yet available, lessons learned from the acquisition and distribution of COVID-19 diagnostics and therapeutics suggest that States begin addressing the challenges of mass distribution before its arrival. Immunizing the U.S. population against COVID-19 will likely require the single largest vaccination campaign ever undertaken and require leaders from state public health, immunization, and emergency management systems to design and execute the vaccination operation. As with many COVID-19 activities, a "whole of government" response, with broad participation by health and human services, economic development, education, and public safety agencies, as well as private sector partners and the public, is crucial to success."*[1]

Background

Vaccination is the primary intervention viewed as having the ability to dramatically decrease the health impacts of the COVID-19 pandemic. The overall impact of a vaccination program during a pandemic depends on how rapidly a viable vaccine becomes available; its effectiveness in preventing further disease spread; its supply; and the ability to allocate and administer it effectively and efficiently.

Even after a safe and effective vaccine has been developed, supply chain challenges that were faced during the distribution of PPE will likely be more complicated with reliance on a temperature-controlled and high-value vaccine, and potentially limited supplies of ancillary supplies required to support vaccination efforts.

In addition, the public's perception of the severity of COVID-19, as well as the perceived safety/efficacy of the vaccine will have a tremendous impact on the success of the state's vaccination program and will required a coordinated communications and outreach effort.

[1] Preparing For The COVID-19 Vaccine And Considerations For Mass Distribution, https://www.nga.org/memos/covid-19-vaccine-considerations-mass-distribution/, accessed September 28, 2020.

Preparedness Planning

Unity of purpose is achieved through coordination and integration of plans across all levels of government, nongovernmental organizations, the private sector, and individuals and families. This supports the fundamental principle that emergency management operations start at the local level and expand to include Federal, state, regional, and private sector assets as the affected local jurisdiction requires additional resources and capabilities.

"Let our advance worrying become advance thinking and planning."
~Winston Churchill

Figure 1-2: Preparedness Planning

This same concept applies to vaccination planning efforts as plans need to be mutually supportive at all levels of government. Horizontal integration ensures that individual stakeholder plans fit into the HDOH COVID-19 Vaccination Plan so that each organization understands, accepts, and is prepared to execute their respective roles and responsibilities.[2]

Due to the requirement to complete the COVID-19 Vaccination Plan in a compressed timeline, HDOH acknowledges that this synchronization of plans will need to take place after the publishing of the draft plan. And, that significant additional planning is needed to operationalize this plan as the challenge of COVID-19 is much larger in scope and complexity than vaccination campaigns conducted in Hawaii for seasonal influenza or other previous outbreaks.[3]

HDOH understands that response planning requires collaboration among a wide range of public- and private- sector partners, including immunization and public health emergency preparedness programs, emergency management agencies, healthcare organizations, industry groups that include critical infrastructure sectors, policy makers, and community vaccination providers (e.g., pharmacies, occupational health settings, doctors' offices). Many of these partners are engaged regularly in seasonal influenza efforts such as the Stop Flu at School (SFAS) program and other outbreak vaccination campaigns, and some served as vaccination providers[4] during the 2009 H1N1 pandemic. A shared planning community increases the likelihood of integration and synchronization, makes planning cycles more efficient and effective, and makes plan maintenance easier.

"Everyone has a plan until they get punched in the mouth"
~Mike Tyson

Figure 1-3: Preparedness Planning

1.3.1.1 Lessons Learned/Mitigation Strategies

Incorporating lessons learned and mitigation strategies will be critical to the success of the HDOH COVID-19 Vaccination Plan. Improvement planning involves the identification of strengths, areas for improvement, and corrective actions that result from workshops, exercises, or real-world events. HDOH plans to test the COVID-19 Vaccination Plan through discussion and operations-based exercises as described below, and to incorporate best practices and lessons learned into the plan as needed. HDOH also encourages stakeholders to review appropriate after-action reports (AARs) to evaluate lessons learned and to implement mitigation strategies to address identified risks. **Table 1-1** below highlights lessons learned (potential Issues/risks for the current planning effort) gathered from previous real-world event and exercise AARs and provides mitigation strategies.

[2] FEMA: Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101 Version 2.0, November 2010, https://www.fema.gov/sites/default/files/2020-05/CPG_101_V2_30NOV2010_FINAL_508.pdf, accessed on October 8, 2020.

[3] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations, September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

[4] For the purposes of this document, "vaccination provider" refers to any facility, organization, or healthcare provider licensed to possess/administer vaccine or provide vaccination services. A "COVID-19 vaccination provider" is any vaccination provider enrolled in the COVID-19 Vaccination Program.

Table 1-1: Risks/Mitigation Strategies

#	Lesson Learned (Issue/Risk)	Action Plan
1	Inadequate vaccination workforce training.	Identify/develop vaccination workforce training requirements and conduct training.
2	Insufficient use of execution checklists.	Develop operational checklists for key positions.
3	Availability of medical and non-medical surge support staff.	Conduct outreach to identify additional medical and non-medical surge resources and consider the use of contract support and/or mutual aid.
4	Space limitations related to receiving and storing vaccines.	Identify, report, and maintain storage capacity by location within each county.
5	Hospital pharmacies may have been underutilized during the pandemic.	Coordinate with hospitals to validate existing capabilities and include in planning efforts.
6	Priority population group definitions were unclear.	Clearly define priority population groups and justification metrics for vaccine allocation.
7	Inconsistent vaccine administration to priority group populations at the local level.	Conduct outreach and training on vaccination allocation procedures.
8	Delays in reporting vaccine administration data due to inconsistent requirements and reporting systems.	Identify and disseminate reporting requirements, systems, and data points, conduct training, and provide supporting checklists to ensure compliance.
9	Developing flexible plans to meet supply availability.	Review/develop logistics plans that track available resources, resource request, resource transfer information to include anticipated resources and resource providers.
10	Lack of stakeholder engagement	Conduct proactive outreach to stakeholders.
11	Plans not developed in accordance with CDC and other guidance documents.	Develop and use a checklist to verify contents during the development of the plan.

1.3.1.2 Exercise Plan

The CDC COVID-19 Vaccination Plan Template for Jurisdictions-FINAL, Section 1B stipulates that vaccination plans should 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. **Table 1-2: Vaccination Exercise Plan (Tent)** highlights the Hawaii Vaccination Exercise Plan which assumes that COVID-19 vaccines will become available after January 2021. HDOH will maintain an updated list of planned exercises in coordination with the Hawaii Emergency Management Agency (HI-EMA) and other stakeholders.

Table 1-2: HDOH Vaccination Program Exercise Plan (Tent)

Exercise Focus Topic	***Exercise Type***	***Target Date of Exercise***
Senior Leader Awareness	Seminar	Nov 2020
Vaccine Program Implementation Committee Coordination	Tabletop Exercise	Dec 2020
Vaccination Program Operations	Drills	Dec 2020
Vaccination Program Operations	Functional Exercise	Jan 2021
Senior Leader Coordination	Workshop	Jan 2021
Vaccination Program Operations	Full-scale Exercise	Jan 2021

1.3.1.3 *Continuous Quality Improvement*

HDOH will follow a continuous improvement process which is a process that helps planners discover trends, learn lessons, and implement courses of action. It consists of Discovery, Validation, Resolution, and Evaluation phases and involves:

- Identifying, validating, and sharing operational strengths, areas for improvement, potential best practices, and mission critical issues from incidents and exercises.
- Developing courses of action (COAs) to maintain strengths, address areas for improvement and mission critical issues, and institutionalize best practices.
- Assigning and tracking COAs until completed.[5]

HDOH will work with stakeholders to effectively implement the continuous quality improvement cycle for each exercise highlighted in **Table 2**, share the resulting information with stakeholders where appropriate, and use the resulting information to improve this and other appropriate plans.

1.3.1.4 *Corrective Action Program*

HDOH implements a Corrective Action Program through which it assigns and tracks corrective actions to completion. Within this program, HDOH coordinates with stakeholders to identify any issues or areas for improvement. HDOH then coordinates to identify corrective actions, aligns the corrective action to POETE (Plans, Organization, Equipment, Training, and Exercise) action items to improve future operations. HDOH coordinates with stakeholders to identify and assign the primary organization responsible for the action item and establishes a targeted completion date **(see Table 1-3: Corrective Action Plan Template)**.

Table 1- 3: Corrective Action Plan Template

Public Health Emergency Preparedness (PHEP) Capability[6]	Issue/Area for Improvement	Corrective Action	Capability Element[7]	Primary Responsible Organization	Organization Point of Contact (POC)	Completion Date
Capability 1: [Capability Name]	1. [Area for Improvement]	[Corrective Action 1]				
		[Corrective Action 2]				
		[Corrective Action 3]				
	2. [Area for Improvement]	[Corrective Action 1]				
		[Corrective Action 2]				

[5] FEMA, IS-0045: Continuous Improvement Overview, https://emilms.fema.gov/is_0045/curriculum/1.html, accessed on October 10, 2020.
[6] https://www.cdc.gov/cpr/readiness/capabilities.htm, accessed on October 10, 2020.
[7] Capability Elements are: Plans, Organization, Equipment, Training, or Exercise.

1.4 Assumptions

The following table includes initial planning assumptions for the COVID-19 Vaccination Plan and the corresponding phase of operations where the planning assumptions are valid **(See Section 3: Concept of Operations for additional details on those three operational phases)**.

Table 1-4: Assumptions

#	COVID-19 VACCINATION PROGRAM PLANNING ASSUMPTIONS[8]	Phase		
		1	2	3
1.0	**COVID-19 VACCINE**			
1.1	*Limited COVID-19 vaccine doses may be available by early November 2020, but COVID-19 vaccine supply will increase substantially in 2021.*	X	X	
1.2	*Initially available COVID-19 vaccines will either be approved as licensed vaccines or authorized for use under an Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA).*	X	X	X
1.3	*Cold chain storage and handling requirements for each COVID-19 vaccine product will vary from refrigerated (2°C to 8°C) to frozen (-15°C to -25°C) to ultra-cold (-60°C to -80°C) temperatures, and ongoing stability testing may impact these requirements. Note: These temperatures are based on information available as of September 15, 2020. Updated information will be provided as it becomes available.*	X	X	X
1.4	*Jurisdictions should develop strategies to ensure the correct match of COVID-19 vaccine products and dosing intervals. Once authorized or approved by the FDA, two doses of COVID-19 vaccine, separated by either 21 or 28 days, will be needed for most COVID-19 vaccine products, and second-dose reminders for patients will be necessary. Both doses will need to match each other (i.e., be the same vaccine product and not interchangeable).*	X	X	X
1.5	*Some COVID-19 vaccine products will likely require reconstitution with diluent or adjuvant at the point of administration.*	X	X	X
1.6	Security measures will be needed to safeguard the supply of COVID-19 vaccine, the safety of staff administering the vaccine and people receiving it, but not to the same level as required in the HDOH Strategic National Stockpile (SNS) plan.	X	X	X
1.7	A range of 50-70% of the population will want to get the COVID-19 vaccine depending on the success of communications and outreach efforts and other factors such as public confidence in the approval or authorization process, safety, and efficacy of COVID-19 vaccines.	X	X	X
1.8	The efficacy of COVID-19 vaccine(s) will be less than 100%, and efficacy may be different across population groups.	X	X	X
2.0	**COVID-19 VACCINE ALLOCATION**			
2.1	*Populations of focus for initial COVID-19 vaccination will likely be:* • *Healthcare personnel likely to be exposed to or treat people with COVID-19* • *People at increased risk for severe illness from COVID-19, including those with underlying conditions and people 65 years of age and older* • *Other essential workers*	X	X	
2.2	*Allocation of COVID-19 vaccine to Hawaii will be based on multiple factors, including:* • *Critical populations recommended by the Advisory Committee on Immunization Practices (with input from the National Academies of Sciences, Engineering, and Medicine)* • *Current local spread/prevalence of COVID-19* • *COVID-19 vaccine production and availability*	X	X	
2.3	*Allocations from the CDC may shift during the response based on supply, demand, and risk.*	X	X	X

[8] Assumptions identified in italics are from the CDC's COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations, September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020. Assumptions listed without citations are from the HDOH COVID-19 Core Planning Team.

#	COVID-19 VACCINATION PROGRAM PLANNING ASSUMPTIONS[8]	Phase		
2.4	*There could be either high-demand or low-demand scenarios for COVID-19 vaccine(s).*	X	X	X
2.5[9]	Hawaii will not initially receive sufficient doses to vaccinate the entire population.	X	X	X
2.6	Allocation of vaccine to Hawaii will be in proportion to its population (aged 18 and older)(1,116,000 = .44% of U.S. population)	X	X	X
2.7	Allocation of vaccine to Hawaii will just be for residents and will not include the visitor population.	X	X	X
2.8	Vaccine providers may not be able to allocate vaccine only to specific designated critical populations due to logistical constraints such as the need to avoid wastage.	X	X	
2.9	The allocation of COVID-19 vaccine to specific critical populations will be difficult to track with high fidelity since residents will fit into numerous categories based on age, occupation, comorbidities, etc.	X	X	X
2.10	Federal agencies in Hawaii (to include DOD) will receive direct shipments of COVID-19 vaccines that will only cover their employees, and HDOH will be responsible for vaccinating federal contract staff, as well as dependents of federal employees residing in Hawaii.	X	X	X
2.11	The allocation of vaccines to provide second dose vaccination will take precedence over first dose administration.	X	X	X
3.0	**COVID-19 VACCINATION PROVIDER OUTREACH AND ENROLLMENT**			
3.1	*To receive and administer COVID-19 vaccine and ancillary supplies, vaccination providers must enroll in the United States Government (USG) COVID-19 Vaccination Program, coordinated through the* HDOH IMB *immunization program, by signing and agreeing to conditions outlined in the CDC COVID-19 Vaccination Program Provider Agreement.*	X	X	X
3.2	*HDOH will be required to maintain COVID-19 Vaccination Program Provider Agreements on file for a minimum of 3 years.*	X	X	X
3.3	*HDOH will be required to collect and submit to CDC information on each enrolled vaccination provider/site, including provider type and setting, patient population (i.e., number and type of patients served), refrigerated/frozen/ultra-cold temperature storage capacity, and logistical information for receiving COVID-19 vaccine shipments.*	X	X	X
3.4	*Some multijurisdictional vaccination providers (e.g., select large drugstore chains, other federal providers) will enroll directly with CDC to order and receive COVID-19 vaccine. These direct partners will be required to report vaccine supply and uptake information back to HDOH. CDC will share additional information when available on these procedures to ensure jurisdictions have full visibility for planning and documentation purposes.*	X	X	X
3.5	*HDOH will partner with commercial entities to reach the initial populations of focus.*	X	X	
3.6	*Routine immunization programs will continue;* however, influenza and COVID-19 vaccine will not be administered at the same time to vaccine recipients.	X	X	X
3.7	HDOH IMB will need to verify and track training and capacity of multijurisdictional providers that the CDC enrolls directly.	X	X	X
4.0	**COVID-19 VACCINE ORDERING AND DISTRIBUTION**			
4.1	*COVID-19 vaccine and ancillary supplies will be procured and distributed by the federal government at no cost to enrolled COVID-19 vaccination providers. CDC will share more information about reimbursement claims for administration fees as it becomes available.*	X	X	X
4.2	*CDC will use its current centralized distribution contract to fulfill orders for most COVID-19 vaccine products as approved by jurisdiction immunization programs. Some vaccine products, such as those with ultra-cold temperature requirements, will be shipped directly from the manufacturer.*	X	X	X
4.3	*Enrolled vaccination providers will follow HDOH IMB vaccine ordering procedures.*	X	X	X

[9] DOH Pandemic Plan 2008_Section 3 Vaccines

#	COVID-19 VACCINATION PROGRAM PLANNING ASSUMPTIONS[8]	Phase		
4.4	*COVID-19 vaccination providers will be required to report COVID-19 vaccine inventory each time a COVID-19 vaccine order is placed.*	X	X	X
4.5	*Vaccine orders will be approved and transmitted in CDC's Vaccine Tracking System (VTrckS) by* HDOH IMB *for vaccination providers they enroll.*	X	X	X
4.6	*Vaccine (and adjuvant, if required) will be shipped to provider sites within 48 hours of order approval by* HDOH IMB *if supply is available. Ancillary supply kits and diluent (if required) will ship separately from the vaccine due to different cold chain requirements, but shipment will be timed to arrive with or before the vaccine.*	X	X	X
4.7	*Ancillary supply kits will include needles, syringes, alcohol prep pads, COVID-19 vaccination record cards for each vaccine recipient, and a minimal supply of personal protective equipment (PPE), including surgical masks and face shields, for vaccinators.* • *Each kit will include supplies needed to administer 100 doses of vaccine.* • *HDOH IMB will need to plan for additional PPE, depending on vaccination site needs.* • *For COVID-19 vaccines that require reconstitution with diluent or mixing adjuvant at the point of administration, these ancillary supply kits will include additional necessary syringes, needles, and other supplies for this purpose.* • *Sharps containers, gloves, bandages, and other supplies will not be included* and HDOH IMB will need to order these supplies as soon as possible since Hawaii will be competing with the rest of the world to get them.	X	X	X
4.8	*Minimum order size for CDC centrally distributed vaccines will be 100 doses per order for most vaccines. Minimum order size for direct-ship vaccines may be much larger. CDC will provide more detail as it becomes available.*	X	X	X
4.9	*Vaccine will be sent directly to vaccination provider locations for administration or designated depots for secondary distribution to administration sites (e.g., chain drugstores' central distribution).*	X	X	X
4.10	*Once vaccine products have been shipped to a provider site, the federal government will not redistribute product.*	X	X	X
4.11	HDOH IMB *will be allowed to redistribute vaccines while maintaining the cold chain. However, with the challenge of meeting cold chain requirements for frozen or ultra-cold vaccines, officials should be judicious in their use of redistribution and limit any redistribution to refrigerated vaccines only.*	X	X	X
4.12	Organizations *are advised* ***not*** *to purchase ultra-cold storage equipment at this time. Ultra-cold vaccine may be shipped from the manufacturer in coolers that are packed with dry ice. These coolers should be repacked with dry ice within 24 hours of receipt of shipment and repacked again within 5 days.*	X	X	X
4.13	The majority of COVID-19 will initially be directly shipped from the CDC contracted distributor to COVID-19 vaccination providers, however, HDOH IMB may need to assist in coordinating distribution to vaccination providers who cannot accept minimum ordering limits.	X	X	X
4.14	HDOH IMB will leverage existing HDOH transportation contracts for delivery/redistribution of vaccine to providers if needed.	X	X	X
4.15	HDOH will coordinate with HI-EMA and county emergency management agencies to support any urgent transportation requirements (ex. – logistics providers typically accept shipments in the evening to arrive at neighbor islands the following morning which may compromise cold chain shipping requirements. In addition, COVID-19 vaccine could need to be rapidly redistributed to other vaccination providers to minimize wastage, which could require emergency shipment).	X	X	X
5.0	**COVID-19 VACCINE ADMINISTRATION DATA REPORTING**			
5.1	*HDOH IMB 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 to the State.*	X	X	X

#	COVID-19 VACCINATION PROGRAM PLANNING ASSUMPTIONS[8]	Phase		
5.2	*All vaccination providers may be required to report and maintain their COVID-19 vaccination information on CDC's Vaccine Finder[10].*	X	X	X
5.3	*CDC has prioritized jurisdiction onboarding to the Immunization (IZ) Gateway[11] to allow Immunization Information Systems (IISs) to receive data directly from national providers, nontraditional vaccination providers, and Vaccine Administration Management System (VAMS), as well as to report vaccine administration data to CDC.*	X	X	X
5.4	*Data Use Agreements (DUAs) will be required for data sharing via the IZ Gateway and other methods of vaccine administration data sharing with CDC and will be coordinated by the CDC and* HDOH IMB.	X	X	X
5.5	*HDOH IMB will have visibility of reporting of data from multijurisdictional providers (ex. – national pharmacy chains).*	X	X	X
5.6	*CDC will provide guidance on the method and frequency for vaccination providers to report information to VaccineFinder.*	X	X	X
5.7	CDC's Vaccine Administration Management System (VAMS) will be available to vaccination provider sites that need assistance in patient registration and scheduling, clinic flow, supply management, patient record management, and reporting.	X	X	X
6.0	**COMMUNICATION**			
6.1	*CDC will develop communication resources for use with key audiences.* • Communication and educational materials about COVID-19 vaccination provider enrollment, COVID-19 vaccine ordering, COVID-19 vaccine storage, handling, administration (i.e., reconstitution, adjuvant use, administration techniques), etc. will be available in a variety of formats. • *These resources will be available on a public-facing website currently under development, but the HDOH COVID-19 Communications Working Group will need to tailor messaging and resources specific to special populations in Hawaii.*	X	X	X
6.2	*CDC will work with national organizations to disseminate key messages.*	X	X	X
6.3	*When vaccine supply is available for expanded groups among the general population, a national COVID- 19 vaccine finder will be available on the public-facing Vaccine Finder.*			X
6.4	*A screening tool on the CDC website will help individuals determine their own eligibility for COVID-19 vaccine and direct them to the Vaccine Finder.*	X	X	X
6.5	Conducting outreach to encourage participation in the COVID-19 vaccination program will be a joint responsibility of Federal, State, and County agencies.[12]	X	X	X
7.0	**COVID-19 VACCINE SAFETY**			
7.1	*Clinically important adverse events following any vaccination will be reported to the Vaccine Adverse Event Reporting System (VAERS).[13]*	X	X	X
7.2	*Adverse events will also be monitored through electronic health record (EHR)- and claims-based systems (e.g., Vaccine Safety Datalink). [14]*	X	X	X
7.3	*Additional vaccine safety monitoring may be required under the Emergency Use Authorization (EUA).*	X	X	X

[10] http://www.vaccinefinder.org/

[11] The IZ Gateway is a portfolio of project components that share a common IT infrastructure. The IZ Gateway aims to rapidly onboard IISs to support readiness for COVID-19 vaccine response through data exchange, both among IIS and between IIS and federal providers, mass vaccination reporting, and consumer access tools. The IZ Gateway aims to increase the availability and volume of complete and accurate immunization data stored within IIS and available to providers and consumers regardless of their jurisdictional boundaries.

[12] DOH Pandemic Plan 2008

[13] https://vaers.hhs.gov/, accessed on October 8, 2020.

[14] https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/index.html, accessed on October 8, 2020.

<table>
<tr><th>#</th><th>COVID-19 VACCINATION PROGRAM PLANNING ASSUMPTIONS[8]</th><th colspan="3">Phase</th></tr>
<tr><td>8.0</td><td>COVID-19 Vaccine Dispensing</td><td></td><td></td><td></td></tr>
<tr><td>8.1[15]</td><td>Multiple satellite, mobile or drive-thru clinics (range 5-20) may be operated throughout the state in each county.
• Each Point of Dispensing (POD) site will need to calculate the number of vaccinations that they can conduct per hour to support staffing/logistics planning using tools such as the CDC's PanFluVaxPlanningTool[16].
o Example Assumptions for a Vaccination Clinic (VC)[17]
▪ One vaccination station (VS) = 1 vaccinator per station
▪ One vaccine preparer per VS (can alternate vaccinating if needed)
▪ Four VS per shift
▪ 8 vaccinators/vaccine preparers are needed per shift
▪ 30 vaccinations per VS/hour (approx. 2 min. per person)
▪ 120 vaccinated each hour per Vaccination Clinic (30 vaccinations/hr x 4 VS)
▪ 1,200 vaccinations per day per VC (w/8 vaccinators/vaccine preparers providing 10 hours of vaccinations)
o See example of calculations for the throughput for one Vaccination Clinic based on the number of vaccination stations operating over a ten hour period.
<table>
<tr><th>Number of Vaccination Staff Needed</th><th>Number of Vaccination Stations (VS)</th><th>Vaccinations Given per Hour per VS</th><th>Total Number of Vaccinations per Hour</th><th>Total Number of Vaccinations per Day</th></tr>
<tr><td>8</td><td>4</td><td>30</td><td>120</td><td>1,200</td></tr>
</table></td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>8.2</td><td>Vaccination clinics will open for a maximum of 12 hours per day w/approx. 10 hours of providing vaccinations (Clinics will need time during each shift to conduct set-up, training, inventory, and close-out during a 12-hour shift)</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>8.3</td><td>Vaccination clinics could be designated to receive only one type of COVID-19 vaccine (if multiple COVID-19 vaccines are available) to administer to minimize administrative errors which will complicate logistics for scheduling and administering vaccines, especially for vaccines requiring a second dose.</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>8.4</td><td>Vaccination clinics will need to maximize throughput and minimize potential wastage of COVID-19 vaccine through the use of on-line scheduling similar to the processes used for COVID-19 testing[18]</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>8.5</td><td>Patients will be encouraged to stay at vaccination clinics for 15 minutes after vaccination to be monitored for adverse events which will impact site selection and throughput given factors such as social distancing considerations.</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>8.6</td><td>Vaccination clinics will comply with COVID-19 planning requirements such as infection control procedures (screening for illness/temperature, social distancing, use of face coverings) to minimize disease transmission.</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>8.7</td><td>Sites used for the current SFAS program could be used as locations for satellite clinics in each county, however as noted previously vaccine recipients will not be able to receive both the influenza and COVID-19 vaccine at the same time.</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>8.8</td><td>Vaccination clinics conducted through satellite, mobile or drive-thru sites will follow CDC guidelines and best practices for vaccine shipment, transport, storage, handling, preparation, administration, and documentation.[19]</td><td>X</td><td>X</td><td>X</td></tr>
</table>

[15] Source: DOH Pandemic Plan 2008_Section 3 Vaccines
[16] https://www.cdc.gov/flu/pandemic-resources/tools/panvax-tool.htm, *accessed on October 10, 2020.*
[17] https://www.cdc.gov/h1n1flu/vaccination/pdf/A_Wortley_H1N1_sample_clinic.pdf, *accessed on October 10, 2020.*
[18] https://www.doineedacovid19test.com/, *accessed on October 10, 2020.*
[19] *https://www.izsummitpartners.org/content/uploads/2019/02/off-site-vaccination-clinic-checklist.pdf, accessed on October 10, 2020.*

<table>
<tr><th>#</th><th>COVID-19 VACCINATION PROGRAM PLANNING ASSUMPTIONS[8]</th><th>Phase</th><th></th><th></th></tr>
<tr><td>8.9</td><td>The HDOH COVID-19 Vaccination Program will need to build enough capacity to vaccinate approx. 121,000 members of critical populations with two doses of COVID-19 vaccine, separated by either 21 or 28 days, within four weeks of pandemic influenza COVID-19 vaccine availability (in Phase 1).[20]
Per CDC guidance Phase 1 could begin as early as November 2020 (See Table G-3: Availability Assumptions)[21]
See Table below for assumptions of doses allocated to Hawaii based on population Age 18 and older (1,116,000)
<table>
<tr><th>Target Date</th><th>Number of Doses Provided by CDC Nationwide</th><th>Doses Allocated to Hawaii (.44% of Doses Available)</th><th>Total Number of People Vaccinated with 1st and 2nd Doses</th><th>Total Percentage of Population of Hawaii Age 18 and older Vaccinated</th></tr>
<tr><td>Nov 2020</td><td>20,000,000</td><td>88,000</td><td>44,000</td><td>4%</td></tr>
<tr><td>Dec 2020</td><td>35,000,000</td><td>154,000</td><td>77,000</td><td>7%</td></tr>
<tr><td>Total</td><td>55,000,000</td><td>242,000</td><td>121,000</td><td>11%</td></tr>
</table></td><td>X</td><td></td><td></td></tr>
<tr><td>8.10</td><td>The HDOH COVID-19 Vaccination Program will need to build enough capacity through a combination of COVID-19 vaccination providers, satellite, mobile and drive-through clinics to vaccinate approx. 70% of the jurisdiction’s adult population with two doses of COVID-19 vaccine, separated by either 21 or 28 days, within 12 weeks of COVID-19 vaccine availability (i.e. – by the end of Phase 2).[22]
<table>
<tr><th>Target Date</th><th>Number of Doses Provided by CDC Nationwide</th><th>Doses Allocated to Hawaii (.44% of Doses Available)</th><th>Total Number of People Vaccinated with 1st and 2nd Doses</th><th>Total Percentage of Population of Hawaii Age 18 and Older Vaccinated</th></tr>
<tr><td>Jan 2021</td><td>300,000,000</td><td>1,320,000</td><td>660,000</td><td>59%</td></tr>
</table></td><td></td><td>X</td><td></td></tr>
<tr><td>8.11</td><td>Building the capacity of the HDOH COVID-19 Vaccination Program to support the assumptions identified in 8.8 and 8.9 for Phases 1 and 2 from November 2020 to January 2021 will require a rapid expansion of dedicated resources that are at 16x greater than current HDOH IMB resources dedicated to the annual influenza campaign which reaches approx. 50,000/year statewide.
<table>
<tr><th>Target Date</th><th>Number of Doses Provided by CDC Nationwide</th><th>Doses Allocated to Hawaii (.44% of Doses Available)</th><th>Total Number of People Vaccinated with 1st and 2nd Doses</th><th>Total Percentage of Population of Hawaii Age 18 and Older (1,116,000) Vaccinated</th></tr>
<tr><td>Nov 2020</td><td>20,000,000</td><td>88,000</td><td>44,000</td><td>4%</td></tr>
<tr><td>Dec 2020</td><td>35,000,000</td><td>154,000</td><td>77,000</td><td>7%</td></tr>
<tr><td>Jan 2021</td><td>300,000,000</td><td>1,320,000</td><td>660,000</td><td>59%</td></tr>
<tr><td>Total</td><td>355,000,000</td><td>1,562,000</td><td>781,000</td><td>70%</td></tr>
</table></td><td>X</td><td>X</td><td></td></tr>
<tr><td>8.12</td><td>Due to the unknown timing of when COVID-19 vaccines will actually be available in Phases 1 and 2, and the actual number of doses that CDC will provide with each direct delivery, the HDOH COVID-19 Vaccination Program may need to rapidly ramp up operations with minimal notice.
This assumption of the need to be prepared with minimal notice to receive COVID-19 vaccine leads directly to HDOH needing dedicated full-time resources, as well as significant on-call support, and commitments from COVID-19 vaccination providers and stakeholders to launch their dedicated COVID-19 vaccination support efforts upon notification from HDOH.</td><td>X</td><td>X</td><td></td></tr>
</table>

[20] https://www.cdc.gov/cpr/readiness/00_docs/PHEP_SupplementalGuidance_Key_Components_for_Pandemic_Influenza_FINAL_3.4.19_updated.pdf, *accessed on October 10, 2020.*

[21] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations, September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

[22] https://www.cdc.gov/cpr/readiness/00_docs/PHEP_SupplementalGuidance_Key_Components_for_Pandemic_Influenza_FINAL_3.4.19_updated.pdf, *accessed on October 10, 2020.*

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2 Mission

HDOH manages the rapid distribution and dispensing of COVID-19 vaccine(s) to affected populations in order to reduce COVID-19-related illnesses, hospitalizations, and death, thereby establishing conditions for economic prosperity and societal normalcy.

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3 Concept of Operations

Throughout the COVID-19 Vaccination Program, stakeholders should provide feedback and recommendations for the implementation of plan elements as described below. While HDOH Immunization Branch (IMB) is the lead, it is supported by the HDOH Office of Public Health Preparedness (OPHP), other state agencies, and subject matter experts to ensure Hawaii is prepared to distribute the vaccine efficiently statewide.

3.1 Operational Priorities and Objectives

HDOH organized the overall concept of operations for the vaccination effort driven by three overarching Operational Priorities supported by nine Operational Objectives to achieve the desired end state of maximizing societal benefit by reducing morbidity and mortality caused by transmission of the novel coronavirus **(see Figure 3-1)**. Planners will use Operational Objectives to select strategies and tactics. Objectives should be realistic, achievable, and measurable, yet flexible enough to allow strategic and tactical alternatives.[1] The HDOH Incident Action Plan (IAP) for each operational period will include the latest updated incident objectives.

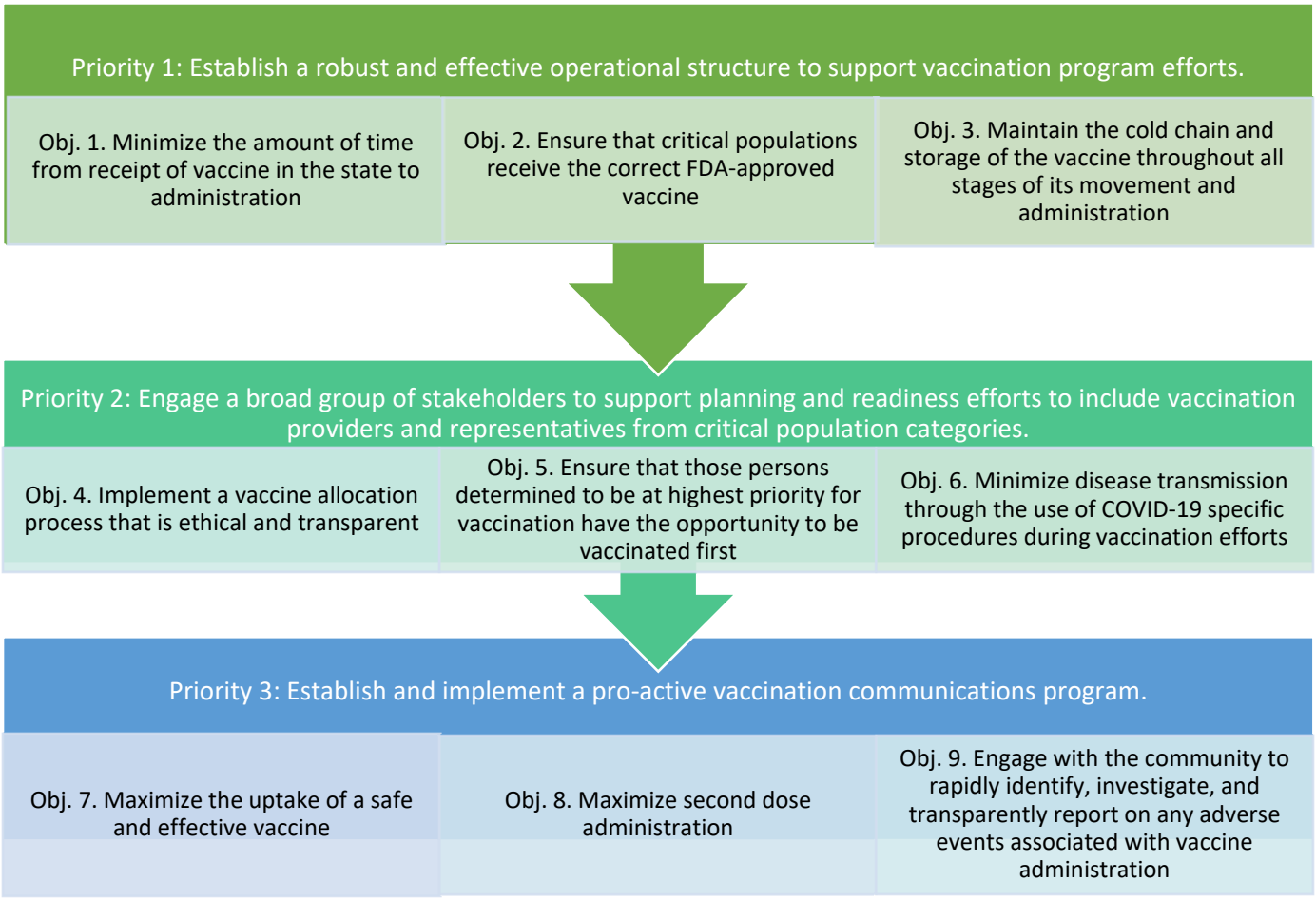

Figure 3-1: COVID-19 Priorities and Objectives

[1] https://www.fema.gov/sites/default/files/2020-07/fema_nims_doctrine-2017.pdf

3.2 Operational Phases

Due to changing vaccine supply levels at various points during the COVID-19 Vaccination Program, planning needs to be flexible but as specific as possible to accommodate a variety of scenarios as described below. The Hawaii COVID-19 Vaccination Plan considers three phases **(Figure 3-2)**:

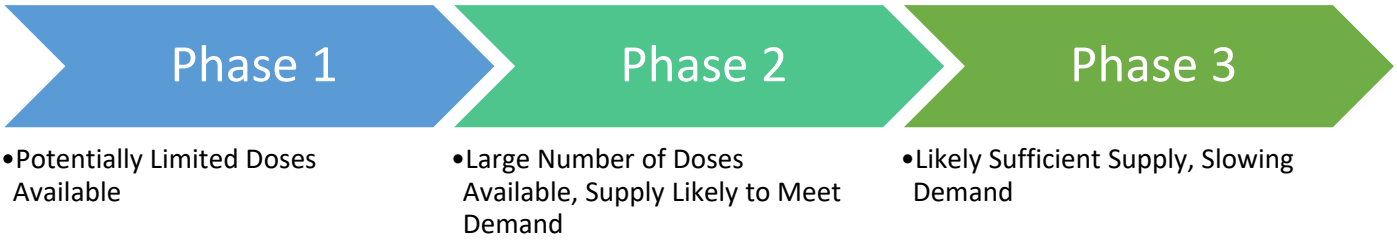

Figure 3-2: Operational Phases

A key point to consider is that vaccine supply will be limited in Phase 1 of the Hawaii COVID-19 Vaccination Program, so the allocation of doses will focus on vaccination providers and settings for vaccination that will be able to rapidly target limited critical populations. The vaccine supply will increase in Phases 2 and 3, allowing vaccination efforts to be expanded to additional critical populations and the general public. **See Figure 3-3**[2] for a high-level overview of guidance provided by the CDC on this phased approach.

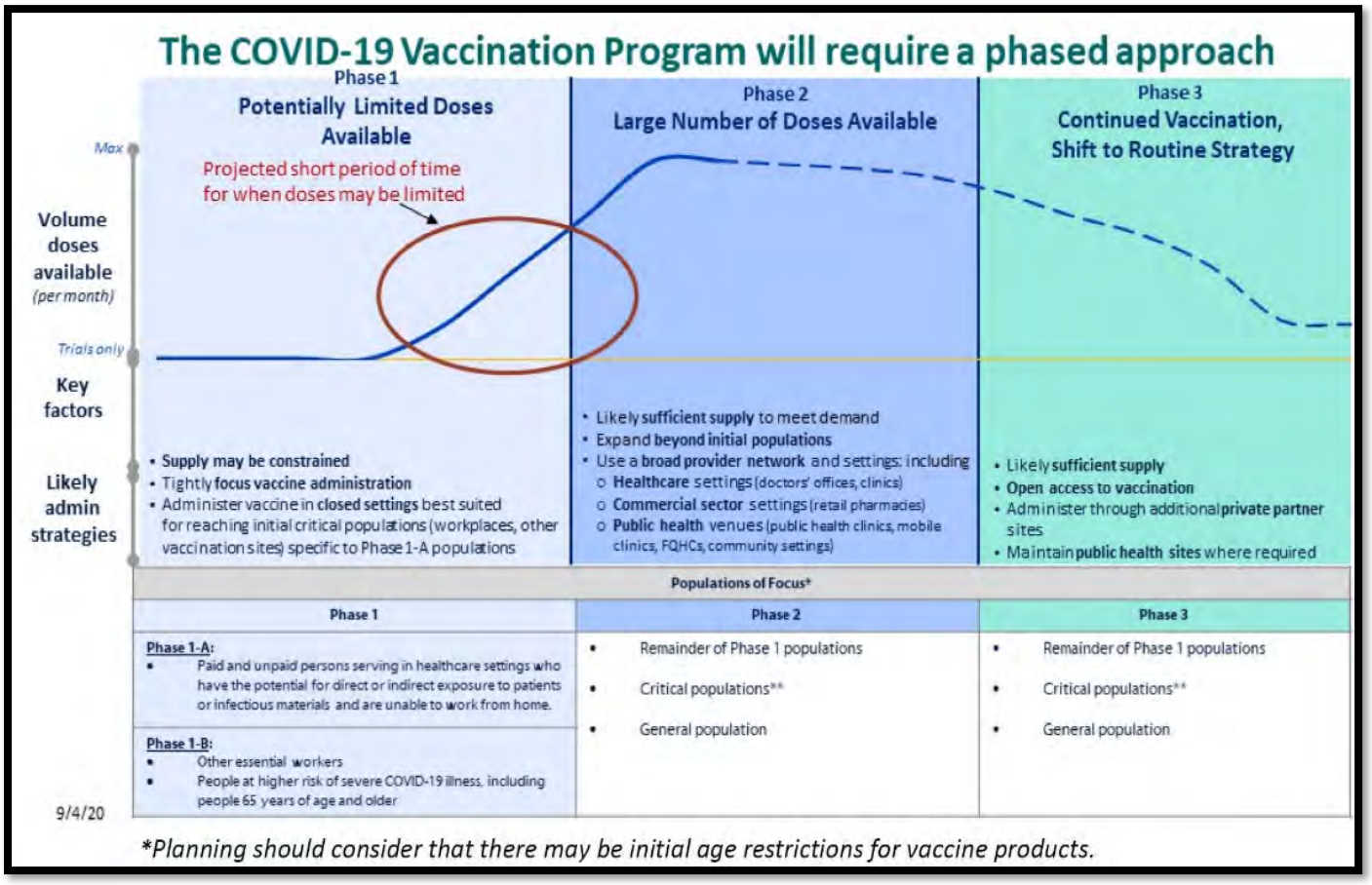

Figure 3-3: Vaccination Program Phases Provided by CDC

[2] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed October 8, 2020.

It is important to note that recommendations on the various population groups to receive initial doses of vaccine could change after vaccine(s) are available, depending on each vaccine's characteristics, vaccine supply, disease epidemiology, and local community factors.[3] HDOH will convene a Vaccine Prioritization/Allocation Working Group (VPAWG) that will consider these factors during their working sessions as they recommend modifications and adjustments to allocation decisions for each phase of operations.

3.2.1 Phase 1: Potentially Limited Doses Available

The focus of initial efforts will be to reach the critical populations identified in Appendix C: Critical Populations, and to ensure selected vaccination locations are able to support efforts to vaccinate those populations, manage cold chain requirements, and meet detailed reporting requirements as mandated by CDC and HDOH **(See Appendix D: Logistics)**.

The primary goals for Phase 1 will be to maximize vaccine acceptance and public health protection while minimizing waste and inefficiency. HDOH will need to closely monitor inventory, distribution, and any repositioning of vaccine to ensure end-to-end visibility of vaccine doses. HDOH will employ strategies such as the following:

- Concentrating early COVID-19 vaccine communications and outreach efforts through a Vaccine Communications Working Group to target critical populations while addressing issues such as vaccine hesitancy and potential concerns over allocation criteria
- Developing flexible logistics procedures, as well as supporting communications strategies to address low demand vs. high demand for vaccine scenarios
- Rapidly recruiting and onboarding COVID-19 vaccination providers, as well as staff to support the Hawaii COVID-19 Vaccination Program
- Allocating COVID-19 vaccine(s) to closed point-of-dispensing (POD) settings that allow for the maximum number of people to be vaccinated while maintaining social distancing and other infection control procedures (e.g., using large hospitals and satellite, temporary, or off-site settings such as mobile or drive-thru clinics)

HDOH will prioritize enrollment activities for vaccination providers and settings who will administer COVID-19 vaccine to the populations of focus for Phase 1, considering factors such as vulnerable populations that live in remote, rural areas and may have difficulty accessing vaccination services.

Due to the possibility that there will likely be insufficient doses available to vaccinate all those included in the initial populations of focus, HDOH will work with stakeholders to identify and estimate subset groups (i.e., Allocation Stage 1-A, Allocation Stage 1-B as described below) within these initial populations of focus to determine who will receive the first available doses of COVID-19 vaccine.[4] Some critical populations identified to potentially receive vaccine during Phase 1 may not be able to be vaccinated in Phase 1 due to limited supplies, and will need to receive their vaccinations in Phase 2 when supply is more readily available. Individuals may fall into more than one of the priority population groups described below **(NOTE: see Appendix C: Critical Populations for additional details)**.

[3] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed October 8, 2020.
[4] Ibid.

3.2.1.1 Allocation Stage 1-A[5]

- In the event that vaccine supplies are severely limited, HDOH will plan to target critical populations in Allocation Stage 1-A. This phase will initially place the highest priority on vaccinating the following groups subject to guidance/recommendations from the Vaccine Prioritization/Allocation Working Group (VPAWG) **(see Appendix C: Critical Populations for additional details)**:
  - Healthcare personnel likely to be exposed to or treat people with COVID-19 within Very High Risk and High-Risk exposure levels as designated by the Occupational Safety and Health Administration (OSHA) **(see below)**.[6]
  - First responders whose jobs put them at high risk of exposure to COVID-19 [7]

Figure 3-4: OSHA Exposure Risk Levels

Very High Risk Exposure	High Exposure Risk
•Healthcare workers (e.g., doctors, nurses, dentists, paramedics, emergency medical technicians) performing aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on known or suspected COVID-19 patients. •Healthcare or laboratory personnel collecting or handling specimens from known or suspected COVID-19 patients (e.g., manipulating cultures from known or suspected COVID-19 patients). •Morgue workers performing autopsies, which generally involve aerosol-generating procedures, on the bodies of people who are known to have, or are suspected of having, COVID-19 at the time of their death.	•Healthcare delivery and support staff (hospital staff who must enter patients' rooms) exposed to known or suspected COVID-19 patients. •Medical transport workers (ambulance vehicle operators) moving known or suspected COVID-19 patients in enclosed vehicles. •Mortuary workers involved in preparing bodies for burial or cremation of people known to have, or suspected of having, COVID-19 at the time of death.

Figure 3-5: Exposure Risks

3.2.1.2 Allocation Stage 1-B[8]

- In the event that vaccine supplies are severely limited, HDOH will continue to target additional critical populations in Allocation Stage 1-B subject to guidance/recommendations from the Vaccine Prioritization/Allocation Working Group (VPAWG) **(see Appendix C: Critical Populations for additional details)** including the following:
  - People of all ages with comorbid and underlying conditions that put them at significantly higher risk
  - Adults aged 65 and older living in congregate or overcrowded settings

NOTE: Due to the large number of the population in Hawaii in the 65+ population group with underlying illnesses (153,000), and others at high risk the VPAWG will provide guidance on further targeting of this population group based on the factors noted previously such as vaccine efficacy data for specific population groups.

[5] Ibid.
[6] https://www.osha.gov/SLTC/covid-19/hazardrecognition.html
[7] Ibid.
[8] Ibid.

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

The focus during this phase will initially target providing vaccine for members of Phase 1 critical populations who were not yet vaccinated, including those who have not received the second dose of the vaccine, and to expand the provider network.[9] As the supply of available vaccine increases, distribution will expand, increasing access to vaccination services for a larger population. When larger quantities of vaccine become available, there will be two simultaneous objectives:

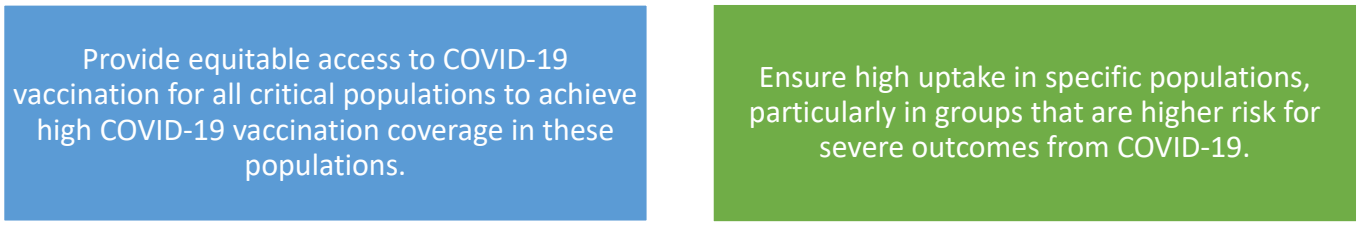

Figure 3-6: Phase 2 Objectives

The key considerations in planning for Phase 2 are:

- COVID-19 vaccine supply will likely be sufficient to meet demand for critical populations as well as the general public.
- Additional COVID-19 vaccine doses available will permit an increase in vaccination providers and locations.
- A surge in COVID-19 vaccine demand is possible, so a broad and flexible vaccine administration network for surge capacity will be necessary. This could include the following:
    1. Public health sites (mobile clinics, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), public health clinics, temporary/off-site clinics)
    2. Commercial and private sector partners (pharmacies, doctors' offices, clinics)
    3. Requests for mutual aid support
- Low COVID-19 vaccine demand is also a possibility, and HDOH will monitor supply and adjust logistics and communications strategies to minimize vaccine wastage.
- Critical Populations Groups during this phase could include the following:
    1. Allocation Stage 2
        - K-12 teachers and school staff
        - Critical risk workers in high-risk settings - workers who are both in industries essential to the functioning of society and at substantially high risk of exposure
        - People of all ages with comorbid and underlying conditions that put them at moderately higher risk
        - People in homeless shelters or group homes for individuals with physical or mental disabilities or in recovery and staff who work in those facilities
        - People in prisons, jails, detention centers, and similar facilities, and staff who work in such settings
        - Adults aged 65 and older not included in Allocation Stage 1
    2. Allocation Stage 3
        - Young Adults
        - Children (0-17)
        - Workers in industries and occupations important to the functioning of society and at increased risk of exposure not included in Allocation Stages 1 or 2
    3. Allocation Stage 4

[9] Ibid.

- Everyone residing in Hawaii who did not have access to the vaccine in previous allocation stages

3.2.3 Phase 3: Likely Sufficient Supply, Slowing Demand

CDC anticipates that COVID-19 vaccine will be widely available in Phase 3 and integrated into routine Hawaii COVID-19 Vaccination Programs, run by both public and private partners. The key considerations in planning for Phase 3 are:

- Likely sufficient COVID-19 vaccine supply where supply might exceed demand[10]
- Continued use of a broad vaccine administration network for increased access
- Critical Populations Groups during this phase would include the following:
    1. Allocation Stage 4
        - Everyone residing in Hawaii who did not have access to the vaccine in previous allocation stages

HDOH will:

1. Continue to focus on equitable vaccination access to vaccination services partnering with organizations serving specific population groups to set up vaccination sites that are as convenient as possible
2. Monitor COVID-19 vaccine uptake and coverage in critical populations and enhance strategies to reach populations with low vaccination uptake or coverage
3. Partner with commercial and private entities to ensure COVID-19 vaccine and vaccination services are widely available
4. Monitor supply and reposition refrigerated vaccine products to minimize vaccine wastage
5. Demobilize resources as demand decreases and routine Hawaii COVID-19 Vaccination Programs take over operations
6. Collect feedback from stakeholders and complete a formal after-action report (AAR)/Improvement Plan (IP).

3.3 Roles and Responsibilities

This section describes organizational constructs, coordination relationships, and roles and responsibilities that the State of Hawaii will observe and employ for this plan. Each primary and supporting organization will operate using an Incident Command System (ICS) structure where appropriate, in accordance with the National Incident Management System (NIMS).[11]

3.3.1 Federal

3.3.1.1 Department of Defense (DOD)

- DOD may provide support subject to force availability and as permitted by law in accordance with the National Response Framework. Potential missions may include transportation (ground and air), logistics, security, medical, and communications.
    - Support for DOD resources will be requested through HI-EMA in accordance with established procedures.
- Additional planning guidance related to coordination with DOD is provided as follows:
    - DOD Instruction (DoDI) 6200.03 effective 28 Mar 2019, Subject: Public Health Emergency Management within the Department of Defense (p.4) states that “f. Military installations are authorized to serve as receipt, staging, and storage (RSS) sites for Strategic National Stockpile

[10] **NOTE:** This was a lesson learned from H1N1 where supply exceeded demand over time.

[11] https://www.fema.gov/national-incident-management-system

(SNS) assets and as closed points of dispensing (PODs) capable of dispensing State, local, tribal, and territorial (SLTT) SNS assets to their DoD population (as defined in Military Department planning guidelines)."[12]

- Section 2, p.11 of the DoDI 6200.03 states that states that Secretaries of the Military Departments will "j. Provide written approval and authorization to military installations in the United States to make agreements with SLTT public health officials to serve as RSS sites and closed PODs for SNS assets when requested, and inform the Combatant Command (CCMD) Surgeon and other relevant officials at the United States Northern Command or United States Indo-Pacific Command, as appropriate.
  - Maintain comprehensive and up-to-date lists of installations that have signed agreements with SLTT SNS coordinators to serve as RSS sites.
  - Encourage military commanders to participate in the CDC's Cities Readiness Initiative and other applicable SLTT public health emergency planning by serving as closed PODs capable of dispensing SNS medical materiel to their DoD populations".
- Section 4, p. 31 of the DoDI 6200.03 states that "The military commander negotiates agreements with SLTT public health officials to serve as RSS sites for SNS materiel if the installation has suitable storage capability and sufficient capacity and if requested by SLTT public health officials. Support agreements are completed in accordance with DoDI 4000.19. Agreements will clarify responsibilities and must address situations when access to the installation is limited or restricted."
- Section 4, p. 40 of the DoDI 6200.03 states that the Public Health Emergency Officer (PHEO) shall: "In the United States, assist the military commander in the execution of agreements with SLTT SNS coordinators regarding the receipt, distribution, and dispensing of SNS assets with the assistance of the EM program manager and PHEO."

3.3.1.2 Department of Health and Human Services (HHS)

3.3.1.2.1 Assistant Secretary for Preparedness and Response (ASPR)

- Leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies.
- Collaborates with hospitals, healthcare coalitions, community members, state/local governments, and other partners to improve readiness and response capabilities.
- Provides technical expertise and guidance to support Hawaii COVID-19 Vaccination Program efforts.

3.3.1.2.2 Centers for Disease Control and Prevention (CDC)

- Maintains the physical custody of vaccine shipments not provided under direct shipment from the COVID-19 authorized distributor until the State or distribution recipient has signed for receipt of the allocated/requested portion.
- Provides technical expertise and guidance to support Hawaii COVID-19 Vaccination Program efforts to include COVID-19 vaccine prioritization strategies
- Coordinates with the Food and Drug Administration for the evaluation of COVID-19 vaccine and vaccine safety

3.3.1.3 Department of Homeland Security (DHS)

3.3.1.3.1 Cybersecurity Infrastructure Security Agency (CISA)

- Supports response and recovery efforts as applicable under the National Response Framework.
- Provides technical expertise and support to address cyber and physical risk to critical infrastructure.

3.3.1.3.2 Federal Emergency Management Agency (FEMA)

- Supports response and recovery efforts as applicable under the National Response Framework.

[12] https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/620003p.pdf

3.3.1.3.2.1 FEMA Region IX

- The FEMA Regional Administrator (RA) within each region is the primary FEMA representative to State governors; other Federal departments and agencies; and State, and local emergency management authorities. The FEMA Region is responsible for:
  - Coordinating Federal regional response efforts
  - Notifying FEMA's national leadership of resource requirements
  - Supporting development of a common operating picture (COP), which requires the region to establish and contribute its own situational awareness for potential and actual incidents
  - Deploying and tracking assets and resources in support of disaster response operations
- FEMA Region IX maintains a Pacific Area Office (PAO) on Oahu to support preparedness, response, recovery, and mitigation efforts in Hawaii.

3.3.1.4 Department of Justice (DOJ)

3.3.1.4.1 United States Marshals Service (USMS)

- The USMS is typically responsible for the security of Strategic National Stockpile (SNS) medical countermeasures until the appropriate signatory at HDOH takes delivery of the shipment. In cases, where vaccine supplies are directly shipped to Vaccine Providers, USMS will not be responsible for security of those assets unless specifically directed through established procedures.
- The USMS is responsible for the security of residual vaccine assets returned to the federal government.

3.3.1.4.2 Federal Bureau of Investigation (FBI)

- Maintains situational awareness of threats to COVID-19 vaccination efforts in Hawaii and notifies the State of elevated or credible threats as appropriate.
- Coordinates federal law enforcement response efforts to terrorist incidents targeting the Hawaii COVID-19 Vaccination Program through either the National Response Framework (NRF) or its own authority.

3.3.1.5 Federal Executive Board

- Provides a forum for coordinating with federal agencies located in Hawaii.

3.3.2 State

3.3.2.1 Governor

- Oversees operational systems that involve nontraditional civilian partners and instill public confidence that vaccine distribution is evenhanded.[13]
- Declares a state of emergency.
- Requests a Declaration of Disaster by the President for the State of Hawaii and receives federal supplemental assistance in support of disaster response/recovery operations.
- Takes all the appropriate response actions under state law and directs execution of the Hawaii Emergency Operations Plan (EOP).
- Sets/approves strategic priorities and objectives for Hawaii COVID-19 Vaccination Program response and recovery efforts.
- Convenes partners for planning.[14]
- Continues to advocate for federal guidance and clarification.
- Empowers staff to build out vaccine distribution scenarios.
- Considers how vaccines should be prioritized.

[13] The Public's Role in COVID-19 Vaccination: Planning Recommendations Informed by Design Thinking and the Social, Behavioral, and Communication Sciences, accessed at https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2020/200709-The-Publics-Role-in-COVID-19-Vaccination.pdf , accessed September 29, 2020.

[14] Preparing For The COVID-19 Vaccine And Considerations For Mass Distribution, available at https://www.nga.org/memos/covid-19-vaccine-considerations-mass-distribution/ , accessed September 29, 2020.

- Assesses logistical capability.
- Determines communication strategies.

3.3.2.2 Lieutenant Governor

- Provides executive oversight and direction of vaccine program operations on behalf of the Governor.
- Establishes strategic response and recovery strategies.
- Supports public messaging efforts during each phase of the operation.

3.3.2.3 Department of the Attorney General (AG)

- Provides guidance and advice for state agencies on COVID-19 related legal and regulatory issues to include working with state agencies and other stakeholders to identify specific statutes, rules, ordinances, etc. that may need to be suspended in future emergency proclamations.
- The Department of the Attorney General serves as the State Emergency Support Function (SESF) Coordinator for SESF #13 (Public Safety and Security).[15]
- Coordinates requests for law enforcement support through HI-EMA and the State Law Enforcement Coalition (SLEC).
- The Attorney General – Investigative Division (AG-ID) supports homeland security and emergency management requirements within the State with armed personnel.

3.3.2.4 Department of Business, Economic Development and Tourism (DBEDT)

3.3.2.4.1 State Energy Office

- Provides SESF #12(Energy) sector related technical assistance and guidance to include coordinating with SESF #12 Critical Infrastructure stakeholders to support Hawaii COVID-19 Vaccination Program related efforts.
- Coordinates with DBEDT stakeholders Hawaii COVID-19 Vaccination Program related efforts to include supporting outreach efforts to tourists.

3.3.2.4.2 Hawaii Tourism Authority (HTA)

- The HTA supports state and county agencies in their collective efforts to help provide visitors with a safe and enjoyable Hawaii visitor experience. In particular, HTA is involved in supporting visitor assistance and crisis management efforts on behalf of Hawaii's visitor industry.

3.3.2.5 Department of Commerce and Consumer Affairs (DCCA)

- Verifies licensure of medical/health care personnel and provides credentialing, as required.[16]

3.3.2.6 Hawaii Department of Defense

3.3.2.6.1 Hawaii Emergency Management Agency (HI-EMA)

- Coordinate with HDOH to support storage, security, and distribution operations, as required.
- Coordinate requests for federal assistance and/or Defense Support to Civil Authorities (DSCA).
- Coordinate and assist with dissemination of public health information, as required through the COVID-19 Joint Information Center (JIC).
- Support preparedness planning with other State departments and counties to develop supporting response plans and procedures.
- Receive and act upon requests for State assistance from county emergency operations centers, state emergency support functions, and State departments in accordance with established procedures.
- Activate and convene the State Emergency Response Team (SERT) as appropriate to support Hawaii COVID-19 Vaccination Program efforts for tasks that may require a coordinated State and/or federal response.
- Coordinate State assets and capabilities as required to support COVID-19 vaccination efforts.

[15] State of Hawaii Emergency Operations Plan (2019)

[16] Ibid.

- Leads the preparation and execution of Emergency Management Assistance Compact (EMAC) contracts for out-of-state support.
- Support SESF #16 (Finance) providing guidance on applicable Public Assistance reimbursement procedures.

3.3.2.6.2 Hawaii National Guard (HING)

- Supports mission assignments and requests for assistance for efforts related to security, transportation, and communications, as required.
- Provides operational support for State Emergency Support Function (SESF) #8 (Public Health and Medical Services).

3.3.2.6.3 Office of Homeland Security (OHS)

- OHS coordinates with stakeholders such as INDOPACOM and DHS Cybersecurity and Infrastructure Security Agency (CISA) to support Hawaii COVID-19 Vaccination Program related efforts and assists with security planning efforts related to Hawaii's vaccination operations.
- Hawaii State Fusion Center (HSFC) supports security planning efforts related to the vaccination operations by gathering, analyzing, and sharing information about potential or current threats.

3.3.2.7 Department of Education (DOE)

- Coordinates with HDOH to support Stop Flu at School (SFAS) vaccination clinics, and potentially COVID-19 vaccination clinics.
- Supports outreach efforts to K–12 teachers and school staff to get vaccinated through the Hawaii COVID-19 Vaccination Program.

3.3.2.8 Hawaii Department of Health (HDOH)

3.3.2.8.1 Office of Public Health Preparedness (OPHP)

- Supports HDOH role as the lead under the Hawaii Emergency Operations Plan (EOP) for SESF #8 (Public Health and Medical Services).
- Serves as the primary planning office for Strategic National Stockpile (SNS) operations.
- Operates a Department Operations Center (DOC) to support COVID-19 related operations to include Hawaii COVID-19 Vaccination Program efforts.
- Provides support in accordance with the Hawaii SNS plan, such as implementing pre-arranged contracts for primary and alternative sites for Receipt, Stage, and Store (RSS) functions.

3.3.2.8.2 District Health Offices (DHOs)

- The Director of HDOH designates the District Health Officer (DHO) on Hawaii, Maui, and Kauai to act on behalf of the HDOH concerning matters pertaining to the movement, storage, and dispensing of vaccines in their respective counties.
- Select sites for mobile, drive-through or satellite vaccination clinics in coordination with respective county emergency management agencies, as well as other relevant stakeholders.
    - Explores collaborations with interagency and nongovernment partners to (1) use nontraditional sites (e.g., places of worship, senior centers) as vaccination sites, and (2) explore opportunities to bundle COVID-19 vaccination with other safety net services.[17]
- Support outreach efforts before, during, and after the release of COVID-19 vaccine(s).

3.3.2.8.3 The HDOH Vaccine Program Coordinator (Immunization Branch (IMB))

- Provides overall management for the Hawaii COVID-19 Vaccination Program.
- Coordinates with stakeholders to receive, store, and distribute COVID-19 vaccine within the state that is not direct-shipped to vaccine providers.

[17] Preparing For The COVID-19 Vaccine And Considerations For Mass Distribution, available at https://www.nga.org/memos/covid-19-vaccine-considerations-mass-distribution/ , accessed September 29, 2020.

    - Maintains custody of the portion of vaccines under its control until its return to CDC custody.
    - Develops pre-arranged contracts and supports statewide distribution for all phases of movement of vaccines and components as required for materials not direct-shipped to vaccine providers.
- Coordinates the recruitment, onboarding, and training of vaccine providers.
- Manages the Hawaii Immunization Registry.
- Manages working groups to address key elements of the Hawaii COVID-19 Vaccination Program.
- Coordinates stakeholder outreach before, during, and after the release of COVID-19 vaccine(s).
- Manages COVID-19 related training and exercise programs.
    - Coordinates with OPHP to validate that there are a sufficient number of HDOH staff trained in the Homeland Security Exercise and Evaluation Program (HSEEP) to develop after-action reports (AAR) and improvement plans (IP).
    - Provides input to the Hawaii multi-year training and exercise plan (MYTEP) through OPHP to ensure that relevant events incorporate vaccination activities and address issues identified in improvement plans.
    - Coordinates with partners to facilitate risk-specific safety and health training to include training for vaccination providers.
    - Coordinates initial, periodic, and just in time training.
- Establishes a public oversight committee to review and report on systems that have an impact on public understanding, access to, and acceptance of COVID-19 vaccines.
- Coordinates the establishment of mobile, drive-through or satellite vaccination clinics on Oahu in coordination with the City and County of Honolulu Department of Emergency Management (DEM) and HI-EMA, as well as other relevant stakeholders (NOTE: DHOs will be responsible for these sites on Neighbor Islands (NI)).
    - Explores collaborations with interagency and nongovernment partners to (1) use nontraditional sites (e.g., places of worship, senior centers) as vaccination sites, and (2) explore opportunities to bundle Hawaii COVID-19 Vaccination Program with other safety net services.[18]
- Supports the conduct of vaccination clinics at previously determined sites.
- Provides standing orders for administration of COVID-19 vaccine in coordination with the AG (as needed).

3.3.2.9 Department of Human Services (DHS)

- Supports Hawaii COVID-19 Vaccination Program outreach efforts to vulnerable populations.

3.3.2.10 Department of Labor and Industrial Relations

- Monitors the health and well-being of emergency workers.
- Provides technical assistance and guidance on health and safety measures for responders.[19]

3.3.2.11 Department of Land and Natural Resources (DLNR) – Division of Conservation and Resource Enforcement (DOCARE)

- Supports the Hawaii COVID-19 Vaccination Program missions with armed personnel which could include armed security during reception, transportation, storage, breakdown, dispensing and reconstitution of vaccination assets.

[18] Preparing For The COVID-19 Vaccine And Considerations For Mass Distribution, available at https://www.nga.org/memos/covid-19-vaccine-considerations-mass-distribution/ , accessed September 29, 2020.

[19] State of Hawaii Emergency Operations Plan (2019)

3.3.2.12 Department of Public Safety (DPS)

- Supports Hawaii COVID-19 Vaccination Program missions with armed personnel which could include armed security during reception, transportation, storage, breakdown, dispensing and reconstitution of vaccination assets.
- Coordinates Hawaii COVID-19 Vaccination Program efforts for vulnerable populations in correctional facilities.

3.3.2.13 Department of Transportation (DOT)

3.3.2.13.1 Airports Division (DOT-A)

- Airport contract security personnel have police powers to carry out the enforcement of applicable laws, rules, and regulations. Their authority encompasses all commercial airports controlled by the State.
- Airport Division security resources assist federal security forces to secure vaccination resources while it is on State airport facilities or to augment other assigned security forces.
- When the vaccination resources are on airport property and under the responsibility of a shipping or storage agent, County police and State Deputy Sheriffs may be tasked as needed to support security requirements above the capability of the shipping agent.

3.3.2.13.2 Harbors Division (DOT-H)

- Harbors Division Enforcement Officers have police powers to carry out the enforcement of applicable laws, rules, and regulations. Their authority encompasses all commercial harbors and waterfront improvement belonging to or controlled by the State, and all vessels and shipping within the commercial harbors.
- Harbors Enforcement Officers, as available, support this plan during the reception and reconstitution of vaccination resources.

3.3.2.14 All State Agencies

- Support Hawaii COVID-19 Vaccination Program efforts as required to include identifying essential personnel to potentially receive COVID-19 vaccine during Phase I or II of operations when vaccine supplies are limited.
- Support could include providing personnel to staff vaccination sites, providing transportation support, providing facilities for temporary vaccination clinics, providing technical experts, supporting vaccination communications/outreach efforts, etc.

3.3.3 Local

3.3.3.1 Hawaii County

3.3.3.1.1 Hawaii County Civil Defense Agency (HCCDA)

- Serves as lead emergency management agency for Hawaii County.
- Coordinates with Hawaii Emergency Management Agency (HI-EMA) and HDOH on vaccination requirements for the county to include identifying essential county personnel to potentially receive COVID-19 vaccine during Phase I or II of operations when vaccine supplies are limited.

3.3.3.1.2 Hawaii County Police Department (HPD)

- Provides security support for vaccines and dispensing sites as appropriate.

3.3.3.1.3 Other County Agencies

- Provide support to vaccination operations as appropriate. This could include providing personnel to staff vaccination sites, providing transportation support, etc.

3.3.3.2 Maui County

3.3.3.2.1 Maui Emergency Management Agency (MEMA)

- Serves as lead emergency management agency for Maui County.

- Coordinates with Hawaii Emergency Management Agency (HI-EMA) and HDOH on vaccination requirements for the county to include identifying essential county personnel to potentially receive COVID-19 vaccine during Phase I or II of operations when vaccine supplies are limited.

3.3.3.2.2 Maui Police Department (MPD)

- Provides security support for vaccines and dispensing sites as appropriate.

3.3.3.2.3 Other County Agencies

- Provide support to vaccination operations as appropriate. This could include providing personnel to staff vaccination sites, providing transportation support, etc.

3.3.3.3 City and County of Honolulu

3.3.3.3.1 Department of Emergency Management (DEM)

- Serves as lead emergency management agency for the City and County of Honolulu.
- Coordinates with Hawaii Emergency Management Agency (HI-EMA) and HDOH on vaccination requirements for the county to include identifying essential county personnel to potentially receive COVID-19 vaccine during Phase I or II of operations when vaccine supplies are limited.

3.3.3.3.2 Honolulu Police Department (HPD)

- Provides security support for vaccines and dispensing sites as appropriate.

3.3.3.3.3 Other County Agencies

- Provide support to vaccination operations as appropriate. This could include providing personnel to staff vaccination sites, providing transportation support, etc.

3.3.3.4 Kauai County

3.3.3.4.1 Kauai Emergency Management Agency (KEMA)

- Serves as lead emergency management agency for Kauai County.
- Coordinates with Hawaii Emergency Management Agency (HI-EMA) and HDOH on vaccination requirements for the county to include identifying essential county personnel to potentially receive COVID-19 vaccine during Phase I or II of operations when vaccine supplies are limited.

3.3.3.4.2 Kauai Police Department (KPD)

- Provides security support for vaccines and dispensing sites as appropriate.

3.3.3.4.3 Other County Agencies

- Provide support to vaccination operations as appropriate. This could include providing personnel to staff vaccination sites, providing transportation support, etc.

3.3.4 Private and Nonprofit Sector

HDOH will engage with a number of private and nonprofit sector stakeholders to support Hawaii COVID-19 Vaccination Program efforts. Organizations could assist with efforts ranging from communications outreach to vulnerable populations to directly supporting vaccination operations as an enrolled COVID-19 vaccination provider, and/or through providing volunteer staff at vaccination sites. The organizations listed below are only a representative listing. HDOH will maintain a contact list separately with organization points of contact.

3.3.4.1 Academic Institutions

- Universities and colleges may be able to assist in outreach efforts and to provide feedback on issues of concern.
- Universities and colleges may also be able to provide resources such as subject matter expertise, and medical and non-medical volunteers in support of the Hawaii COVID-19 Vaccination Program, as well as facilities for satellite, mobile or drive-thru vaccination clinics. This could include operating a Closed POD as Vaccination Providers.

3.3.4.2 *Community Groups*

- Community groups that are not members of HSVOAD such as Papa Ola Lokahi[20] and We Are Oceania[21] may be able to assist in reaching out to vulnerable populations.
- Includes religious organizations which may be able to assist in reaching out to vulnerable populations.

3.3.4.3 *Hawaii State Voluntary Organizations Active in Disasters (HSVOAD)[22]*

- The Hawaii Voluntary Organizations Active in Disaster (HSVOAD) is a coalition of nonprofit, faith-based, and community organizations that respond to disasters as part of their overall mission.
- HSVOAD includes member organizations such as the American Red Cross, The Salvation Army and Team Rubicon that could provide COVID-19-related support such as medical and non-medical volunteers in support of the Hawaii COVID-19 Vaccination Program, as well as support outreach efforts (ex. - Aloha United Way[23]).

3.3.4.4 *Healthcare Association of Hawai'i (HAH)[24]*

- HAH can coordinate with its 170 member organizations that include all of the acute care hospitals in Hawaii, all public and private skilled nursing facilities, all the Medicare-certified home health agencies, all hospices, all assisted living facilities, durable medical equipment suppliers and home infusion/pharmacies. Members also represent other healthcare providers from throughout the continuum including case management, air and ground ambulance, blood bank, dialysis, and more.

3.3.4.4.1 *Hawaii Healthcare Emergency Management (HHEM)[25]*

- HHEM (a subsidiary of HAH) coordinates overall healthcare emergency response and recovery operations statewide with county, state, and federal agencies in support of SESF #8.
- HHEM and HAH work in coordination with HDOH to disseminate communications to the healthcare community.

3.3.4.5 *Hawaii State Center for Nursing[26]*

- Assists with identify nursing supply resources to help with distribution (Advance Practice Registered Nurses, school nurses, student nurses who can help administer vaccines, etc.) as well as connect University health centers.
- Can provide support with accessing on-demand training platforms for provider training/reporting/etc.

3.3.4.6 *Private Sector*

- Security Contractors could provide armed/unarmed security services at various locations statewide through pre-arranged contract agreements.
- Transportation Contractors (Air & Ground) could provide transport services for the Hawaii COVID-19 Vaccination Program and its components through pre-arranged contract agreements with HDOH to designated points in the state.
- Warehouse Contractors provide services and space for RSS Site functions through pre-arranged contract agreements with HDOH.
- Private sector organizations could potentially operate closed Points of Dispensing (PODs) to serve as Vaccination Providers in coordination with HDOH.

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[20] http://www.papaolalokahi.org/

[21] http://www.weareoceania.org/

[22] https://hivoad.communityos.org/cms/home

[23] https://www.auw.org/

[24] http://hah.org/about-hah/

[25] http://hawaiihealthcareemergencymanagement.net/

[26] https://www.hawaiicenterfornursing.org/

- Private sector organizations such as Hawaii Medical Service Association (HMSA)[27] could also provide volunteers and other resources to support vaccination efforts, and assist with outreach to essential personnel, vaccination providers as well as vulnerable populations.

3.3.4.7 Professional Associations

- Professional associations such as the Kapolei Local Emergency Action Network (KLEAN)[28] may be able to assist in reaching out to their member organizations to assist in outreach efforts and to provide feedback on issues of concern, as well as raise awareness of available resources.

3.3.4.8 Vaccination Partners

Some multi-county vaccination providers (e.g., select large drugstore chains (ex. - Walgreens, Longs), Veterans Administration clinics and hospitals, and other federal providers) will enroll directly with CDC to order and receive COVID-19 vaccine. CDC will notify HDOH of any entities receiving direct allocations within their areas.

- Direct partners are required to report vaccine supply and uptake information to HDOH IMB.
    - HDOH may partner with commercial entities that are enrolled directly with CDC to reach their populations.

[27] https://hmsa.com/

[28] http://kleanhawaii.org/

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4 Administration, Resources and Funding

4.1 Administration[1]

Organizations should review appropriate county and state laws and administrative rules and the State of Hawaii Emergency Operations Plan (EOP) for applicable administrative requirements. All organizations will enter agreements and understandings in accordance with the provisions of federal and state laws as appropriate. **NOTE:** A State Disaster Proclamation issued by the Governor may suspend select rules and regulations affecting support operations. As of this writing, the Governor of Hawaii has issued an emergency proclamation and thirteen supplementary emergency proclamations for COVID-19 **(see Figure 4-1)**. Organizations should go to the listing of the Governor of Hawaii's emergency proclamations for the latest available guidance. [2]

Governor's Proclamations	Date Issued
Emergency Proclamation, COVID-19	4 March 2020
First Supplementary Proclamation	16 March 2020
Second Supplementary Proclamation	21 March 2020
Third Supplementary Proclamation	23 March 2020
Fourth Supplementary Proclamation	31 March 2020
Fifth Supplementary Proclamation	16 April 2020
Sixth Supplementary Proclamation	25 April 2020
Seventh Supplementary Proclamation	5 May 2020
Eighth Supplementary Proclamation	18 May 2020
Ninth Supplementary Proclamation	10 June 2020
Tenth Supplementary Proclamation	17 July 2020
Eleventh Supplementary Proclamation	6 August 2020
Twelfth Supplementary Proclamation	20 August 2020
Thirteenth Supplementary Proclamation	22 September 2020

Figure 4-1: Governor of Hawaii's emergency proclamations related to COVID-19

Additionally, each of the county Mayors have issued emergency proclamations related to the COVID-19 emergency **(see Figure 4-2)**:

- Hawaii County[3]
- Maui County[4]
- City and County of Honolulu[5]
- Kauai County[6]

Mayor's Proclamations	Date Issued
Hawaii County	
Emergency Proclamation	28 February 2020
First Supplementary Emergency Proclamation	11 March 2020
Second Supplementary Emergency Proclamation	24 March 2020
Third Supplementary Emergency Proclamation	1 April 2020
Maui County	
Public Health Emergency Proclamation	4 March 2020
City and County of Honolulu	
COVID-19 Proclamation	4 March 2020
First Supplemental Proclamation	18 March 2020
Second Supplemental Proclamation	6 May 2020
Third Supplemental Proclamation	20 June 2020
Fourth Supplemental Proclamation	29 July 2020
Fifth Supplemental Proclamation	6 August 2020
Sixth Supplemental Proclamation	23 September 2020
Kauai County	
Emergency Proclamation	4 March 2020
First Supplementary Emergency Proclamation	8 April 2020
Second Supplementary Emergency Proclamation	27 April 2020
Third Supplementary Emergency Proclamation	26 June 2020
Fourth Supplementary Emergency Proclamation	25 August 2020

Figure 4-2: Emergency proclamations from Mayors related to COVID-19

[1] Hawaii SNS Plan
[2] https://governor.hawaii.gov/covid-19/covid-19-emergency-proclamations/
[3] https://www.hawaiicounty.gov/departments/civil-defense/active-emergency-proclamations
[4] https://www.mauicounty.gov/2006/Declarations
[5] http://www.honolulu.gov/mayor/proclamations-orders-and-rules.html
[6] https://www.kauai.gov/Government/Departments-Agencies/Emergency-Management-Agency-formerly-Civil-Defense/Emergency-Proclamations

4.1.1 Personnel Administrative Management Responsibilities

Departments and agencies shall:

- Follow established agency policies for personnel augmentation in accordance with statutes, regulations and authorities, Memoranda of Understanding (MOUs), Emergency Management Assistance Compact (EMAC), and Mutual Aid Agreements.
- Ensure employees engaged in incident response activities are able to perform in accordance with resource typing guidelines and operational requirements (e.g., Federal Emergency Management Agency (FEMA) resource typing library: https://rtlt.preptoolkit.fema.gov/Public.
- Ensure employee compliance with parent organization's travel policies and procedures for travel and travel reimbursement.

4.2 Resources

Each organization is responsible for acquiring, monitoring, and maintaining resources to support their responsibilities under this plan. Organizations will identify potential resource shortfalls to HDOH in a timely manner. **See Appendix D: Logistics** of this plan for specific resource guidance.

Counties must also immediately report resource shortfalls to HDOH to avoid unexpected obstacles to the progress of the COVID-19 Vaccination Program. **Organizations should not expend funds in support of this plan in the anticipation that HDOH will provide reimbursement without prior authorization through the HDOH COVID-19 Vaccination Program authorizing agent.**

REIMBURSEMENT GUIDANCE

NOTE: Certain private non-profit (PNP) organizations are eligible to apply for funding through FEMA's Public Assistance program in support of their efforts for the COVID-19 incident (https://www.fema.gov/fact-sheet/coronavirus-covid-19-pandemic-private-nonprofit-organizations). SESF #16 (Finance) under HI-EMA coordinates the State's Public Assistance program. There may also be other funding authorities to support the Hawaii COVID-19 Vaccination Program through other programs. Organizations are responsible for following all applicable local, state, and federal guidelines in support of the Hawaii COVID-19 Vaccination Program, which includes any applicable expenditures where they anticipate applying for reimbursement.

Figure 4-3: Reimbursement Guidance

4.2.1 Staffing

HDOH will need to ensure that there are adequately trained staff to support a successful COVID- 19 Vaccination Program. HDOH anticipates that specialized expertise is required, and organizations should identify both primary and backup staffing support to guard against interruption of activities because of illness or other issues. For example, if staff are supporting temporary or off-site COVID-19 vaccination clinics, the hours are likely to be long and physically taxing. Managers and supervisors need to regularly check in with and support assigned staff's wellness and overall resilience to perform the assigned tasks and ensure that additional staff are available as needed.

4.2.2 Inventory

Important activities during the COVID-19 Vaccination Program could be halted if certain supplies are depleted without replenishment. Organizations will need to track inventory for various program components (e.g., temporary/off-site clinic supplies/equipment, vaccine, sharps containers, and ancillary kits for vaccination providers) in accordance with HDOH reporting guidance. Regular monitoring of such data fosters early prompts to order and replenish supplies and ensure availability as needed. For example, jurisdictions need to project and monitor use of PPE and cleaning supplies throughout the response effort and have ordering and procurement protocols in place for securing additional supplies. Organizations should anticipate that some supplies and equipment will be in short supply with long lead times due to vaccination efforts occurring simultaneously throughout the world.

4.3 Funding

County, state, and federal funding to support COVID-19 vaccination efforts will be consistent with applicable laws and authorities. **This plan does not provide additional funding mechanisms.** Each organization is responsible for establishing administrative controls necessary to manage the expenditure of funds and provide reasonable accountability and justification for federal reimbursement in accordance with established guidelines. Organizations must coordinate with HDOH prior to expending any funding if they anticipate requesting reimbursement.

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5 Oversight, Coordinating Instructions, and Communications

5.1. Oversight

HDOH exercises primary oversight and responsibility for programs that comprise the Hawaii COVID-19 Vaccination Program. County and state agencies will use established emergency operating procedures to provide situational awareness of their ongoing efforts to support the Hawaii COVID-19 Vaccination Program efforts. This will include the use of situation reports, Incident Action Plans, and WebEOC as appropriate. See applicable sections of this plan for additional details as noted in **Table 5-1** below.

Table 5-1: CDC Playbook Requirements/Recommendations

CDC Playbook Requirement/Recommendation	Locations within the Plan
Does the plan address Vaccine Administration Documentation and Reporting processes and procedures?	Appendix D: Logistics Tab 5: Vaccine Administration Documentation and Reporting
Does the plan address Vaccination Program Monitoring?	Section 5.1. Oversight Appendix B: Situational Awareness
Does the plan reference CDC Dashboards?	Appendix B: Situational Awareness
Does the plan address Resource Monitoring?	Appendix B: Situational Awareness Appendix D: Logistics
Does the plan address Staffing?	Appendix A: Task Organization
Does the plan address Inventory procedures?	Appendix D: Logistics Vaccine Inventory Management
Does the plan address monitoring CDC messaging?	Section 5.3 Communications

In addition, the CDC has provided initial program management reporting guidance as described below. HDOH will implement procedures to gather and report this data as required:

As of today, how many providers have completed Section A (i.e., the provider agreement) of the COVID-19 Vaccination Program Provider Agreement and Profile Form?

Among the providers who have completed Section A (i.e., the provider agreement), how many currently have a VTrckS ID?

As of today, what is the total number of providers for which you have received a completed Section B (i.e., the provider profile) of the COVID-19 Vaccination Program Provider Agreement and Profile Form?

Among the providers with a completed Section B (i.e., the provider profile), how many currently have a VTrckS ID?

Figure 5-1: Example of CDC Reporting Requirements

This section provides coordinating instructions applicable to all organizations that support COVID-19 vaccine operations in Hawaii. Organizations supporting Hawaii vaccine operations are responsible for:

- Executing their roles and responsibilities
- Participating in periodic reviews of this plan to incorporate best practices/lessons learned
- Developing and maintaining plans, standard operating procedures, coordinating MOUs, notification lists, and resource data to ensure prompt and effective vaccination operations; and
- Conducting and/or participating in training activities and exercises designed to enhance their ability to accomplish their responsibilities as assigned by this plan in accordance with **Appendix F: Vaccine Program Training Requirements.**

5.2. Communications

Constant and clear communications among HDOH and all partners (public health officials, State agencies, government, health care professionals, industry, public, etc.) across the State as well as with Federal level agencies is critical. Public health education is a necessary foundation for all activities to enhance understanding and cooperation with guidance issued by HDOH.[1]

The purpose of this section of the Vaccination Plan is to outline guidance and procedures for establishing and maintaining communications between the HDOH Department Operations Center (DOC), other Operations Centers such as the State Emergency Operations Center, transport vehicles, security, and Point of Dispensing Sites (PODs). HDOH will identify available communication systems, complete communication plans, and test all communications methodologies with stakeholders during Phase 1 of this plan.[2]

CDC

The CDC is expected to provide timely messaging throughout the COVID-19 vaccination response via all-jurisdiction calls,
regular e-mail communication, and website updates. HDOH will routinely monitor both CDC and local-level messaging to inform its communications efforts through the use of a COVID-19 Communications Working Group. Variations in messaging between the federal, state, and local level can create confusion and hamper the effective implementation of the vaccination program and will require coordination through the COVID-19 Joint Information Center (JIC) as needed **(see Appendix E: Vaccine Program Communications for additional details)**.[3]

Messaging must be clear, current, and received as intended by the audience. Monitoring social media will be critical in assessing message delivery and reception and dispelling inaccurate information.

Figure 5-2: Messaging Guidance

HDOH

HDOH establishes communications with all agency Incident Command System (ICS) structures following plan activation and uses the Hawaii Health Alert Network (HHAN) as its primary notification system for outreach to the medical community. The HHAN is a secure communication system that provides a comprehensive information sharing, collaboration, alerting, and notification solution. HDOH is able to rapidly alert key personnel of emergent incidents (i.e. vaccine arrival in the state) and to share critical information from a secure web portal, which facilitates coordinated inter-jurisdictional planning, response, mitigation, and recovery operations. Its unique flexible directory reflects role, organizational, and jurisdictional

[1] DOH Pandemic Influenza Preparedness and Response Plan_01012008

[2] Hawaii SNS Plan

[3] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

structures, providing the ability to rapidly distribute information to critical roles in emergency situations. See additional details below:

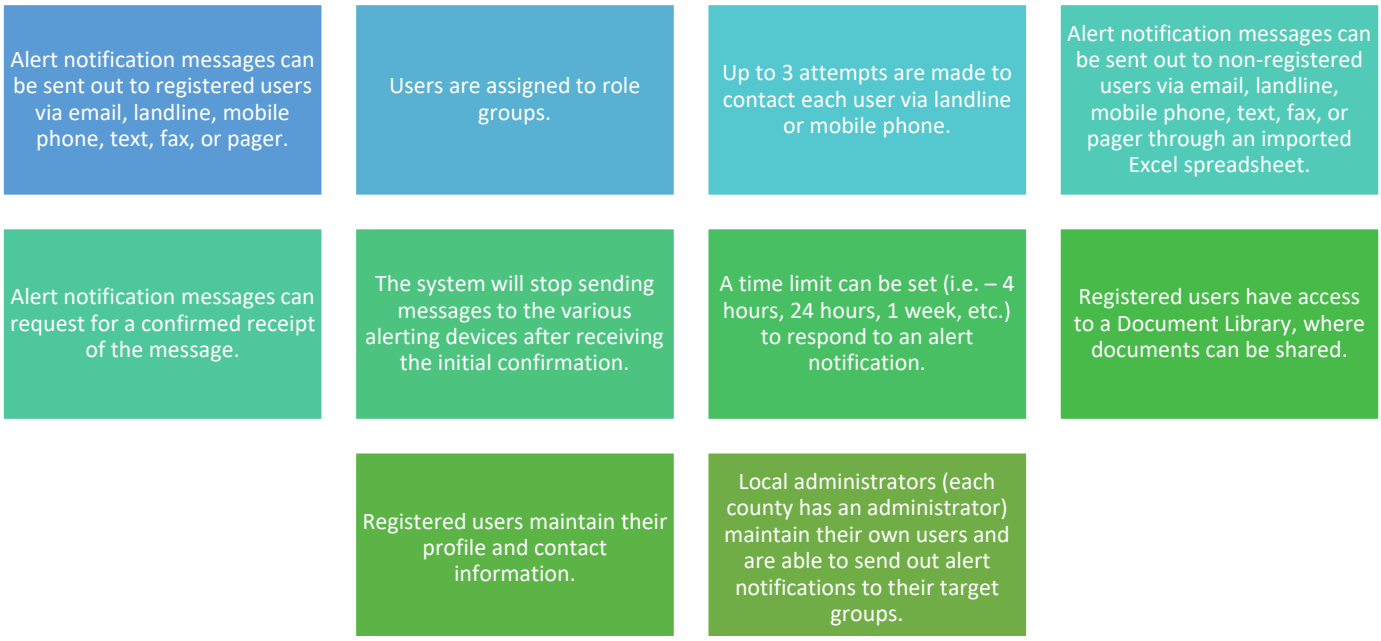


Figure 5-3: HHAN Capabilities

Department and Agency communications centers maintain control of operations and equipment under their jurisdiction. When possible, these centers use their existing facilities and maintain contact with the HDOH through secure radio, telephone, email, and fax networks. Each agency:

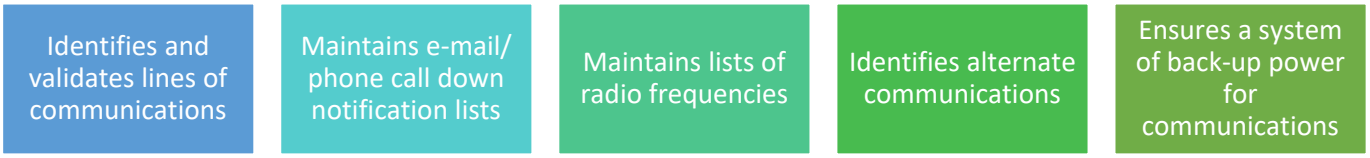


Figure 5-4: Agency Responsibilities

HDOH implements and exercises information security practices. Tactical communications between facilities, transport vehicles, operations centers, etc. are kept secure by:

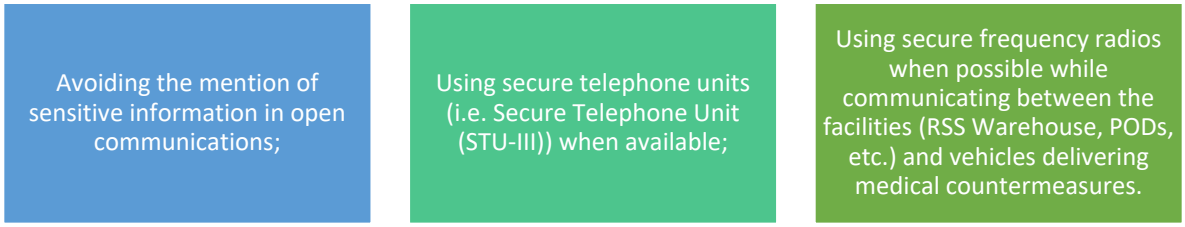


Figure 5-5: Communications Security Best Practices

Each agency establishes ICS structures and communicates sensitive status information to the HDOH DOC via the most secure means available in accordance with the ICS 205 in the IAP. DOC Communications staff work with stakeholders Communication Leads to ensure that communication systems function efficiently and collaborate to implement troubleshooting solutions. HDOH DOC maintains communication with:

Figure 5-6: HDOH DOC Communications stakeholders

HDOH coordinates to provide U.S. Marshals with secure radios from state/local law enforcement to communicate with security forces providing escort as required.

Receipt, Store, Stage (RSS) Site:

- Establish a communications center at the RSS Site as appropriate.
- Use e-mail, phone/fax lines in accordance with the existing Hawaii Strategic National Stockpile (SNS) Plan, Annex 4: MCM Warehouse/Delivery Operations.[4]

Distribution dispatcher and Drivers:

- Use Cell Phone or Secure radios (if available)

Point of Dispensing (POD) Sites:

- Conduct communications within each POD as provided in each site POD Plan. Typically, this will be through either cell phones or radios (if available)

Other:

- 800 MHz Radios will be used for joint operations communication as needed. Specific channels will be briefed or handed out during the Incident Action Plan (IAP) briefing as appropriate.
- Support (if requested) may be provided by the local chapter of the Radio Amateur Civil Emergency Services (RACES) or Amateur Radio Emergency Service (ARES) organizations or other public service and private organizations in the community.
- In addition to the HDOH talk group, interoperable channels will be available to communicate with City and County of Honolulu Department of Emergency Management (DEM), Ocean Safety, Honolulu Police Department (HPD), Honolulu Fire Department (HFD), and Emergency Medical Services (EMS) as needed.
- Each county DHO will establish communication procedures with their stakeholders.

[4] Hawaii SNS Plan

Appendix A: Task Organization

Appendix A: Task Organization describes organizational constructs and coordination relationships that the State of Hawaii will observe and employ for this plan. Each primary and supporting organization will operate using an Incident Command System (ICS) structure where appropriate, in accordance with the National Incident Management System (NIMS). In order to support COVID-19 Vaccination Program efforts, HDOH will use two primary coordinating bodies, a Vaccination Core Planning Team (CPT), and a Vaccination Program Implementation Committee (VPIC). The Vaccination Program will use standing or ad hoc working groups as needed such as a Vaccine Prioritization/Allocation Working Group, a Vaccine Communications Working Group, a Vaccine Medical Advisory Working Group, a Vaccine Provider Outreach and Enrollment Working Group, and a Vaccination Program Training and Exercise Working Group **(see Figure A-1 below)**.

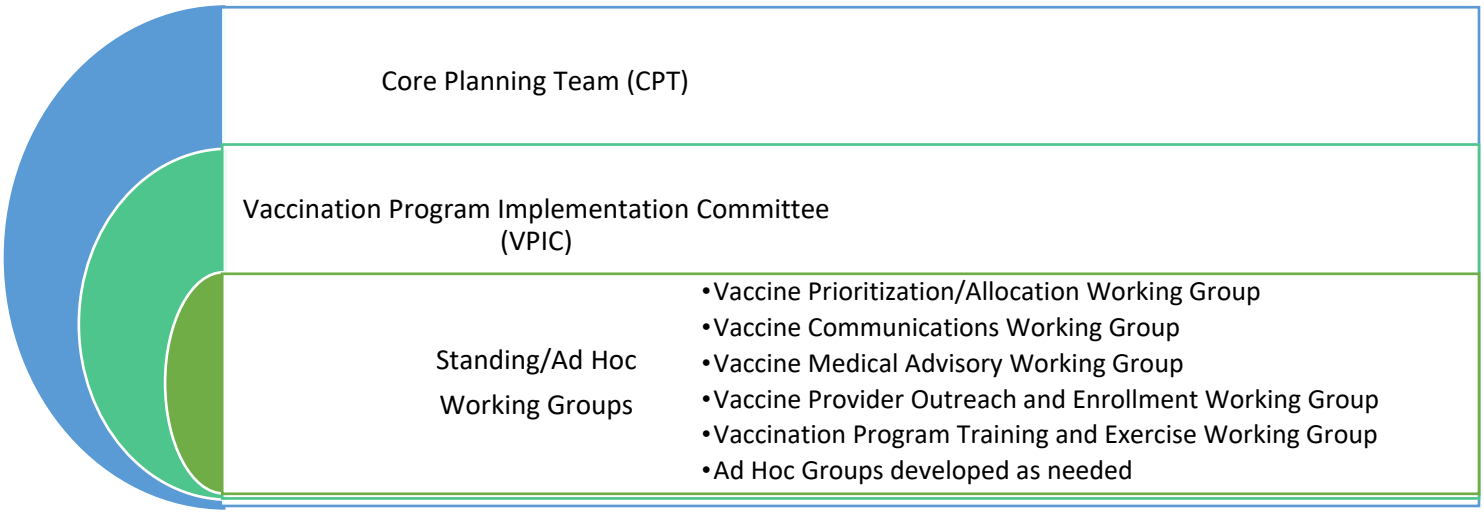


Figure A-1: Coordinating Bodies and Standing/Ad Hoc Working Groups

An initial Phase 1 COVID-19 organizational structure with working groups is shown below in **Figure A-2**.

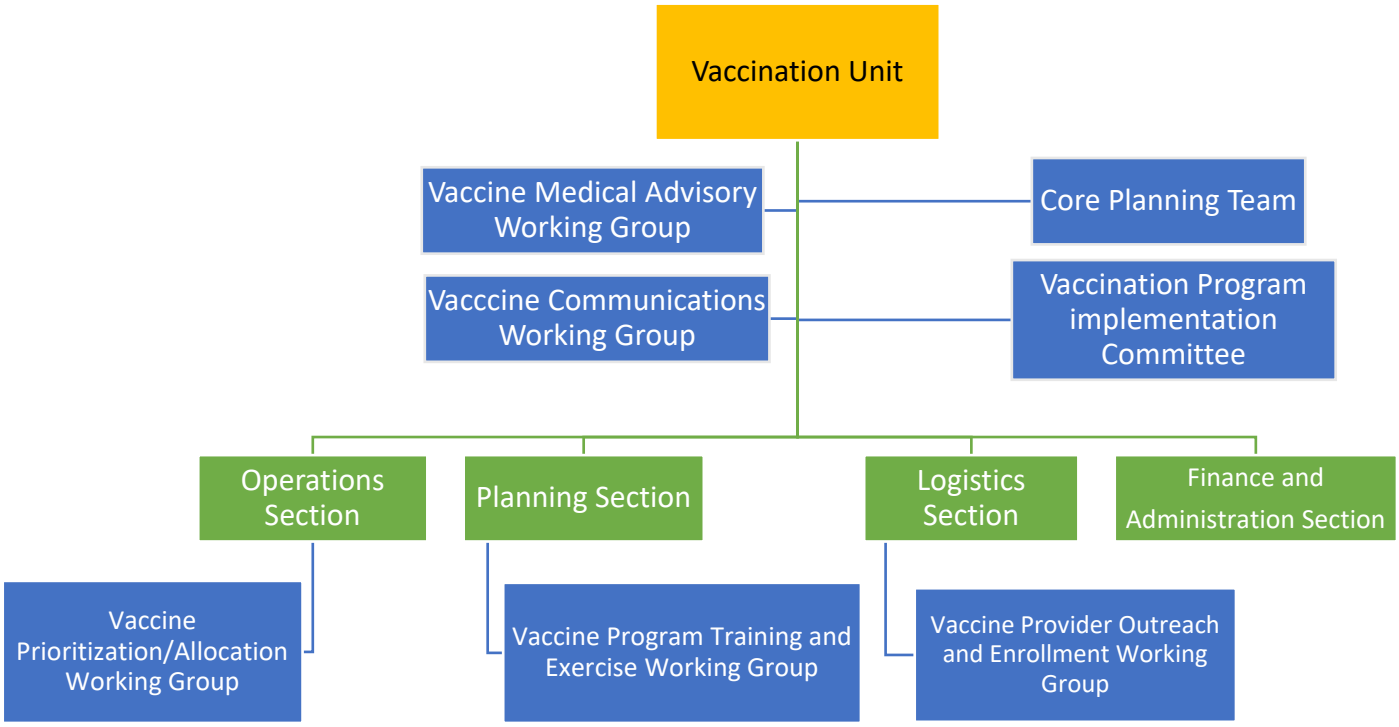


Figure A-2: COVID-19 Organizational Structure with Working Groups

HDOH selected stakeholders from organizations to support the COVID-19 Vaccination Program based on four recommended categories for critical populations identified in CDC's Guidance for allocating vaccine during a pandemic **(see Figure A-3 below)**.[1]

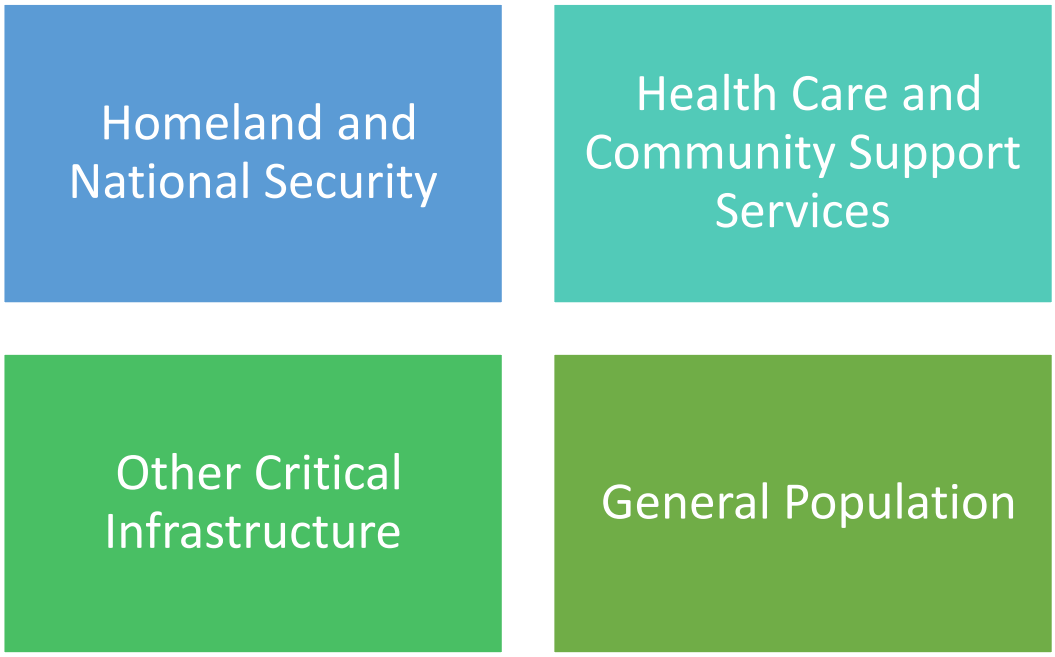


Figure A-3: CDC Categories for Critical Populations

Vaccination Core Planning Team (CPT)

The CPT serves as an executive body for the COVID-19 Vaccination Program supporting efforts such as the development of relevant plans, policies, and procedures. Organizations will provide primary and alternate members for the CPT and will notify HDOH of any updates to their representatives **(see Table A-1 below for a list of CPT member organizations)**.[2]

[1] https://www.cdc.gov/flu/pandemic-resources/national-strategy/planning-guidance/index.html, Accessed October 8, 2020
[2] NOTE: HDOH maintains point of contact information for each organization on the MS Teams project.

Table A-1: Core Planning Team (CPT) Organizations

Organization	Category/Critical Population Groups		
	Health Care and Community Support Services	Homeland and National Security	Other Critical Infrastructure
	• Public health personnel • Inpatient health care providers • Outpatient & home health providers • Health care providers in long-term care facilities • Pharmacists & pharmacy technicians • Community support & emergency management • Mortuary services personnel • Other health care personnel	• Deployed & mission essential personnel • Essential military support & sustainment personnel • Intelligence services • National Guard personnel • Other domestic national security personnel • Other active duty military & essential support	• Emergency services & public safety sector personnel (EMS, law enforcement, & fire services) • Communications/information technology (IT) • Electricity, oil & gas, water sector personnel • Critical government personnel – operational & regulatory functions • Banking & finance, chemical, food & agriculture • Postal & shipping, & transportation sector personnel • Other critical government personnel
Attorney General (AG)/ State Law Enforcement Coalition (SLEC)			X
Centers for Disease Control and Prevention (CDC) • Including Operation Warp Speed (OWS) rep	X		
County Emergency Management Agencies (HCCDA, MEMA, DEM, KEMA)	X		X
District Health Office (DHO) – Hawaii, Kauai, and Maui	X		
FEMA Region IX	X	X	X
Hawaii National Guard (HING)	X	X	X
Hawaii State Center for Nursing	X		
HDOH - Disability Communications and Access Board (DCAB); Immunization Branch (IMB); Office of Healthcare Association; Office of Public Health Preparedness (OPHP); Public Information	X		
Health and Human Services Assistant Secretary for Preparedness and Response (HHS ASPR)	X	X	X
Hawaii Emergency Management Agency (HI-EMA)			X
LT Governor	X		X
Office of Homeland Security (OHS)		X	X
Organizations Supporting State Emergency Support Function (SESF) #8 • Healthcare Association of Hawaii (HAH) • Hawaii Healthcare Emergency Management (HHEM) • Hawaii Medical Service Association (HMSA) • Hawaii Primary Care Association (HPCA)	X		
University of Hawaii – Hilo – College of Pharmacy	X		

NOTE: Core Planning Team meetings have also included representatives from DOD (US Army Pacific Defense Coordinating Office), Tripler Army Medical Center, Hawaii Military Health System), Honolulu Police Department, and Maui Police Department

Vaccination Program Implementation Committee (VPIC)

The CDC noted in its COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations that "jurisdictions should establish a COVID-19 Vaccination Program implementation committee to enhance development of plans, reach of activities, and risk/crisis response communication messaging and delivery. Committee membership should include leadership from the jurisdiction's COVID-19 planning and coordination team as well as representatives from key COVID-19 vaccination providers for critical population groups identified by CDC, as well as representatives from other sectors within the community." [3]

HDOH will chair the Vaccination Program Implementation Committee (VPIC). Key responsibilities include the following:

- Provide recommendations for efforts needed to achieve desired levels of COVID-19 vaccination coverage within critical populations in Hawaii.
- Provide input to enhance the development of plans and procedures.
- Support outreach efforts to reach critical populations and key stakeholders.
- Identify the most important areas of government and non-government cooperation that should be considered in implementing the COVID-19 Vaccination Plan.

Committee membership will include leadership from the COVID-19 Core Planning Team, as well as representative organizations aligned to critical population groups as noted above. The Core Planning Team initially identified over 90 organizations that could potentially support the COVID-19 Vaccination Program on the Vaccination Program Implementation Committee (VPIC) and/or various working groups. **See Table A-2** for an initial list of potential organizations that HDOH IMB will refine and validate as needed.[4]

[3] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

[4] NOTE: HDOH maintains point of contact information for each organization on the MS Teams project site.

Table A- 2: Vaccination Program Implementation Committee (Proposed Members - Not all inclusive)

AARP Hawaii	District Health Office (DHO) - Hawaii county	Hawaii State Judiciary
American Academy of Family Physicians	District Health Office (DHO) - Maui	Hawaii State Teachers Association (HSTA)
American Academy of Pediatricians	DOD - Hawaii Military Health System	Hawaii State Voluntary Organizations Active in Disasters (HSVOAD)
American Academy of Pediatrics – Hawaii Chapter (AAP-HI)	DOD - INDOPACOM	Hawaii Tourism Authority (HTA)
American College of Emergency Physicians	DOD - Tripler Army Medical Center (TAMC)	Hawaiian Electric Company (HECO)
American College of Obstetricians and Gynecologists	DOD - USARPAC	Healthcare Association of Hawaii (HAH)
American College of Physicians	Enterprise Technology Services (ETS)	HHS Region IX Assistant Secretary for Preparedness and Response (ASPR)
American Red Cross	Federal Executive Board (FEB)	Honolulu Emergency Services Department
Amerisource Bergen	FEMA	Honolulu Fire Department
Association for Professionals in Infection Control (Hawaii Chapter)	Governor's Office	Honolulu Police Department
Attorney General (AG)	Harry and Jeanette Weinberg Foundation	Kaiser Permanente Hawaii
Cardinal Health	Hawaii Association of Health Plans	Kauai Emergency Management Agency (KEMA)
Centers for Disease Control and Prevention (CDC)	Hawaii Association of Independent Schools (HAIS)	Kauai Fire Department
Chamber of Commerce	Hawaii Community Foundation (HCF)	Kauai Police Department
Chaminade	Hawaii County Civil Defense Agency	Legislature--House
City and County of Honolulu Department of Emergency Management (DEM)	Hawaii Department of Health (HDOH)	Legislature--Senate
CVS	Hawaii Emergency Management Agency (HI-EMA)	Lieutenant Governor
Department of Accounting and General Services (DAGS)	Hawaii Financial Industry Resilience, Security and Teamwork (HawaiiFIRST)	Maui Emergency Management Agency (MEMA)
Department of Agriculture	Hawaii Fire Department	Maui Fire Department
Department of Business, Economic Development and Tourism (DBEDT) - State Energy Office	Hawaii Funeral and Cemetery Association	Maui Police Department
Department of Commerce and Consumer Affairs (DCCA)	Hawaii Government Employees Association (HGEA)	McKesson
Department of Education (DOE)	Hawaii Healthcare Emergency Management (HHEM)	Med-Quest
Department of Hawaiian Home Lands (DHHL)	Hawaii Independent Physician Association	Office of Hawaiian Affairs (OHA)
Department of Homeland Security - Cybersecurity and Infrastructure Security Agency (CISA)	Hawaii Medical Association	Office of Homeland Security (OHS)
Department of Human Resources (DHRD)	Hawaii Medical Service Association	Papa Ola' Lokahi
Department of Human Services (DHS)	Hawaii National Guard (HING)	Queens Medical Center
Department of Labor and Industrial Relations (DLIR)	Hawaii Pacific Health	The Interfaith Alliance of Hawaii
Department of Land and Natural Resources (DLNR)	Hawaii Pacific University (HPU)	U.S. Marshals Service (USMS)
Department of Public Safety (PSD)	Hawaii Pharmacists Association	University of Hawaii (UH)
Department of Transportation (DOT)	Hawaii Police Department	University of Hawaii (UH) - Community Colleges
District Health Office (DHO) - Kauai	Hawaii Primary Care Association	University of Hawaii (UH) - Hilo
District Health Office (DHO) - Hawaii county	Hawaii State Center for Nursing	Walgreens

Vaccine Prioritization/Allocation Working Group

The Core Planning Team identified the need for a Vaccine Prioritization/Allocation Working Group. Key responsibilities include the following:

- Develop/refine initial prioritization/allocation criteria/strategy.
- Update prioritization/allocation criteria as additional data becomes available on issues such as vaccine efficacy especially in target populations.
- Provide subject matter expertise to support Vaccine Prioritization/Allocation efforts.
- Refine critical population data.

See Table A-3 for a list of member organizations.[5]

Table A-3: Vaccine Prioritization/Allocation Working Group

Category	Organization
Health Care and Community Support Services	HDOH
Homeland and National Security	
Other critical infrastructure	
General Population	

Vaccine Communications Working Group

The Core Planning Team identified the need for a Vaccine Communications Working Group. Key responsibilities include the following:

- Develop initial communications messages to be used in the period of time before a COVID-19 vaccine becomes available to raise awareness of the importance of participating in the state's Vaccination Program, as well as to encourage COVID-19 Vaccination Provider enrollment.
- Update prioritization/allocation criteria communications as additional data becomes available on issues such as vaccine efficacy especially in target populations.
- Support communication/outreach efforts within each phase of operations to include monitoring media/social media for feedback/suggestions regarding the COVID-19 Vaccination Program, as well as to address questions/concerns, such as vaccine hesitancy.
- Develop and implement a robust communications plan that customizes CDC resources and products.

See Table A-4 for a list of member organizations.[6]

Table A-4: Vaccine Communications Working Group

Category	Organization
Health Care and Community Support Services	HDOH
Homeland and National Security	
Other critical infrastructure	
General Population	

[5] HDOH maintains point of contact information for each organization on the MS Teams project site. HDOH will populate this table after identifying specific participating organizations.
[6] Ibid.

Vaccine Medical Advisory Working Group

The Core Planning Team identified the need for a Vaccine Medical Advisory Working Group. Key responsibilities include the following:

- Review the status of vaccine development efforts under Operation Warp Speed (OWS) and provide technical expertise as needed for outreach efforts to vaccination providers and the community before the approval of a COVID-19 vaccine.
- Review safety, adverse events, and efficacy data throughout each phase of COVID-19 vaccination efforts and provide guidance and recommendations as appropriate.

See Table A-5 for a list of member organizations.[7]

Table A-5: Vaccine Medical Advisory Working Group

Category	Organization
Health Care and Community Support Services	HDOH
Homeland and National Security	
Other critical infrastructure	
General Population	

Vaccine Provider Outreach and Enrollment Working Group

The Core Planning Team identified the need for a Vaccine Provider Outreach and Enrollment Working Group. Key responsibilities include the following:

- Support the identification and enrollment of COVID-19 vaccine providers.
- Identify barriers (PPE, reimbursement of administration fees) for providers and strategies to mitigate.

See Table A-6 for a list of member organizations.[8]

Table A-6: Vaccine Provider Outreach and Enrollment Working Group

Category	Organization
Health Care and Community Support Services	HDOH
Homeland and National Security	
Other critical infrastructure	
General Population	

[7] HDOH maintains point of contact information for each organization on the MS Teams project site. HDOH will populate this table after identifying specific participating organizations.
[8] Ibid.

Vaccination Program Training and Exercise Working Group

The Core Planning Team identified the need for a Vaccination Program Training and Exercise Working Group. Key responsibilities include the following:

- Support the development of exercises for the COVID-19 Vaccination Program.
- Support the development of training for the COVID-19 Vaccination Program.

See Table A-7 for a list of member organizations.[9]

Table A-7: Vaccination Program Training and Exercise Working Group

Category	Organization
Health Care and Community Support Services	HDOH
Homeland and National Security	
Other critical infrastructure	
General Population	

[9] HDOH maintains point of contact information for each organization on the MS Teams project site. HDOH will populate this table after identifying specific participating organizations.

Organizational Structure

Initial Phase 1 response organizational structures for the implementation of this plan are shown in **Figures A-4 through A-9** below. These are initial organizational structures that include overall COVID-19 response efforts. This is a pre-decisional organization structure, not the current approved unified command organizational structure that can be found in the latest Incident Action Plan (IAP). HDOH will update this section as the Core Planning Team finalizes organizational structures specific to the COVID-19 Vaccination Program.

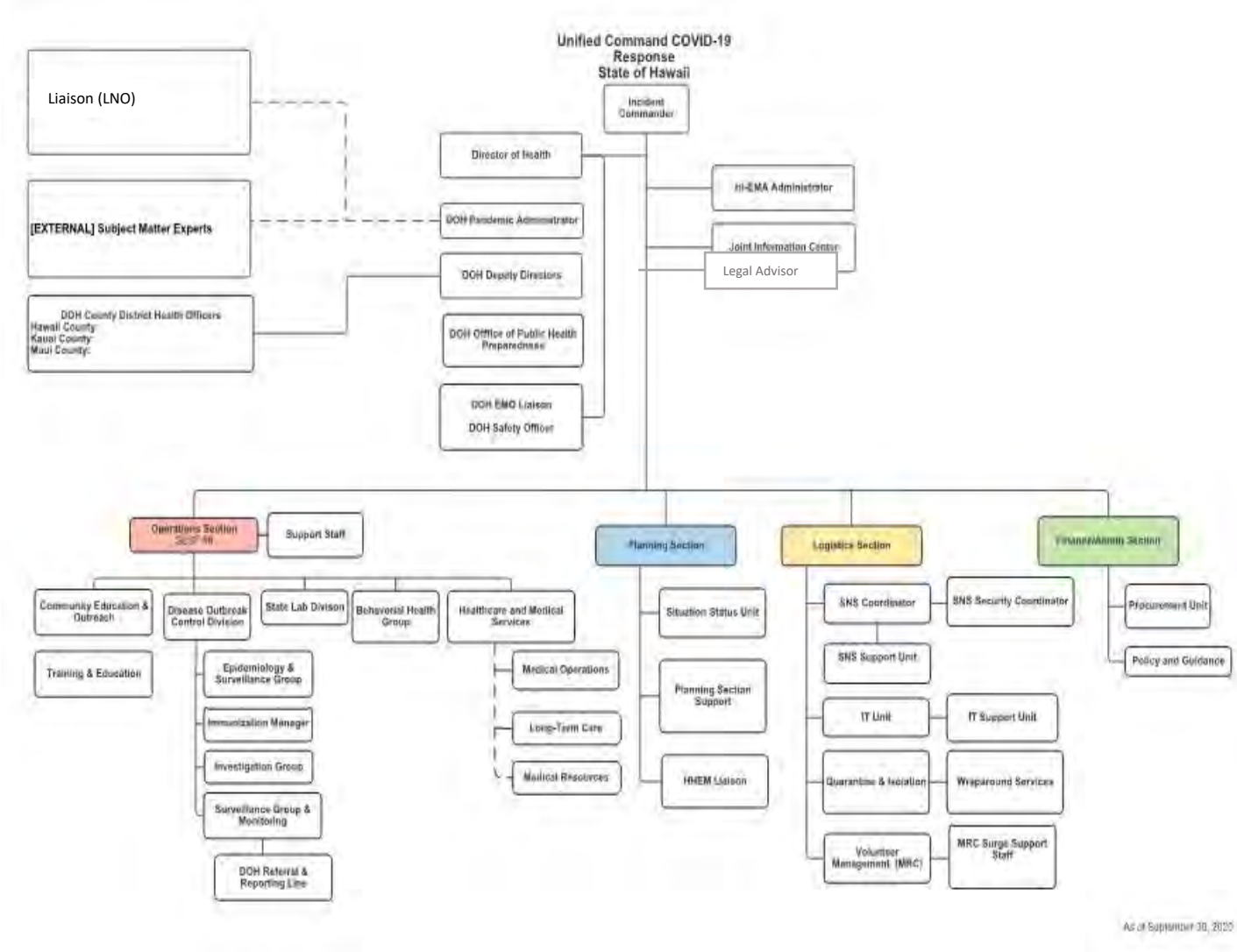


Figure A-4: Unified Command COVID-19 Response

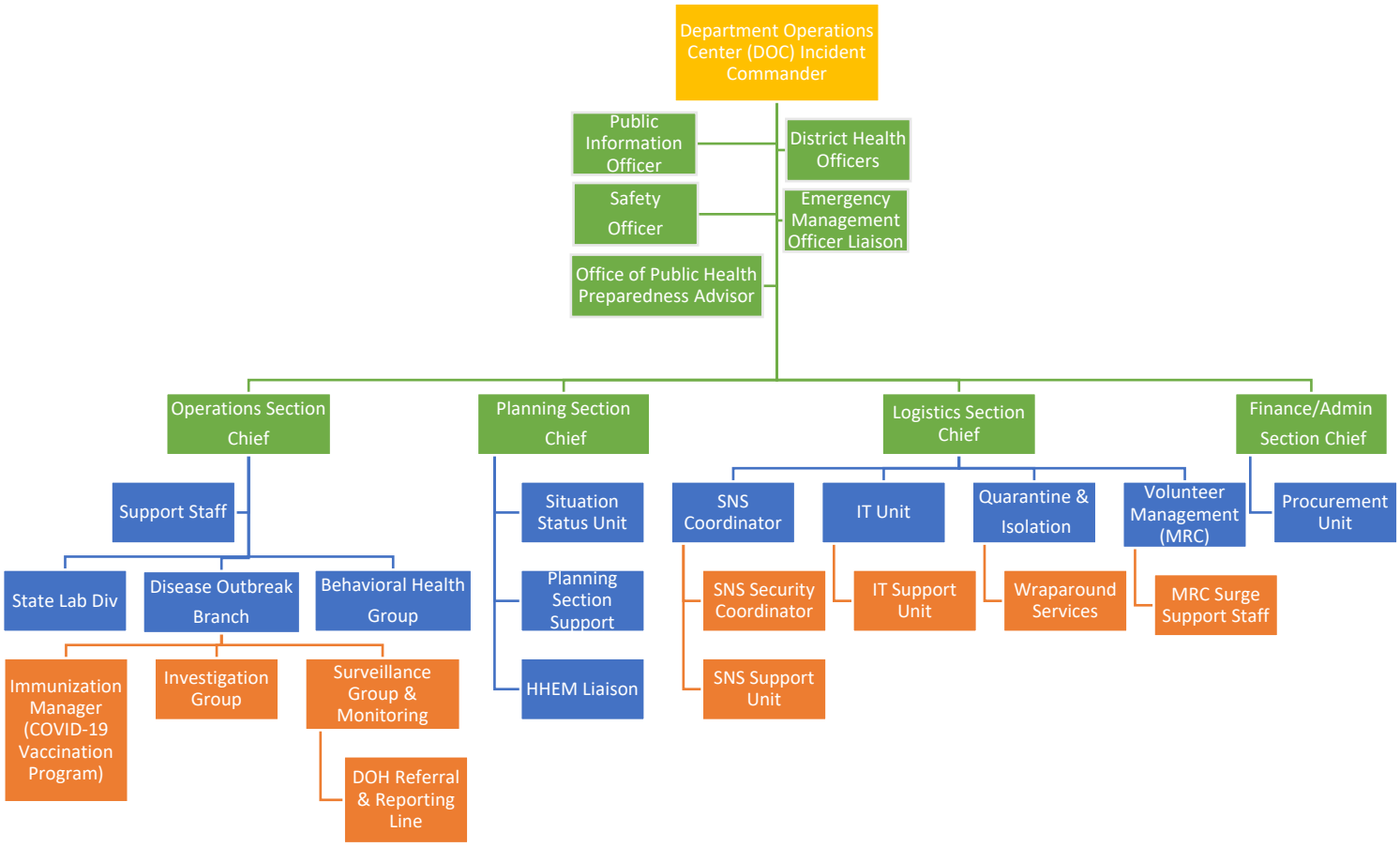
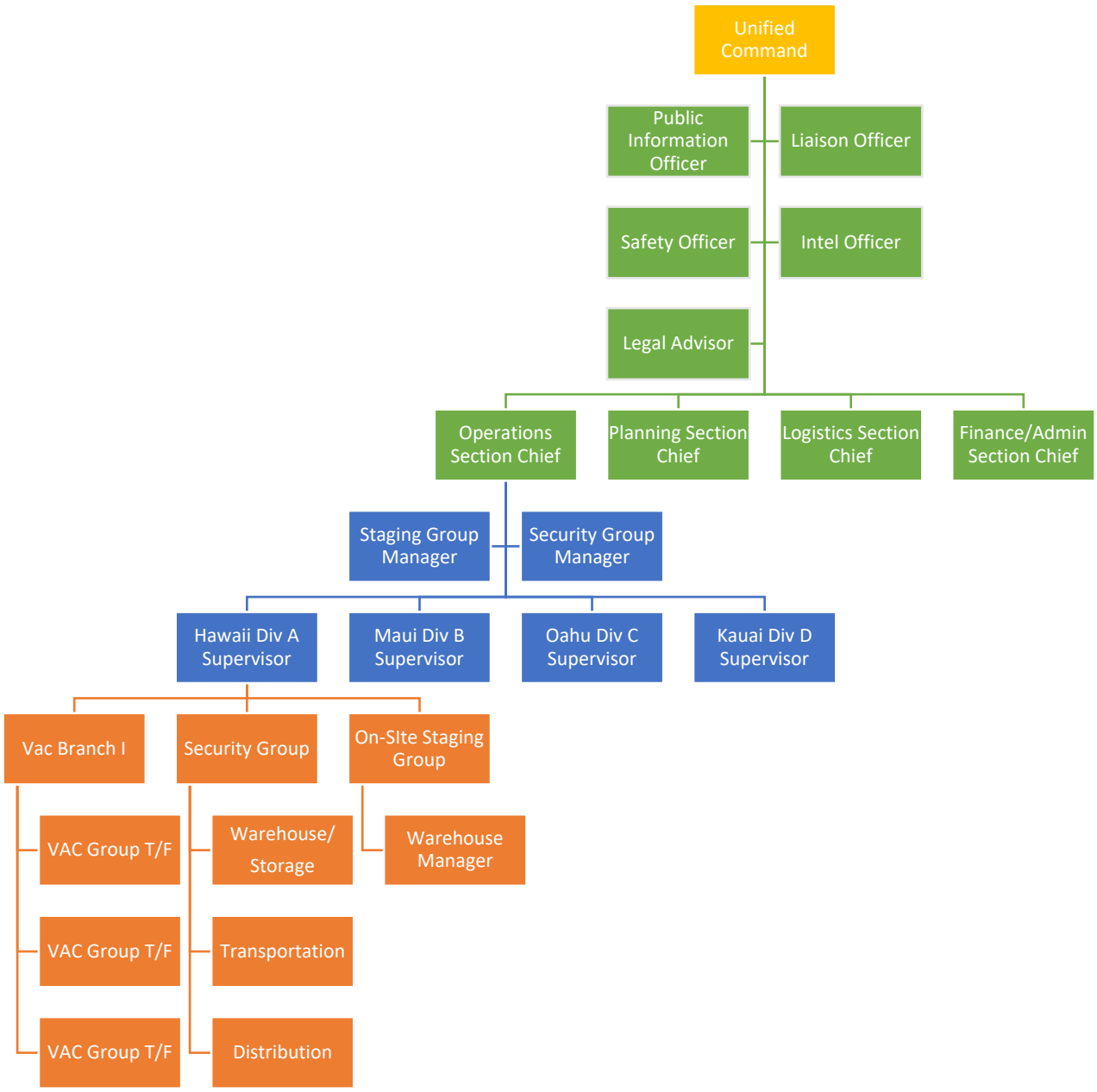


Figure A-5: Department of Health Department Operations Center (DOC) Operational Structure

1
2



NOTE: Each Division has the same structure as shown for Hawaii Div A; Vaccine Group Task Forces can be expanded/contracted as needed

Figure A-6: Operations Section

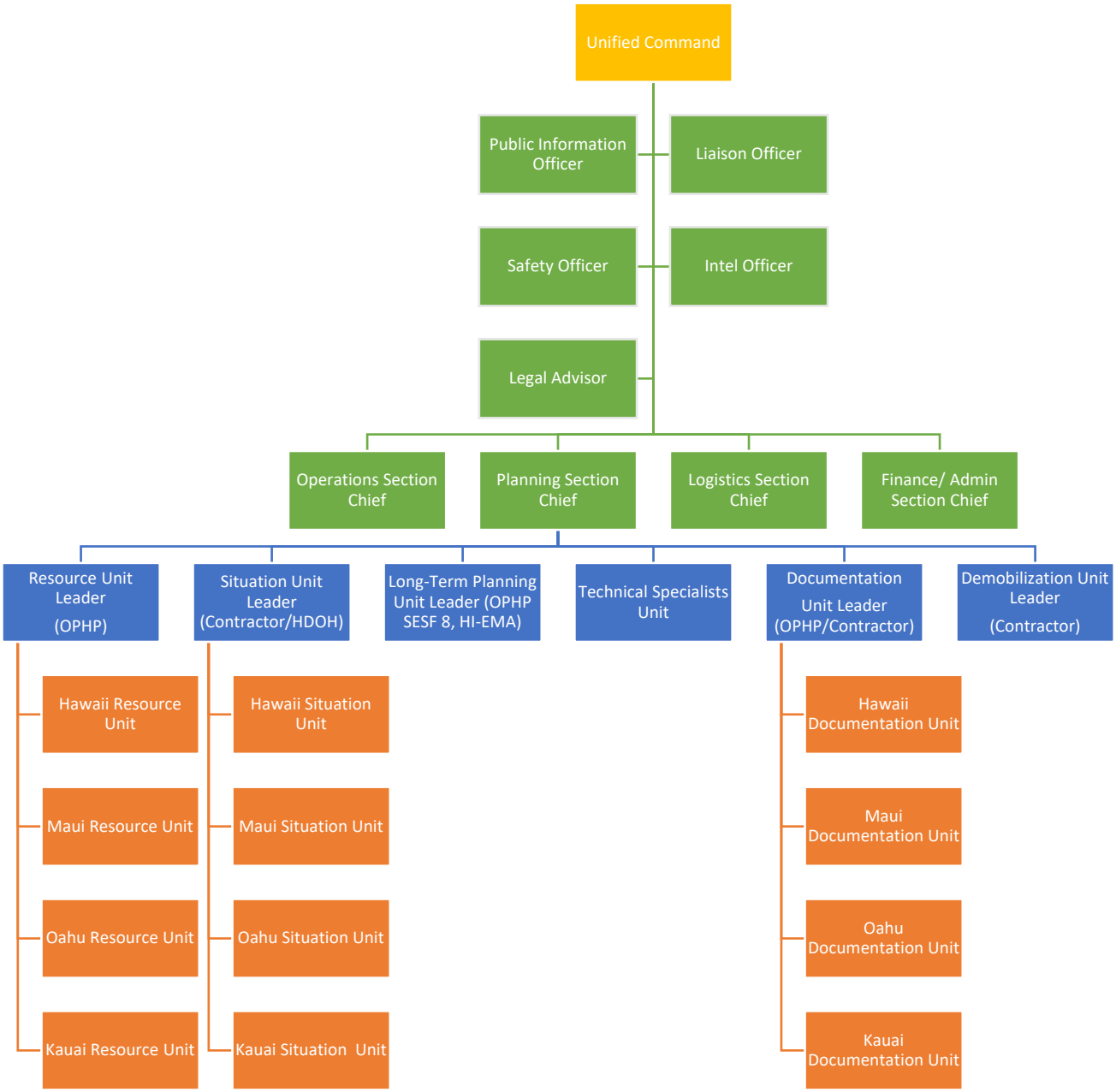


Figure A-7: Planning Section

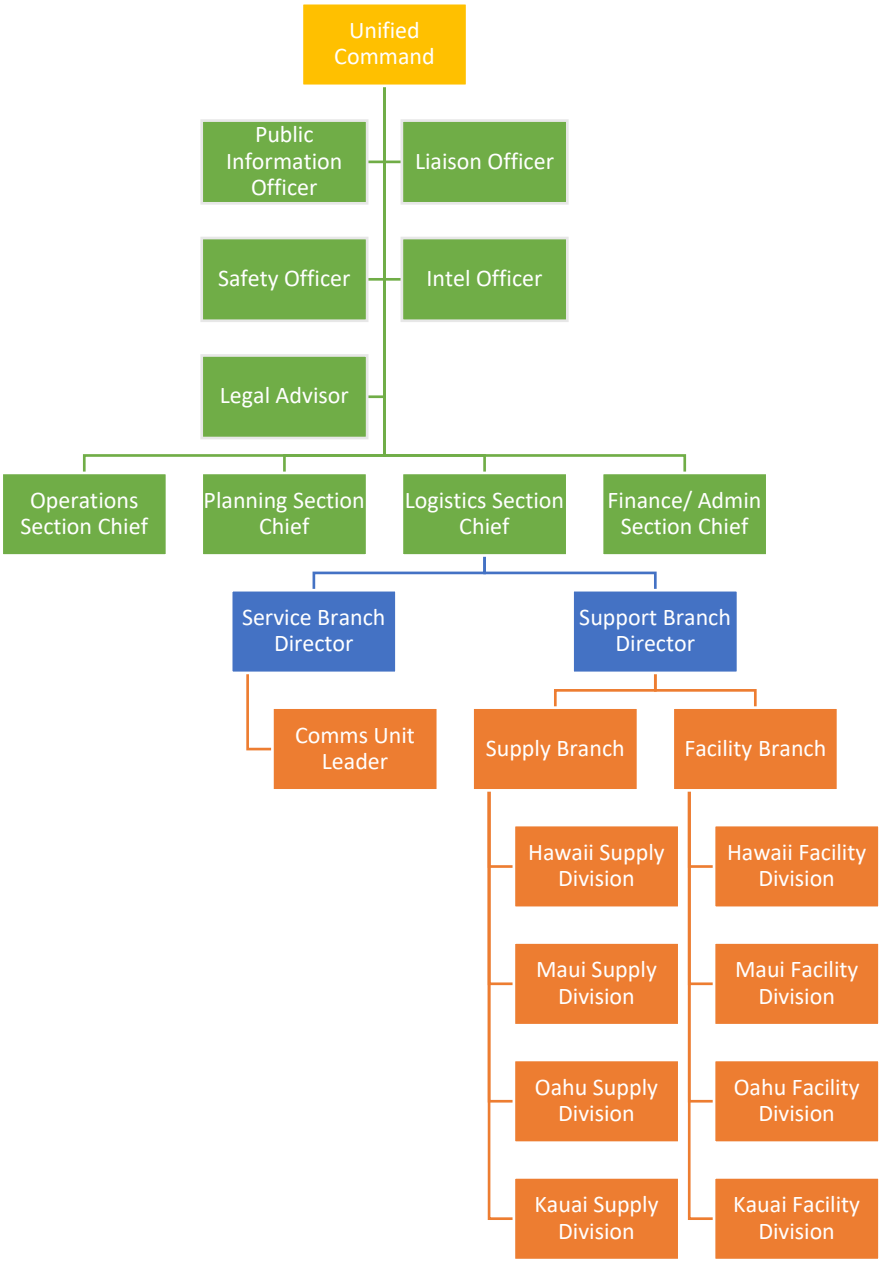


Figure A-8: Logistics Section

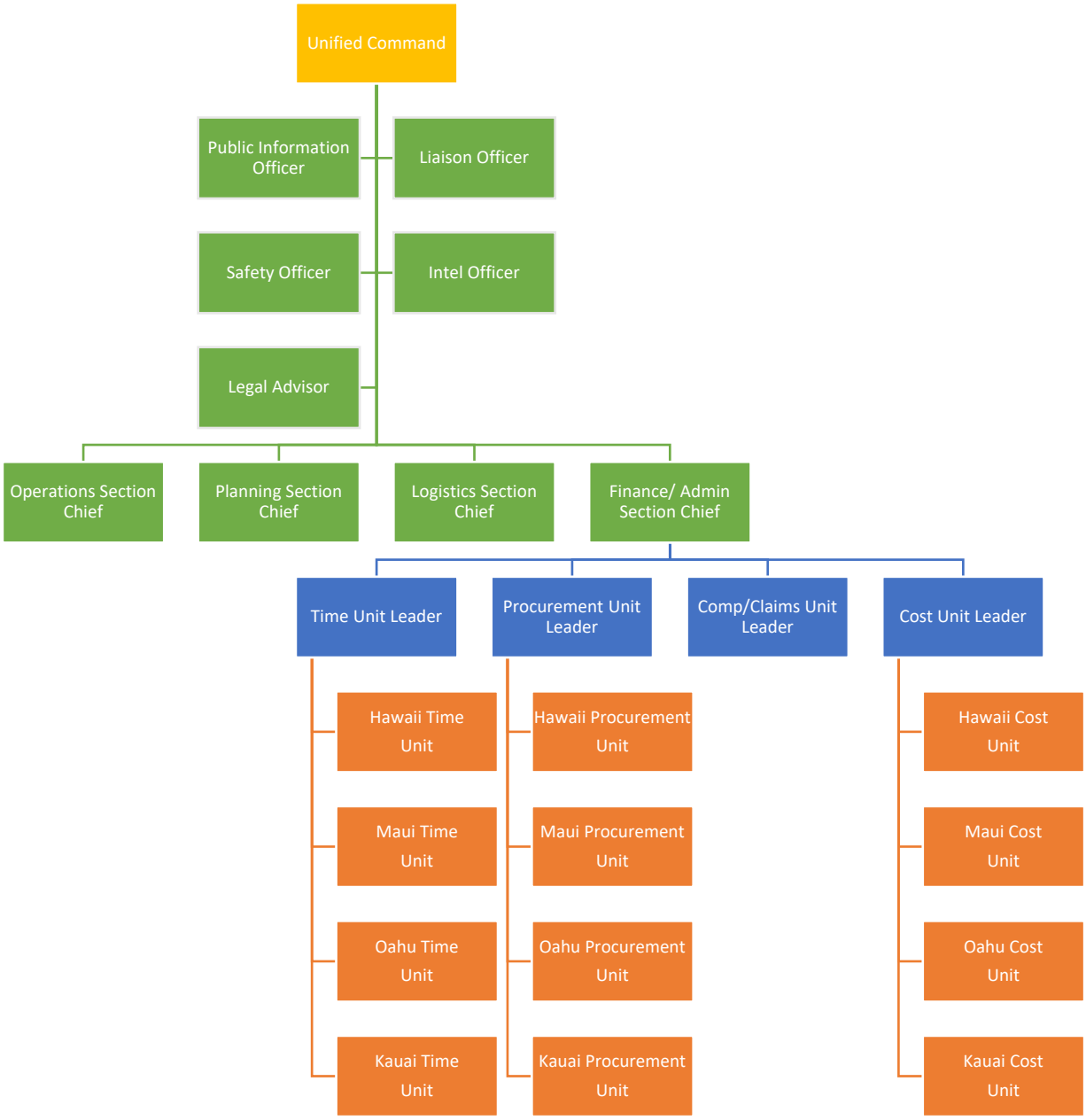


Figure A-9: Finance and Administration Section

The Core Planning Team will develop a Phase 2 response organizational structure if needed for the implementation of this plan and include it in **Figure A-10** below.

To be developed if needed

Figure A-10: Phase 2 Organizational Structure

The Core Planning Team will develop a Phase 3 response organizational structure if needed for the implementation of this plan and include it in **Figure A-11** below.

To be developed if needed

Figure A-11: Phase 3 Organizational Structure

Tab 1: Hawaii County Organizational Structure

Hawaii County will provide their COVID-19 Vaccination Program organizational structure to support operations to include in the HDOH Incident Action Plan (IAP). See below for the initial Hawaii County DHO organizational structure.

Figure A-12: Hawaii County District Health Office Organizational Structure

Tab 2: Maui County Organizational Structure

Maui County will provide their COVID-19 Vaccination Program organizational structure to support operations to include in the HDOH Incident Action Plan (IAP). See below for the initial Maui County DHO organizational structure.

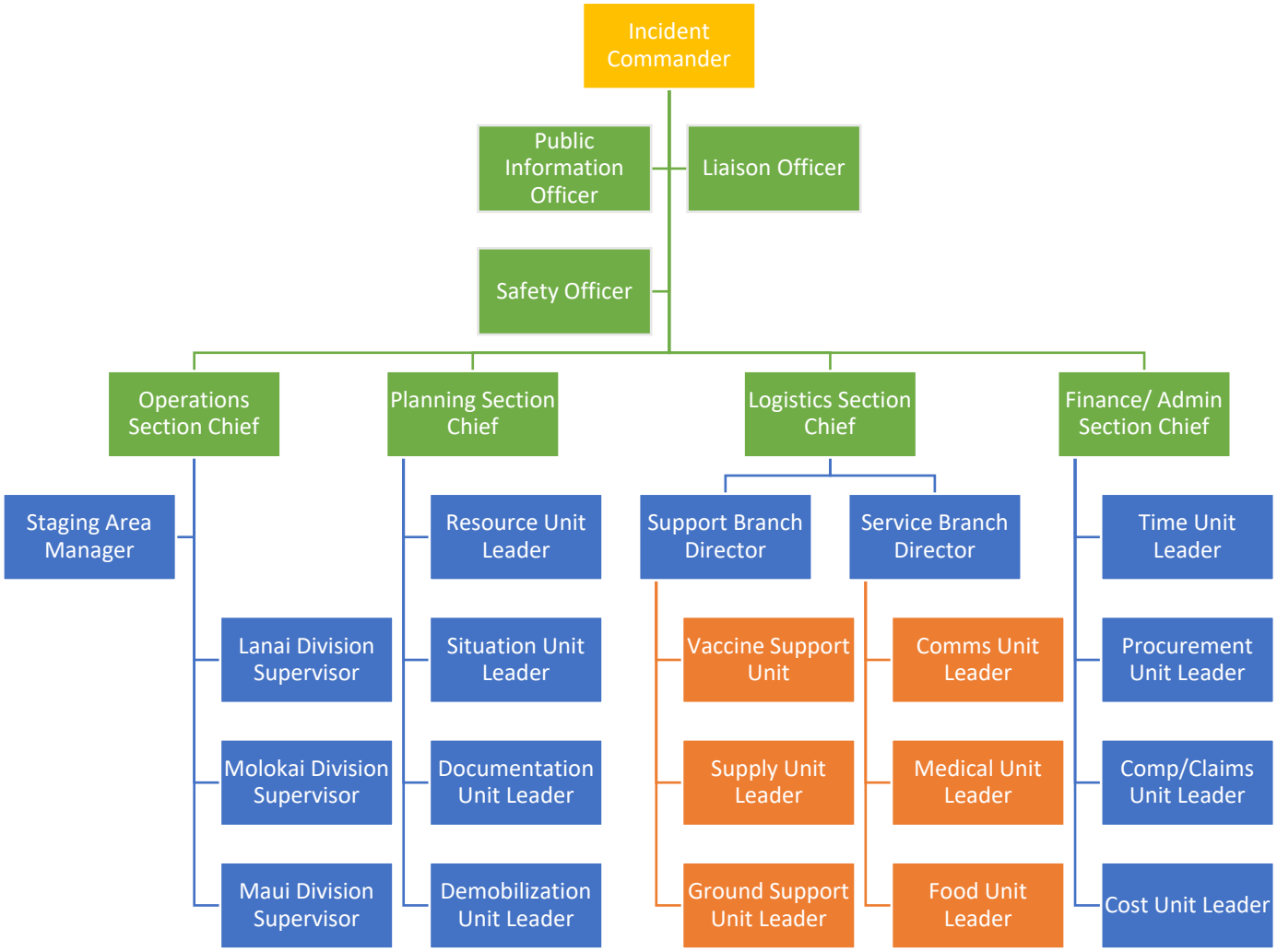


Figure A-13: Maui County District Health Office Organizational Structure

Tab 3: City and County of Honolulu Organizational Structure

The City and County of Honolulu will provide their COVID-19 Vaccination Program organizational structure to support operations to include in the HDOH Incident Action Plan (IAP). NOTE: unlike the neighbor islands, the City and County of Honolulu is not supported with a District Health Office from HDOH. HDOH coordinates with the City and County of Honolulu Department of Emergency Management through HDOH liaison officers assigned to support DEM.

To be developed if needed

Figure A-14: City and County of Honolulu Organizational Structure

Tab 4: Kauai County Organizational Structure

Kauai County will provide their COVID-19 Vaccination Program organizational structure to support operations to include in the HDOH Incident Action Plan. See below for the Kauai County DHO organizational structure.

Figure A-15: Kauai County Organizational Structure

Tab 5: Contact List for Key stakeholders

The HDOH Vaccination Program maintains a list of organizations and points of contact on the COVID-19 MS Teams project site. The list also identifies members and contact information for COVID-19 working groups and committees.

Tab 6: Memorandum of Understanding for Vaccination Program Support

A memorandum of understanding (MOU) is a formal agreement that sets forth terms between two or more parties. Organizations, including public health agencies and pharmacies, can use MOUs to establish official partnerships. MOUs are typically not legally binding, but they are often used as the first step toward a legal contract. Some users refer to MOUs as handshakes that set forth the parameters for agreement and action ahead of time so that participants can avoid exploring and vetting them during an emergency. MOUs are also sometimes referred to as no-cost contracts and can be drafted to be either binding or non-binding.[10] In all cases, organizations should seek legal guidance before completing an MOU with another organization. The following is an example MOU that HDOH could use and modify as necessary to document relationships with stakeholder organizations if needed.

[10] Memorandum of Understanding Toolkit for Public Health Agencies and Pharmacies, available at https://www.astho.org/Infectious-Disease/Pandemic-Influenza/MOU-State-Pharmacy-Pandemic-Influenza-Vaccination-Campaign/, accessed September 28, 2020.

Example MOU

Memorandum of Understanding between (Your Organization) and (Partnering Organization) for Application to (Specific program, if necessary)

I. MISSION

Include a brief description of your organization's mission and the partnering organization's mission. You may also want to include a sentence about the specific program, if applicable. Together, the parties enter this Memorandum of Understanding to mutually promote _____. Accordingly, (Your Organization) and (Partnering Organization) agree to the following:

II. PURPOSE AND SCOPE

Describe the intended results or effects that your organization and the partnering organization hope to achieve, and the area(s) that the specific activities will cover.

Answering the following questions may help you develop this section.

- Why are the organizations forming a collaboration? What are the benefits for the organization?
- Include issues of funding if necessary. For example: Each organization of this MOU is responsible for its own expenses related to this MOU. There will/will not be an exchange of funds between the parties for tasks associated with this MOU.

III. RESPONSIBILITIES

Each party will appoint a person to serve as the official contact and coordinate the activities of each organization in carrying out this MOU.

- List contact persons with address and telephone information.

The organizations agree to the following tasks for this MOU.

Your organization will:

- List tasks of your organization as bullet points

Partnering organization will:

- List tasks of partnering organization as bullet points

Your organization and Partnering organization will:

- List shared tasks as bullet points

IV. TERMS OF UNDERSTANDING

The term of this MOU is for a period of insert length of MOU, usually 1 to 3 years from the effective date of this agreement and may be extended upon written mutual agreement. It shall be reviewed at least insert how often, usually annually to ensure that it is fulfilling its purpose and to make any necessary revisions.

Either organization may terminate this MOU upon thirty (30) days written notice without penalties or liabilities.

V. AUTHORIZATION

The signing of this MOU is not a formal undertaking. It implies that the signatories will strive to reach, to the best of their ability, the objectives stated in the MOU.

On behalf of the organization I represent, I wish to sign this MOU and contribute to its further development.

Your organization

Name:
Title:
Organization:
Date:

Partnering organization

Name:
Title:
Organization:
Date:

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Appendix B: Situational Awareness

Accurate situational awareness is essential throughout the life cycle of an incident. After the initial efforts to gain situational awareness, an iterative information collection process continues to inform all aspects of action planning. This process includes the collection, analysis, and dissemination of information to assist operations and support functions in planning for the provision of support and resources. The main objective of situational awareness efforts is to build a common operating picture (COP) concerning the overall situation and to ensure the COP is provided to appropriate stakeholders to ensure a common understanding. To achieve this, leaders identify information requirements, timelines, and formats.

Organizations supporting the HDOH COVID-19 Vaccination Program will follow established policies and procedures as they have been developed and modified over time in responding to COVID-19 in Hawaii. That includes the use of situation reports, an incident action plan (IAP), WebEOC, and COVID-19 specific dashboards to share critical information with stakeholders.

For the COVID-19 vaccination effort, HDOH will use an information collection plan (ICP) to quickly gain awareness of both Essential Elements of Information (EEIs), as well as Critical Information Requirements (CIRs). Organizations will need to maintain situational awareness throughout each COVID-19 vaccination operations phase **(see Section 3: Concept of Operations)** to effectively respond to requests for information (RFIs), requests for assistance (RFAs), and to identify information to share with stakeholders.

A typical situational awareness process flow is shown in the figure below **(see Figure B-1: Situational Awareness)** that provides the basic steps needed to gain situational awareness during a typical shift (Note: not all personnel will need to maintain the same level of situational awareness. Staff with limited roles/responsibilities for their specific position will not need to review all of these materials). As personnel gain situational awareness, they continue to move through the sources of information to maintain situational awareness throughout the event and share information to improve response actions.[1]

Figure B-1: Situational Awareness

[1] Hawaii SNS Plan

Common Operating Picture/Data Dashboards

HDOH as the lead agency for State Emergency Support Function (SESF) #8 (Public Health and Medical Services) will coordinate with HI-EMA and other stakeholders to develop and maintain a Common Operating Picture (COP) for Hawaii in support of the COVID-19 Vaccination Program.

Staff will share and disseminate information to build a COP at all levels, including state and county emergency operations centers (EOCs), DHOs, activated Emergency Support Functions (ESFs), non-governmental organizations (NGOs), and the private sector. Reporting will be through formats established by HI-EMA/HDOH policies and Standard Operating Procedures (SOPs), county and state level Emergency Operations Plans (EOPs), as well as guidance from federal partners such as the CDC. For example, based on the CDC dashboards described below, HDOH will need to provide the following data:

Figure B-2: Sample Common Operating Picture

- Estimates of critical population categories, number and attributes of healthcare providers and facilities, number of enrolled healthcare providers (including which ones have completed their provider agreement section A and section B and have a VTrcks ID), status of COVID-19 vaccine supply and distribution, and COVID-19 administration locations.

CDC Dashboards

To provide situational awareness for jurisdictions and the general public throughout the COVID-19 vaccination response, CDC will have two dashboards available.[2] Both dashboards will include a view tailored for jurisdictions, available through Security Access Management Services (SAMS), and a view for the general public on CDC's website.

COMMON OPERATING PICTURE (COP)

A Common Operating Picture (COP) is the shared understanding of a situation based on the ability to see and use identical data. Possible sources of information to develop a COP include situation reports, messages (verbal/written) from stakeholders, GIS modeling and maps, county, state, and federal department/agency EOC products, incident action plans (IAPs), information from Vaccination Providers, imagery, and news/social

Figure B-3: Common Operating Picture

[2] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

Weekly Flu Vaccination Dashboard	COVID-19 Vaccination Response Dashboard
•Will include weekly estimates of influenza vaccination for adults, children, and pregnant women (when approved for these groups) using existing (National Immunization Survey [NIS]-Flu) and new (IQVIA) data sources. •Data and estimates from additional sources will be added, as available.	•Data for planning (e.g., estimates of critical population categories, number and attributes of healthcare providers and facilities) •Implementation data (e.g., number of enrolled COVID-19 vaccination providers, COVID-19 vaccine supply and distribution, COVID-19 vaccine administration locations) •COVID-19 vaccine administration data •The COVID-19 Vaccination Response Dashboard will be implemented in stages based on data availability and shareability.

Figure B-4: CDC Dashboards

Vaccine Program Monitoring

Pandemic vaccination planning and monitoring actions are combined state and local responsibilities that require close collaboration between public health, external agencies, and community partners. Counties will play a key role in carrying out the vaccination program. It is imperative that both state and county agencies and their planning partners clearly understand each other's roles and responsibilities as it relates to planning and monitoring the effectiveness of the Hawaii COVID-19 Vaccination Program.[3]

PROGRAM MONITORING REQUIREMENTS
HDOH provides oversight and program monitoring for all aspects of the COVID-19 Vaccination Program based on guidance and direction from the CDC.

Figure B-5: Program Monitoring Requirements

Planning and Coordination Team (Internal and External)

HDOH recognized the importance of establishing a COVID-19 Vaccination Program planning and coordination team to ensure the successful planning and execution of its vaccination efforts. In mid-September 2020, HDOH identified a wide array of expertise from across the state to participate as Core Planning Team members. Representatives include members from local, state, and federal agencies, as well as private sector and non-governmental organizations **(see Appendix A: Task Organization)**.

HDOH coordinated with team members and assigned responsibilities based on their individual expertise to best enhance plan development and to better enable monitoring activities and coordination before and during COVID-19 response efforts. To mitigate any unexpected situations affecting a team member, HDOH IMB asked each organization to identify a primary and a backup representative. HDOH will work with stakeholders to identify gaps and to fill any team member vacancies as early as possible.

COVID-19 Vaccination Program Implementation Committee (Internal and External)

HDOH established a COVID-19 Vaccination Program Implementation Committee to enhance development of plans, reach of activities, reporting, and risk/crisis response communication messaging and delivery. This group builds on the Core Planning Team and incorporates a number of additional stakeholders. These members will assist HDOH with reaching intended vaccine recipients by providing information about critical populations, identifying logistical requirements for providing them access to COVID-19 vaccination services, and supporting outreach efforts.

[3] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020, available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed October 8, 2020.

Committee membership includes leadership from a wide variety of local, state and federal agencies, as well as representatives from key COVID-19 vaccination providers for critical population groups identified by CDC, as well as representatives from other sectors within the community, such as those shown in **Table: B-1: Vaccination Providers Identified by CDC (see Appendix A: Task Organization for additional details on the composition of this committee).**

State-Local Coordination

- HDOH provides public health support throughout the state, and there are no local public health departments.
- HDOH maintains District Health Offices (DHOs) in the counties of Hawaii, Maui and Kauai staffed by HDOH employees (there is no corresponding DHO for the City and County of Honolulu).
- DHOs work closely with county officials on the Neighbor Islands, coordinating extensively through county emergency management agencies.
- HDOH coordinates with the City and County of Honolulu Department of Emergency Management through a liaison dedicated to providing support to DEM.
- HDOH staff to include DHOs will closely monitor activities at the local level to ensure adherence with federal guidance and requirements regarding the COVID-19 Vaccination Program. This will include monitoring for equitable access to COVID-19 vaccination. HDOH staff to include DHOs will work with counties as they develop plans and procedures in support of this plan.

Figure B-6: State-Local Coordination

Table B-1: Vaccination Providers Identified by CDC

Key COVID-19 vaccination providers for critical population groups identified by CDC	
Health systems and hospitals (including critical access hospitals for rural areas, in-patient psychiatric facilities)	Long-term care facilities (LTCFs): Includes nursing home, assisted living, independent living (e.g., intermediate care facilities for individuals with intellectual and developmental disabilities), skilled nursing facilities)
Organizations serving people with limited English proficiency	Businesses and occupational health organizations
Immunization coalitions	Health insurance issuers and plans
Pharmacies	Education agencies and providers
Correctional facilities	Organizations serving people with disabilities
Community health centers	Organizations serving racial and ethnic minority groups
Rural Health Clinics (RHCs)	Emergency management agencies
Religious leaders	Healthcare coalitions
Community representatives	Entities involved in COVID-19 testing center organization

If needed, HDOH can establish a Memorandum of Understanding (MOU) with stakeholders to document roles, responsibilities, and the level of support they can potentially provide **(see example MOU in Appendix A: Task Organization)**.

Additional Working Groups/Committees

In addition to the COVID-19 Vaccination Program Implementation Committee, HDOH established the following working groups committees **(see Appendix A: Task Organization for additional details on the composition of these working groups/committees)**. HDOH may establish ad hoc working groups/committees to support COVID-19 Vaccination Program efforts as needed.

Figure B-7: Additional COVID-19 Working Groups/Committees

Information Collection Plan

An information collection plan (ICP) provides a starting point for information collection in accordance with federal and state law through the life cycle of an incident and consists of predetermined Critical Information Requirements (CIRs) and Essential Elements of Information (EEI) that may be expanded or contracted to meet the information needs of COVID-19 Vaccination Program response efforts **(see Figure B-8: Information Collection Plan for a graphic representation of the ICP)**.

HDOH develops and maintains an ICP **(see Tab 1: Information Collection Plan Template)** in coordination with HI-EMA and other stakeholders and monitors the ICP within the HDOH DOC **(see Figure B-8: Information Collection Life-Cycle)**. The ICP identifies sources of information and organizations tasked to monitor and provide pertinent information to HDOH within a required time limit, in addition to the method or reporting that information.

Figure B-8: Information Collection Life-Cycle

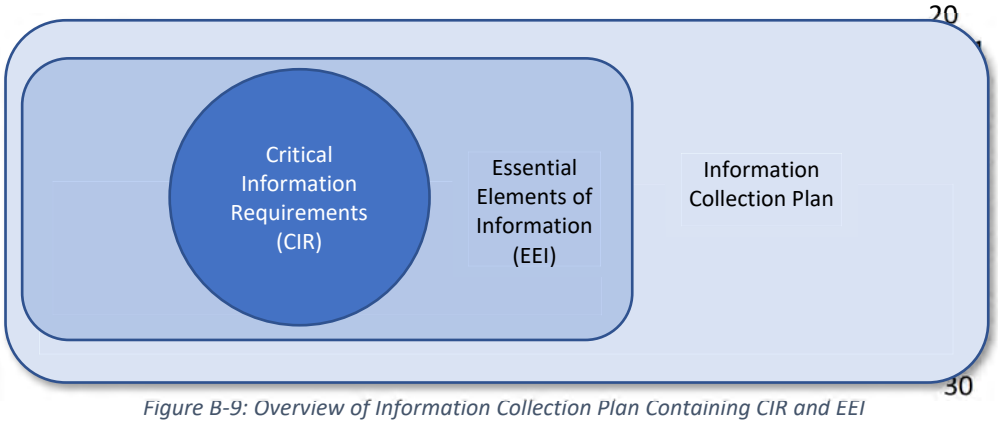

Figure B-9: Overview of Information Collection Plan Containing CIR and EEI

Critical Information Requirements

Critical Information Requirements (CIRs) are particular elements of information that senior leaders and incident managers specifically request. These items are of such importance that leaders are typically notified immediately when the Planning Section receives updates on a CIR item **(see Table B-2: Critical Information Requirements)**.

Essential Elements of Information

Essential Elements of Information (EEIs) are important and standard information items that senior leaders and incident managers need to make timely and informed decisions. EEIs also provide context and contribute to analysis and are most often included in situation reports **(see Table B-3: Essential Elements of Information)**.

Table B-2: Critical Information Requirements

CIR #	CIR	Specific Information Required	Proposed Methodology / Sources	Deliverables	Distribution
1	Death, serious injury, hospitalization of any member of staff supporting vaccination response efforts.	Who, what, when, where, why, how the incident occurred	Reports from organizations Media/Social Media	Situation Report Direct notification to senior leaders	Senior Leaders
2	Any incident involving vaccine program related transportation vehicles, equipment, or facilities that results in the loss or serious damage to that equipment or property.	Who, what, when, where, why, how the incident occurred	Reports from organizations Media/Social Media	Situation Report Direct notification to senior leaders	Senior Leaders
3	Casualties (deaths, serious injuries, and hospitalization) at a vaccination site.	Who, what, when, where, why, how the incident occurred	Reports from organizations Media/Social Media	Situation Report Direct notification to senior leaders	Senior Leaders
4	Degradation and restoration of critical Information Technology (IT)/communications systems/vaccine reporting systems critical to state-wide vaccination operations.	Who, what, when, where, why, how the incident occurred	Reports from organizations Media/Social Media Reports from HDOH IT Reports from ETS	Situation Report Direct notification to senior leaders	Senior Leaders
5	Activation and deactivation of county and agency EOCs due to an incident not related to ongoing vaccine operations (i.e. terrorist attack).	Who, what, when, where, why, how the incident occurred	Reports from organizations Media/Social Media State led VTC	Situation Report Direct notification to senior leaders	Senior Leaders
6	Degradation and restoration of critical infrastructure capabilities (power, water, transportation, supply chain, cyber, and communications affecting vaccine operations).	Who, what, when, where, why, how the incident occurred	Reports from organizations Media/Social Media State led VTC	Situation Report Direct notification to senior leaders	Senior Leaders
7	Immediate Request for Assistance from counties or other agencies that for life safety issue	Details on RFA	WebEOC Reports from organizations	Situation Report Direct notification to senior leaders	Senior Leaders
8	Any event, not captured above that could result in the loss of public trust/confidence, degradation of credibility and negative media coverage for the HDOH and the state.	Who, what, when, where, why, how the incident occurred	Reports from organizations Media/Social Media State led VTC	Situation Report Direct notification to senior leaders	Senior Leaders

NOTE: Columns may be added (i.e. Responsible Agency, Suspense Time, etc.) to meet organizational requirements.

Table B-3: Essential Elements of Information

EEI #	EEI	Specific Information Required	Proposed Methodology/ Sources	Deliverables	Distribution
1	Major changes or issues/activities/ Mission Assignments of ESFs/Other Federal Agencies (OFAs)	Who, what, when, where, why, how	WebEOC Reports from organizations	Situation Report	Planning Section Operations Section Senior Leaders
2	Resource shortfalls	Resource type/ Current Qty/ Remaining Qty/Qty Needed	WebEOC Reports from organizations	Situation Report WebEOC Updates	Operations Section Logistics Section
3	Status of key personnel	Key leader's absence Key staff absence	WebEOC Reports from organizations	Situation Report WebEOC Updates	Planning Section Operations Section
4	Safety hazards	Who, what, when, where, why, how	Reports from organizations	Situation Report Direct reporting	Planning Section Operations Section Senior Leaders
5	Status of vaccine related transportation assets	Who, what, when, where, why, how	Reports from organizations	Situation Report Direct reporting	Operations Section Logistics Section
6	Status of COVID-19 administration locations	# Open/# Closed/# Out of Operation/ Expected date/time of return to operational status	Reports from organizations	Situation Report Direct reporting Dashboards Vaccine Finder Website	Planning Section Operations Section
7	Estimates of critical population receiving vaccine	Data elements required by CDC – **see Appendix D: Logistics**	HIR; Reports from Vaccination Providers	Updates to HIR and CDC systems	Planning Section Operations Section Senior Leaders
8	Number and attributes of healthcare providers and facilities	Data elements required by CDC – **see Appendix D: Logistics**	HIR; Reports from Vaccination Providers	Situation Report Direct reporting Dashboards Vaccine Finder Website	Planning Section Operations Section Senior Leaders
9	Number of enrolled healthcare providers	Including which ones have completed their provider agreement section A and section B and have a VTrcks ID	HIR; Reports from Vaccination Providers	Situation Report Direct reporting Dashboards Vaccine Finder Website	Planning Section Operations Section Senior Leaders
10	Status of COVID-19 vaccine supply and distribution operations	Red, Yellow, Green Status (Criteria to be defined by leaders)	HIR; Reports from Vaccination Providers	Situation Report Direct reporting Dashboards Vaccine Finder Website	Planning Section Operations Section Senior Leaders

NOTE: Columns may be added (i.e. Responsible Agency, Suspense Time, etc.) to meet organizational requirements. For example, Situation Reports could be required daily or weekly. This will be described in the Incident Action Plan (IAP) when it is published for each operational period.

Situation Reporting Guidance

During COVID-19 Vaccination operations DHOs on neighbor islands and the DEM HDOH LNO will coordinate the collection of information to support reporting efforts. Each DHO and the DEM HDOH LNO will submit input for situation reports as designated by the HDOH DOC in the IAP. The HDOH DOC Planning Section Chief or their designee will compile information into a comprehensive COVID-19 situation report. The HDOH DOC will disseminate situation reports to the Director, Deputies, Departmental Executive Committee members, partnering emergency management agencies, and other stakeholders.

Information Sharing

HDOH will attempt to support the widest dissemination of information through the use of standing and ad hoc committees and working groups such as the Vaccination Program Implementation Committee. Through regular information sharing HDOH will maintain transparency for its COVID-19 Vaccination Program efforts.

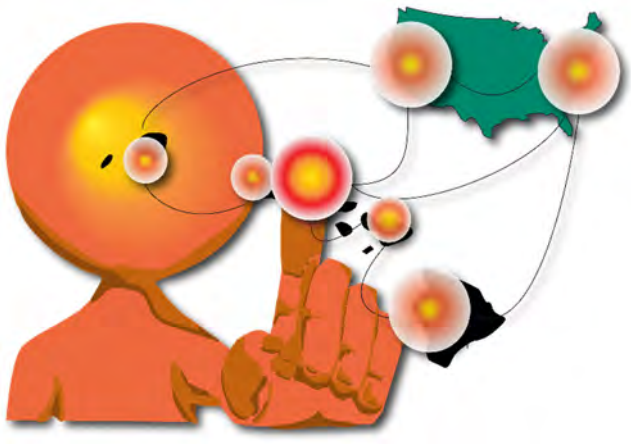

Figure B-10: Information Sharing

Microsoft Teams

HDOH will primarily use Microsoft Teams (MS Teams) to share information via a common web-based portal with stakeholders. MS Teams provides features such as document collaboration, one-on-one chat, team chat, and video conferencing support.

NOTE: Currently Hawaii only allows other State of Hawaii (SOH) email addresses (i.e. *@hawaii.gov, *@doh.hawaii.gov, *@dps.hawaii.gov, etc.) to be added as members to the HDOH MS Teams site.

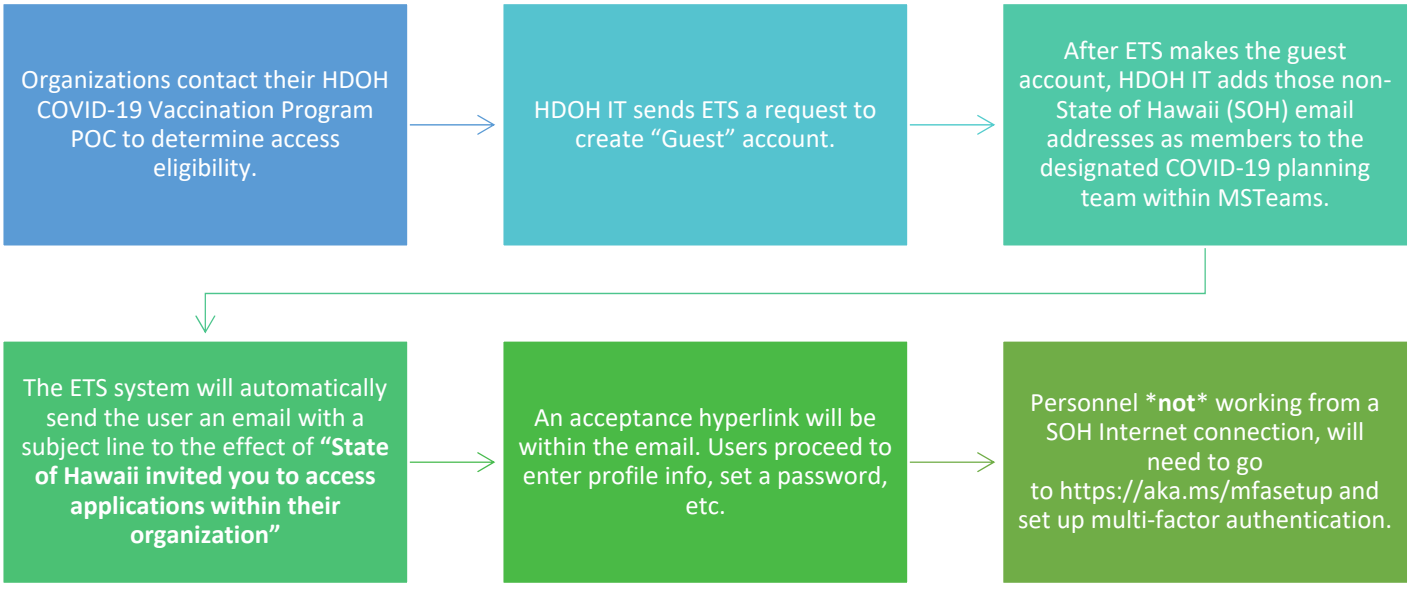

Figure B-11: Procedures to Request Access to MS Teams

WebEOC

WebEOC[4] is the primary information management system used by HI-EMA to coordinate response efforts. State and local agencies along with select stakeholders have access to the system. This includes state agencies with lead and

[4] https://webeoc.dod.hawaii.gov/

supporting State Emergency Support Function (SESF) roles. WebEOC includes status reporting, incident library, status boards, contact lists and request for information (RFI)/request for assistance (RFA) boards.

Websites

Organizational websites[5] are one of the primary information sharing tools used to immediately connect with external audiences. Staff supporting COVID-19 Vaccination Program efforts should ensure they have clear procedures in place for updating relevant websites (especially outside of regular work hours).

Email Notification Systems

The COVID-19 Vaccination Program will develop and maintain distribution lists to rapidly share information with appropriate stakeholders.

Text Messaging

HDOH maintains several systems that provide the opportunity for the COVID-19 Vaccination Program to send text messages to appropriate audiences. This includes the Hawaii Health Alert Network (HHAN) and HIR **(see Section 5.3 for additional details on HHAN and Appendix D: Logistics for additional information on HIR)**.

Social Media

The COVID-19 Communications Working Group will develop procedures to monitor and share information through social media. Established and widespread social media networks allow for the dissemination of data-rich, contextual multimedia including narrative, photos, and videos with media outlets, businesses, employees, and members of the public to provide situational awareness to with timely, geographic-based information.

News Media

The COVID-19 Communications Working Group will work through established procedures with the COVID-19 JIC to share information with the news media.

Figure B-12: Social Media

Information Security

COVID-19 Vaccination Program will comply with HDOH information security practices to include HIPAA requirements.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The US Department of Health and Human Services (HHS) issued the HIPAA Privacy Rule to implement the requirements of HIPAA. The HIPAA Security Rule protects a subset of information covered by the Privacy Rule.

INFORMATION SECURITY

Organizations must use the most secure and appropriate communication means available and observe information security practices when communicating sensitive vaccine related messages.

Figure B-13: Information Security

[5] https://health.hawaii.gov/coronavirusdisease2019/

HIPAA Lessons Learned from Previous Events:

- Consult with legal advisors regarding HIPAA throughout the planning process.
- Place dividers between vaccination or screening stations to avoid HIPPA violations.
- Maintain a copy of the HIPAA policy on-hand at each vaccination location.
- Ensure staff receive JITT HIPAA training prior to conducting vaccination operations.
- Ensure HIPAA policies are maintained in various languages.
- HIPPA guidance may be accessed at:
  - HIPAA Guidance. https://www.fbi.gov/file-repository/hipaa-guide.pdf/view
  - Information on the ways that covered entities and business associates may share protected health information under the HIPAA Privacy Rule during a public health emergency. https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf[6]
  - Civil Rights, HIPAA, and the Coronavirus Disease 2019 . https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf[7]
- All vaccination program staff handling data must complete a HIPAA Patient Confidentiality Statement.[8 and 9]

Figure B-14: HIPAA

HIPAA and Cybersecurity:

The HIPAA Security Information Series is a group of educational papers which are designed to give HIPAA covered entities insight into the Security Rule and assistance with implementation of the security standards.

See the following links for additional information:

- Cyber Security Guidance Material.https://www.hhs.gov/hipaa/for-professionals/security/guidance/cybersecurity/index.html
- Security Rule Guidance Material. https://www.hhs.gov/hipaa/for-professionals/security/guidance/index.html

[6] February 2020 Office for Civil Rights, U.S. Department of Health and Human Services BULLETIN: HIPAA Privacy and Novel Coronavirus, https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf, accessed on September 30, 2020.

[7] BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19), https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf?fbclid=IwAR351WokrC2uQLIPxDR0eiAizAQ8Q-XwhBt_0asYiXi91XW4rnAKW8kxcog, accessed on September 30, 2020.

[8] SNS_Mass_Prophy_Planning_Guide_2_2

[9] HI MRC Policy and Procedure Manual_2014

Tab 1: Information Collection Plan Template

Table B-4: Information Collection Plan Template

Information Collection	Data to be Collected	Collection POC/ Section	Source of Data	Provider POC/ Section	Collection Method	Data Point	Data Storage	Data Usage Comment
Example - Vaccine Doses	COVID-19 Doses Administered	Planning Section (Person's Name)	HIR	IMB	HIR	Number of doses administered by county	HIR	Information to be provided in IAP and COVID-19 dashboard(s).

Appendix C: Critical Populations

The end state of HDOH's COVID-19 Vaccination Plan is to maximize societal benefit by reducing morbidity and mortality caused by transmission of the novel coronavirus. The purpose of this section of the plan is to describe critical populations of focus for COVID-19 vaccination that will ensure equity in access to COVID-19 vaccination availability within the state of Hawaii to achieve that end state. The methodology used to develop the approach that Hawaii will follow is based on the work of the National Academies of Sciences, Engineering, and Medicine (NASEM) which published the "*Framework for Equitable Allocation of COVID-19 Vaccine" on October 2, 2020*".[1]

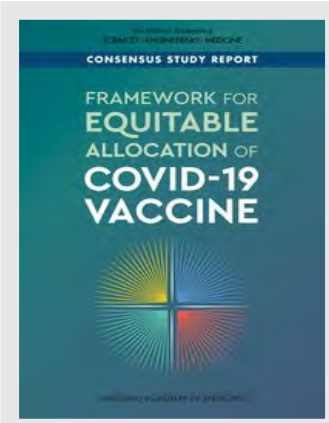

Figure C-1: Framework for Equitable Allocation of COVID-19 Vaccine

The Immunization Branch (IMB) of the Disease Outbreak Control Division (DOCD) of HDOH leads the management of vaccination policy. HDOH will use a COVID-19 Vaccine Prioritization/Allocation Working Group, as well as a COVID-19 Vaccine Medical Advisory Working Group **(see Appendix A: Task Organization for additional details)** to support prioritization/allocation efforts, especially in Phase 1 of this plan when vaccine supply will potentially be severely limited. For example, the COVID-19 Medical Advisory Working Group will review evidence on COVID-19 epidemiology and disease burden within the state as well as safety data on COVID-19 vaccine(s), vaccine efficacy, evidence quality, and potential implementation issues to provide recommendations to support the COVID-19 Vaccine Prioritization/Allocation Working Group's efforts.[2]

One of the most important efforts within this plan is to initially identify and estimate sizes of critical populations in each county in Hawaii, particularly those that could receive first available doses of vaccine(s), and other populations that may require special consideration for distribution and expanded access. This section will address critical populations and describe how the COVID-19 Vaccine Prioritization/Allocation Working Group will identify where these populations live within the state to include places of employment as appropriate for logistical planning purposes.

EXAMPLES OF CRITICAL POPULATIONS

- **Critical infrastructure/critical workers in high risk settings** (e.g., health care, homeland and national security, public safety, education, food, and agriculture workers)
- **People at increased risk for severe illness** (e.g., persons ≥65 years of age, people with underlying medical conditions that are risk factors for severe COVID-19, long-term care/ assisted living facility residents, and people from racial and ethnic minority populations)
- **People living in group settings** (e.g., people who are incarcerated/detained, experiencing homelessness or living in shelters, attending colleges/universities)
- **People with limited access to vaccination services** (e.g., rural communities, individuals with disabilities, under- or uninsured people)

Figure C-2: Examples of Critical Populations

[1] https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus

[2] Covid-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

As noted in the *Framework for Equitable Allocation of COVID-19 Vaccine*, "*Current evidence has shown how COVID-19 disproportionately affects particular racial and ethnic minority groups, including Black, Hispanic or Latinx, American Indian and Alaska Native, and* ***Native Hawaiian and Pacific Islander communities*** [emphasis added]."

The framework also notes that *"COVID-19 has also disproportionately affected members of other groups. In particular, older adults are extremely vulnerable to severe outcomes and death due to COVID- 19; people aged 65 and older represent 8 out of every 10 reported deaths due to COVID-19 in the United States* **(See Tab 1 at the end of this section below)**."[3] The COVID-19 Vaccine Prioritization/Allocation Working Group will take these factors into account in its allocation efforts. The table below only includes data retrieved prior to the publishing of this plan. The COVID-19 Vaccine Prioritization/Allocation Working Group will update information within the plan as applicable as it becomes available, and/or maintain this information separately to include the impact of COVID-19 by ethnicity (**See Figure C-3**).

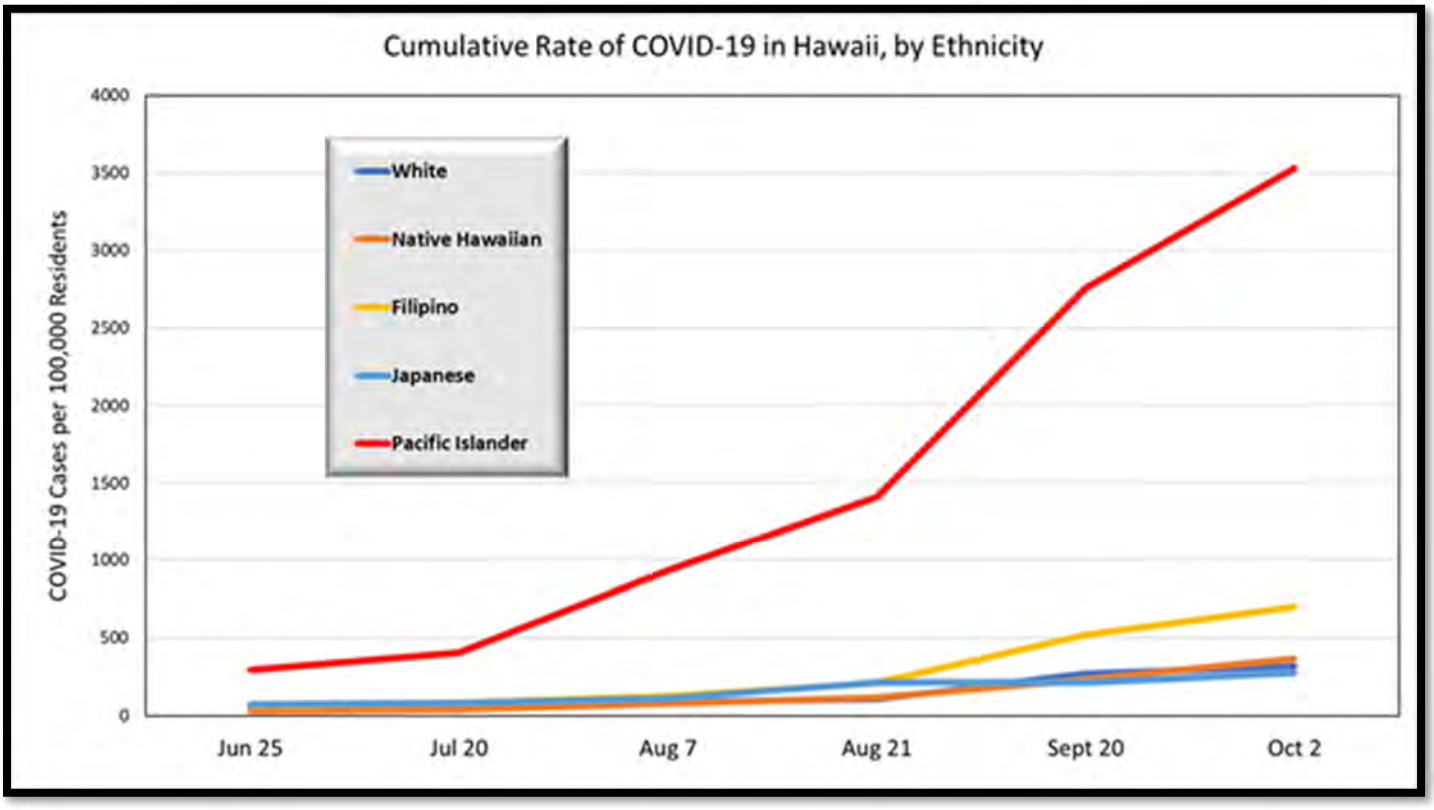

Figure C-3: Cumulative Rate of COVID-19 in Hawaii, by Ethnicity

[3] National Academies: A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus, available at: https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus, accessed October 8, 2020.

In addition, the COVID-19 Vaccine Prioritization/Allocation Working Group will need to address a number of scenarios based on the current uncertainty surrounding COVID-19 vaccines as shown in **Table C-1** below (adapted from the NASEM framework).[4]

Table C-1: Impact of Scenarios on Allocation Framework

Scenario	Change in Allocation Framework
Number and Timing of Vaccine Doses	
Fewer vaccine courses available than expected by Operation Warp Speed	Allocation framework is unchanged. Some individuals receive vaccination later than they would otherwise.
Vaccine requires two doses, rather than one	Allocation framework is unchanged, but some individuals receive vaccination later. Vaccination should use strategies and systems (e.g., use of established providers or use of federally qualified health centers) to ensure continuity of care between the first and second dose. Both doses would need to be the same type of vaccine, so this would complicate the second dose if several types are available.
Vaccine Efficacy	
Low vaccine efficacy among older adults or other population subgroup	Only allocate to this population subgroup if vaccine benefits outweigh the risks.
Vaccine Safety	
Unanticipated vaccine side effects	Continuously monitor vaccine safety as the vaccine is rolled out. Only allocate to individuals for whom vaccine benefits outweigh the risks.
Significant vaccine side effects among older adults or other population subgroups	Continuously monitor vaccine safety as the vaccine is rolled out. Only allocate to this population subgroup if vaccine benefits outweigh the risks.
Vaccine Uptake	
Vaccine uptake is lower than expected	Allocation framework is unchanged. The communication campaign accompanying the vaccine must outline the risks and benefits of the vaccine in a factual way that members of the population can understand.
Number of Vaccine Types	
More than one vaccine type available	Allocation framework is unchanged, but which vaccines are allocated to which population groups must take into account the benefits and harms of the vaccine for each population group.
Epidemic Conditions and Immune Status	
Epidemic spread is continuing across much of the United States when the vaccine becomes available	Allocation framework is unchanged. Public health messages must continue to stress the need for personal protective measures (e.g., masks, social distancing).
Epidemic is spreading most rapidly in particular hot spots when the vaccine becomes available	A certain fraction of vaccine courses (e.g., 10 percent) is reserved for vaccinating individuals in hot spots. Public health messages must continue to stress the need for personal protective measures (e.g., masks, social distancing).
Vaccine Distribution and Administration	
States are required to follow federal guidelines for vaccine allocation	Allocation framework is unchanged.
States have some leeway in the extent to which they follow federal guidelines for vaccine allocation	States adapt the allocation framework to their needs (e.g., they may set aside a certain number of doses for particularly vulnerable populations in their state).
Social, Economic, and Legal Contexts	
Some employers require proof of vaccination	Allocation framework is unchanged, but such requirements could change rates of vaccine uptake, and would pose hazards for those individuals for whom the vaccine is medically contraindicated and could raise issues around discrimination against those unable to obtain the vaccine and therefore unable to work.
Some states do not provide free vaccine access to people without documentation of legal status	Allocation framework is unchanged. Other sources of financial support (e.g., philanthropy, health systems, pharmaceutical companies) should be sought to provide vaccination for those individuals.

[4] National Academies: A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus, available at: https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus, accessed October 8, 2020.

The COVID-19 Vaccine Prioritization/Allocation Working Group will adhere to the guiding principles noted below in **Figure C-4** for allocating scarce medical resources during the COVID-19 Pandemic.[5]

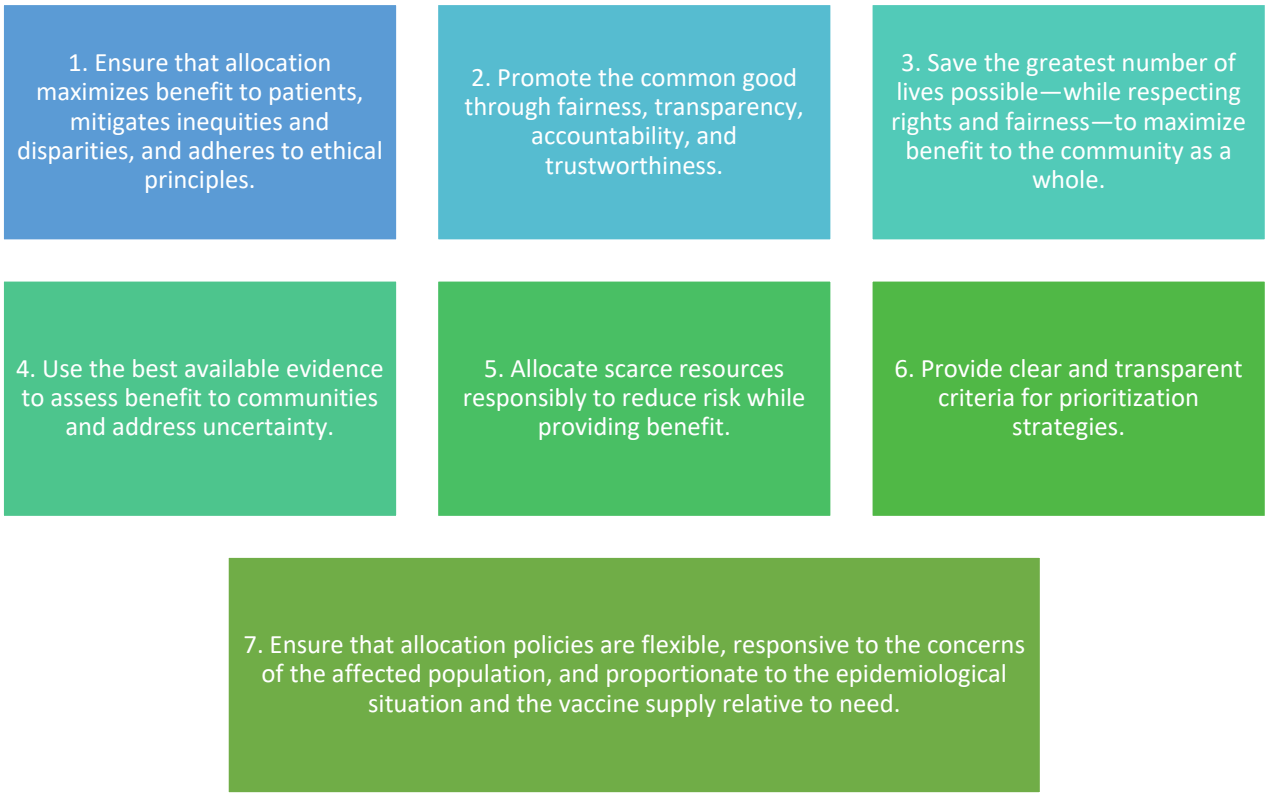

Figure C-4: Risk-Based Criteria for Vaccine Distribution

And the COVID-19 Vaccine Prioritization/Allocation Working Group will use Risk-Based Criteria for Vaccine Distribution as shown in **Figure C-5** below:

Criteria 1: Risk of acquiring infection	Criteria 2: Risk of severe morbidity and mortality	Criteria 3: Risk of negative societal impact	Criteria 4: Risk of transmitting infection to others
•Individuals have higher priority to the extent that they have a greater probability of being in settings where SARS-CoV-2 is circulating and of being exposed to a sufficient dose of the virus.	•Individuals have higher priority to the extent that they have a greater probability of severe disease or death if they acquire infection.	•Individuals have higher priority to the extent that societal function and other individuals' lives and livelihood depend on them directly and would be imperiled if they fell ill.	•Individuals have higher priority to the extent that there is a higher probability of their transmitting the infection to others.

Figure C-5: Allocating Scarce Medical Resources During the COVID-19 Pandemic

In order to use these criteria for prioritization/allocation decisions, the working group will apply these criteria to specific population groups across "Allocation Stages" (NOTE: Previous CDC criteria used the term "Tiers" to prioritize population groups (according to the NASEM's framework, within each allocation stage, all groups have

[5] National Academies: A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus, available at: https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus, accessed October 8, 2020.

equal priority). In addition, the framework recommends using the term "critical workers in high-risk settings" not "essential workers". According to the framework, access to COVID-19 vaccine should not be defined by professional title, but rather by an individual's actual risk of exposure to COVID-19. **See examples in Table C-2 below**, along with risk criteria and mitigating factors to consider when identifying risk to specific groups[6]:

Table C-2: Applying the Allocation Criteria to Specific Population Groups Using Allocation Stages

Allocation Stages	Population Group	Criterion 1: Risk of Acquiring Infection	Criterion 2: Risk of Severe Morbidity and Mortality	Criterion 3: Risk of Negative Societal Impact	Criterion 4: Risk of Transmitting Infection to Others	Mitigating Factors for Consideration
Stage 1a	High-risk health workers	H	M	H	H	Adequate access to personal protective equipment. Workplace management of exposure.
Stage 1a	First responders	H	M	H	H	Adequate access to personal protective equipment. Workplace management of exposure.
Stage 1b	People with significant comorbid conditions (defined as having two or more)	M	H	M	M	Ability to maintain social distance and isolate.
Stage 1b	Older adults in congregate or overcrowded settings	H	H	L	M	Effective institutional management of exposure.
Stage 2	K–12 teachers and school staff and childcare workers	H	M	H	H	Online schooling, especially for lower grades, recognizing educational and social impacts.
Stage 2	Critical workers in high-risk settings	H	M	H	M	Adequate access to personal protective equipment. Workplace management of exposure.
Stage 2	People of all ages with moderate comorbid conditions	M	M	M	M	Ability to maintain social distance and isolate.
Stage 2	People in homeless shelters or group homes and staff	H	H	L	H	Adequate access to personal protective equipment. Effective institutional/ workplace management of exposure.
Stage 2	Incarcerated/ detained people and staff	H	M	L	H	Adequate access to personal protective equipment. Effective institutional/workplace management of exposure.
Stage 2	All older adults not included in Stage 1	M	H	L	L	Ability to maintain social distance and isolate.
Stage 3	Young adults (18-24)	H	L	M	H	Ability to maintain social distance and isolate. Closure of congregate settings (e.g., bars).
Stage 3	Children (0-17)	M	L	M	H	Ability to participate in online schooling.
Stage 3	Workers in industries important to the functioning of society and at increased risk of exposure not included in Stages 1 or 2.	M	M	M	M	Adequate access to personal protective equipment. Effective institutional/workplace management of exposure.
Stage 4	Everyone residing in Hawaii who did not have access to the vaccine previously	**L**	**L**	**L**	**L**	Ability to maintain social distance and isolate.

NOTE: When individuals within a group fall into multiple allocation stages, the higher stage should take precedent.

[6] National Academies: A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus, available at: https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus, accessed October 8, 2020.

Vaccine Allocation Process

A key point to consider is that vaccine supply will be limited in Phase 1 (as described in Section 3 – Concept of Operations). It is important to note that recommendations on the various population groups to receive initial doses of vaccine could change after vaccine(s) are available, depending on each vaccine's characteristics, vaccine supply, disease epidemiology, and local community factors.[7] And, the duration of each phase is uncertain. As noted previously, HDOH will convene a Vaccine Prioritization/Allocation Working Group that will recommend modifications and adjustments to allocation decisions for each phase of operations **(see Figure C-6: Vaccine Allocation Process)**.

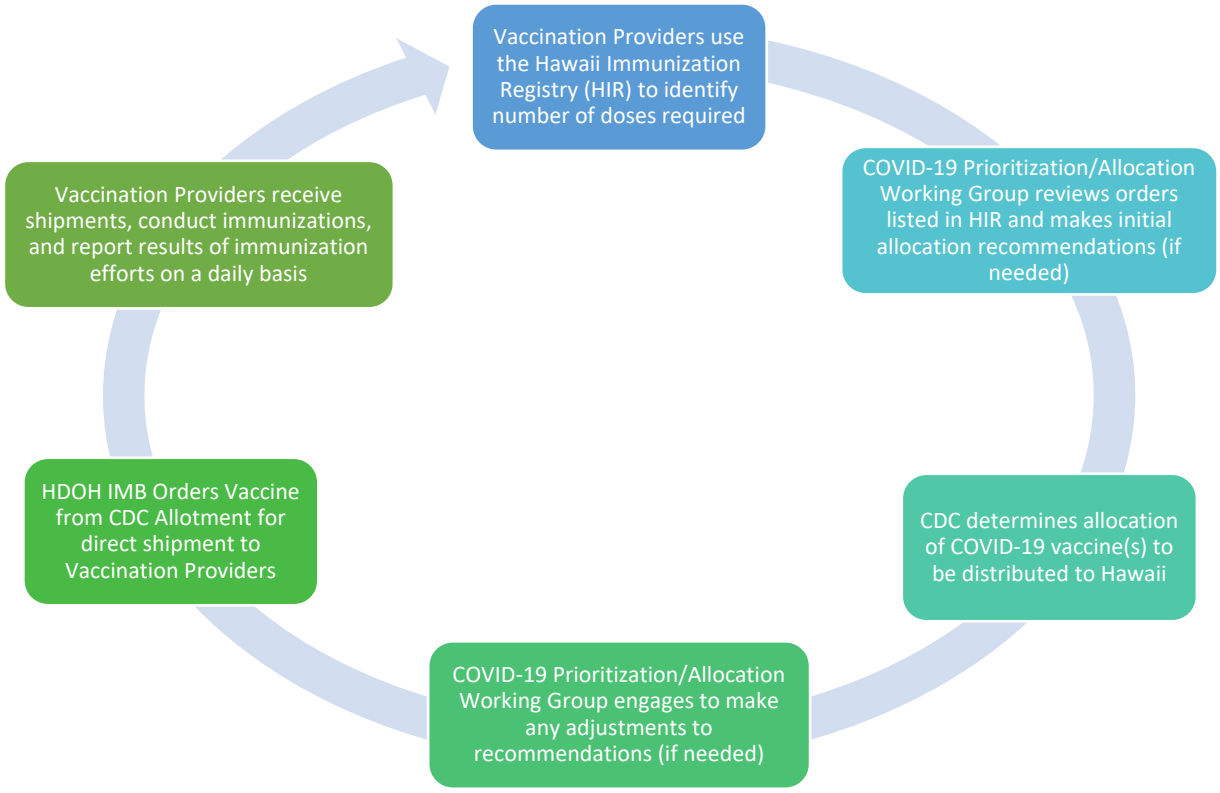

Figure C-6: Vaccine Allocation Process

[7] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

Vaccine Priority Groups by Allocation Stage

Critical Population Groups - Initial Estimates

The COVID-19 Core Planning Team will continue to refine population estimates and maintain the latest population estimates and planning scenarios on the project MS Teams site, as well as through other tools as they become available. For example, there is a tool called Tiberius[8] (**see Figure C-7**) being developed through Operation Warp Speed (OWS) that could provide the ability to gather and incorporate data regarding critical populations from multiple streams such as Census data, Biomedical Advanced Research and Development Authority (BARDA) data and Cybersecurity and Infrastructure Security Agency (CISA) data.[9]

The tables below show initial estimates state-wide (**see Table C-3**), as well as in each county (**see Tables C-4 to C-8**). HDOH will continue to validate, modify, and add data to sections of these tables that are currently blank as appropriate. For example, some data sources provide conflicting information that HDOH will need to resolve as additional data becomes available. HDOH will engage with counties to develop supporting plans and procedures as necessary to effectively and efficiently reach the critical populations identified in the tables below.

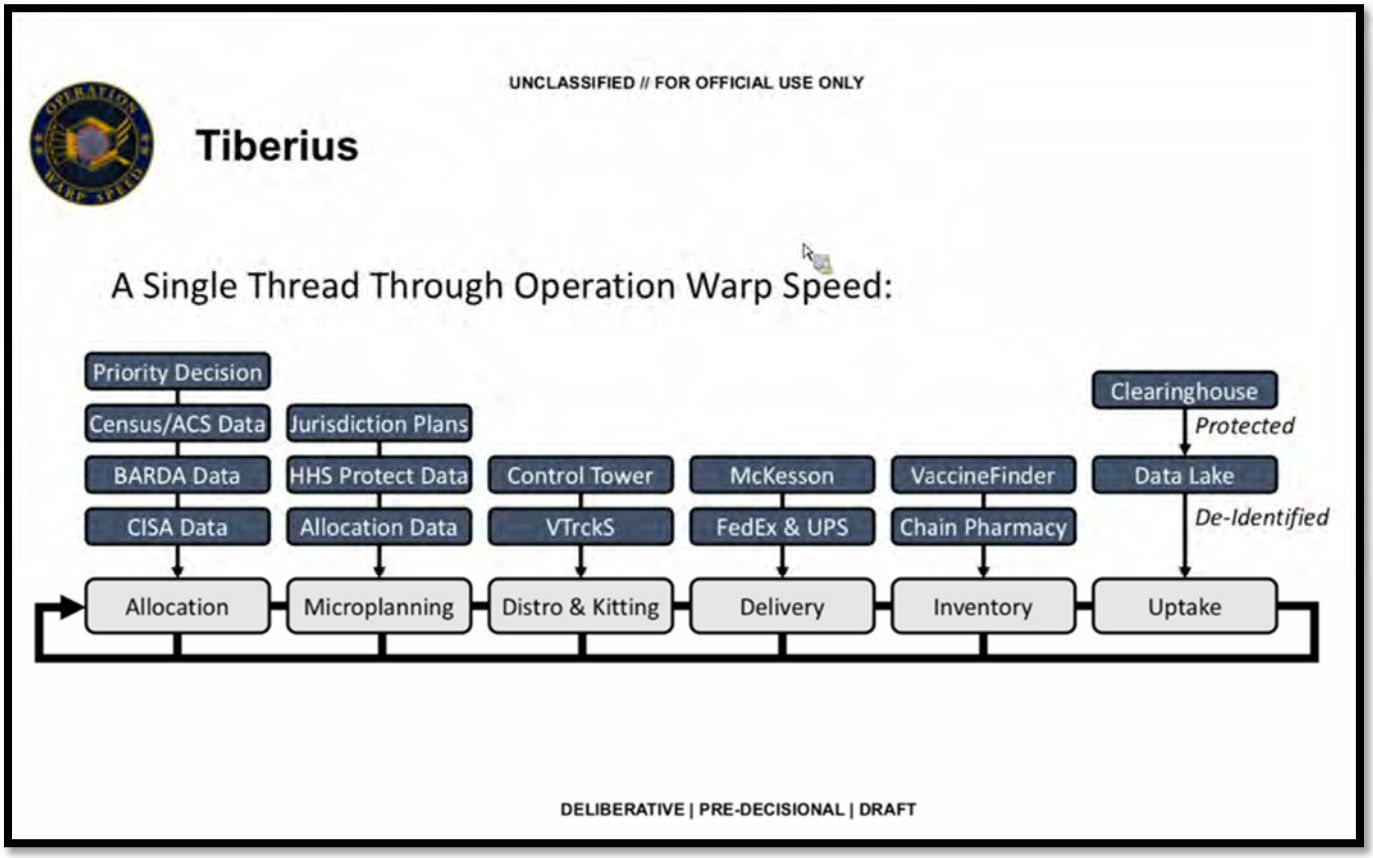

Figure C-7: Overview of Tiberius Software Tool

[8] CDC Vaccine Planning Webinar 10/07/20

[9] https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-09/COVID-04-Messonnier.pdf, accessed October 9, 2020.

State of Hawaii

Table C-3: Critical Population Groups – Initial Estimates – State of Hawaii

Allocation Stage	Population Group Description	Approximate number in group
Stage 1a	High-risk health workers (e.g., in hospitals or nursing homes, or providing home care)—these health professionals are involved in direct patient care. Also included are workers who provide transportation, environmental services, and other health care facility services and who risk exposure to bodily fluids or aerosols.	35,000[10]
	First responders whose jobs put them at high risk of exposure to COVID-19	11,000[11]
Stage 1b	People of all ages with comorbid and underlying conditions that put them at significantly higher risk (defined as having two or more)	40,000[12]
	Adults aged 65 and older living in congregate or overcrowded settings	35,000[13]
Stage 2	K-12 teachers and school staff	22,000[14]
	Critical risk workers in high-risk settings - workers who are both in industries essential to the functioning of society and at substantially high risk of exposure, (i.e. healthcare workers and healthcare students)	35,000[15]
	People of all ages with comorbid and underlying conditions that put them at moderately higher risk	240,000[16]
	People in homeless shelters or group homes for individuals with physical or mental disabilities or in recovery and staff who work in those facilities	11,000[17]
	People in prisons, jails, detention centers, and similar facilities, and staff who work in such settings	5,000[18] [19]
	Adults aged 65 and older not included in Allocation Stage 1	136,500[20]
Stage 3	Young Adults (18-24)[21]	88,900
	Children (0-17)[22]	214,200
	Workers in industries and occupations important to the functioning of society and at increased risk of exposure not included in Allocation Stages 1 or 2	100,000
Stage 4	Everyone residing in Hawaii who did not have access to the vaccine in previous allocation stages	TBD

Estimated group sizes across allocation stages are not cumulative, and there is overlap between the group estimates shown. When individuals within a group fall into multiple stages, the higher stage should take precedent. NOTE: The NASEM framework did not include pregnant women in the allocation stages, or infants <1 year of age due to uncertainty concerning vaccine testing on those groups. As noted previously, allocation decisions could change dramatically when vaccine efficacy data is available for specific population groups.

[10] https://cca.hawaii.gov/pvl/files/2020/08/WebGeo_072820.pdf: NOTE: Based on assumption of 70% of 50,000 in this category
[11] NOTE: Based on assumption of 70% of 15,000 in this category
[12] NOTE: Based on assumption of 121,000 initial doses for Stages 1a, 1b. This category would use the remaining doses.
[13] NOTE: Based on assumption of 70% of 50,000 in this category
[14] http://www.hawaiipublicschools.org/ConnectWithUs/Employment/JobOpportunities/Pages/home.aspx
[15] NOTE: Based on assumption of 70% of 50,000 in this category
[16] county_pop2018_18 and older: NOTE: assumes 70% of approx. 400,000 in this category = 280,000 – 40,000 (Stage 1b) = 240,000
[17] NOTE: Based on assumption of 70% of people in homeless shelters/group homes and staff (10,000 people/6,000 staff in 2,000 facilities).
[18] http://dps.hawaii.gov/about/divisions/corrections/ NOTE: 2979 (prisoners)
[19] https://dps.hawaii.gov/wp-content/uploads/2019/11/PSD-ANNUAL-REPORT-2019.pdf NOTE: 256 (staff)
[20] NOTE: Based on assumption of 70% of 195,000 in this category
[21] ACS popln age 18-24 Hawaii 2014-2018: NOTE: Based on assumption of 70% in this category of 127,000
[22] ACS 2014-2018: NOTE: Based on assumption of 70% in this category of 306,000

Table C-4: Critical Population Groups – Initial Estimates – State of Hawaii – Stage 1a

	Population Group	Hawaii County	Maui[23]	Molokai	Lanai	City and County of Honolulu	Kauai County	Total[24]
Stage 1a	**High-risk health workers**	3,906	5,240	TBD	TBD	23,327	2,195	35,000
	First responders	TBD	TBD	TBD	TBD	TBD	TBD	11,000
	Stage 1a Total	TBD	TBD	TBD	TBD	TBD	TBD	**46,000**

Table C-5: Critical Population Groups – Initial Estimates – State of Hawaii – Stage 1b

	Population Group	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total
Stage 1b	People with significant comorbid conditions (defined as having two or more)	TBD	TBD	TBD	TBD	TBD	TBD	40,000
	Adults aged 65 and older living in congregate or overcrowded settings	TBD	TBD	TBD	TBD	TBD	TBD	35,000
	Stage 1b Total	TBD	TBD	TBD	TBD	TBD	TBD	**75,000**

Table C-6: Critical Population Groups – Initial Estimates – State of Hawaii – Stage 2

	Population Group	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total
Stage 2	K-12 teachers and school staff	TBD	TBD	TBD	TBD	TBD	TBD	22,000
	Critical workers in high-risk settings	TBD	TBD	TBD	TBD	TBD	TBD	35,000
	People of all ages with comorbid and underlying conditions that put them at moderately higher risk	TBD	TBD	TBD	TBD	TBD	TBD	240,000
	People in homeless shelters or group homes for individuals with physical or mental disabilities or in recovery and staff who work in those facilities	1,594[25]	1,578			2,720[26]	848	6,740
	People in prisons, jails, detention centers, and similar facilities, and staff who work in such settings	671	441			5,570	256	7,000[27]
	Adults aged 65 and older not included in Allocation Stage 1	TBD	TBD	TBD	TBD	TBD	TBD	136,500
	Stage 2 Total	TBD	TBD	TBD	TBD	TBD	TBD	**425,240**

[23] NOTE: Data for Molokai and Lanai are included in Maui at this time.
[24] The DCCA GeoMap shows the number of current licenses by license type, by island, and by type of entity. State and County workforce estimates 9 29 2020.1
[25] https://www.btghawaii.org/media/uploads/2020_btg_pit_count_report_final_-_5.6.20.pdf
[26] https://files.hudexchange.info/reports/published/CoC_Dash_CoC_HI-501-2019_HI_2019.pdf
[27] Input from DPS – includes all of DPS

Table C-7: Critical Population Groups – Initial Estimates – State of Hawaii – Stage 3

	Population Group	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total
Stage 3	Young adults (18-24)	14,749	10,393	1,077	88	95,902	4,950	127,161
	Children (0-17)	43,220	34,318	1,691	508	211,029	15,731	306,501
	Workers in industries important to the functioning of society and at increased risk of exposure not included in Stages 1 or 2.	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Stage 3 Total	TBD	TBD	TBD	TBD	TBD	TBD	**TBD**

Table C-8: Critical Population Groups – Initial Estimates – State of Hawaii – Stage 4

	Population Group	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total
Stage 4	Everyone residing in Hawaii who did not have access to the vaccine previously	TBD	TBD	TBD	TBD	TBD	TBD	TBD

Example Summary Table of County Level Data

HDOH will continue to refine population estimates and maintain the latest population estimates in MS Teams with data specific to each county such as depicted below in **Table C-9**.

Table C-9: Critical Population Groups – Initial Estimates by County/Island

Allocation Stage	Population Group	Hawaii County
Stage 1a	High-risk health workers	TBD
	First responders whose jobs put them at high risk of exposure to COVID-19	TBD
Stage 1b	People of all ages with comorbid and underlying conditions that put them at significantly higher risk	TBD
	Adults aged 65 and older living in congregate or overcrowded settings	TBD
Stage 2	K-12 teachers and school staff	TBD
	Critical risk workers in high-risk settings - workers who are both in industries essential to the functioning of society and at substantially high risk of exposure	TBD
	People of all ages with comorbid and underlying conditions that put them at moderately higher risk	TBD
	People in homeless shelters or group homes for individuals with physical or mental disabilities or in recovery and staff who work in those facilities	TBD
	People in prisons, jails, detention centers, and similar facilities, and staff who work in such settings	TBD
	Adults aged 65 and older not included in Allocation Stage 1	TBD
Stage 3	Young Adults (18-22)	TBD
	Children (0-17)	TBD
	Workers in industries and occupations important to the functioning of society and at increased risk of exposure not included in Allocation Stages 1 or 2	TBD
Stage 4	Everyone residing in Hawaii who did not have access to the vaccine in previous allocation stages	TBD
	Total	TBD

Supporting Data for Critical Population Groups

Table C- 10: Data for Stages 1a - High-risk health workers

Population Group	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total
Physician (MD/DO)	535	472			3,870	203	5,080
Pharmacist	166	119			1,100	70	1,455
Physician's Assistant	38	52			183	14	287
Licensed Practical Nurse	261	248			910	110	1,529
Registered Nurse	1,880	1,605			11,800	750	15,285
Advanced Practice Registered Nurse	144	95			941	46	1,226
Nurse Aide	770	-			4,130	240	5,140
Medical Assistant	70	2,320			320	440	3,150
Support Staff[28]							
*Student LPN	10	10			25	25	70
*Student ADN	53	70			107	25	255
*Student BSN	97	0			702	0	799
*Student GEPN	0	0			130	0	130
*Student MSN	0	0			54	0	54
*Student DNP	34	0			27	0	61
Medical Students							
Total	194	80			1,045	50	1,369

* Hawaii State Center for Nursing (2020). *Hawaii State Nurse Education Capacity Report, Academic Year 2018-2019.* *https://www.hawaiicenterfornursing.org/wp-content/uploads/2020/09/2018-2019-Hawaii-Nurse-Education-Capacity-Statewide-Report-vFinal.pdf*

[28] NOTE: Support staff includes workers who provide transportation, environmental services, and other health care facility services and who risk exposure to bodily fluids or aerosols.

Table C- 11: Data for Stages 1a - First responders

Population Group	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total
Emergency Medical Technicians	42	329			73	322	766
Firefighters	326	272			985	129	2,039
Law Enforcement			22[29]	12[30]	1,820[31]	140	4,067
Other (Ex. – Ocean Safety)							744
Total							

Table C-12: Data for Stages 1b and 2 - People of all ages with comorbid and underlying conditions

Data from CDC[32]	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total
Population 18 and older	154,438	121,389	5,057	2,318	776,609	55,646	1,115,528
Any comorbid or underlying 2 or more chronic conditions[33]	59,700	42,800	2,900	900	268,500	19,600	400,700
Obesity	38,000	25,000	2,600	800	168,300	12,500	254,300
Heart disease[34]	12,335	8,376	Not avail.	Not avail.	45,399	3,764	69,874
Chronic obstructive pulmonary disease (COPD)	7,900	4,800	300	n/r	26,500	2,500	43,700
Diabetes	17,000	11,700	1,200	n/r	83,000	5,600	123,000
Chronic kidney disease (CKD)	4,800	3,300	400	n/r	25,400	1,800	36,800

[29] https://www.mauicounty.gov/DocumentCenter/View/123988/2019-MPD-Annual-Report
[30] https://www.mauicounty.gov/DocumentCenter/View/123988/2019-MPD-Annual-Report
[31] http://www.honolulupd.org/department/index.php
[32] File Name: cdc_90519_DS1 and BRFSS 2016-2018 vs. ACS 2014-2018 Table S0101
[33] http://ibis.hhdw.org/ibisph-view/query/result/brfss/ChronMlt2/ChronMlt2Crude11_.html; (BRFSS 2013, 2015, 2017)
[34] CHD, heart attack and stroke

Table C-13: Data for Stage 2 - K-12 Teachers and School Staff

Education, Training, and Library Occupations					
	Hawaii	Maui	Honolulu	Kauai	Total
Preschool Teachers, Except Special Education					1,470
Elementary School Teachers, Except Special Education	640	600	5,220		6,380
Middle School Teachers, Exc. Special & Career/Technical Edu.	300	280	1,420		2,060
Secondary School Teachers, Exc. Special & Career/Technical Edu.	460	300	3,050		4,550
Self-Enrichment Education Teachers	160	330	1,110		
Teachers and Instructors, All Other, *Except Substitute Teachers*	740	420	1,400		8,200
Substitute Teachers	440	160	5,420		3,010
Librarians	40	50	520		570
Instructional Coordinators	170	60	1,150		970
Teacher Assistants	810	590	5,810		6,190
Education, Training, and Library Workers, All Other	40		630	160	530
Hawaii private schools					6,200[35]
Total	3,800	2,790	25,730	160	40,000[36]

Table C-14: Data for Stage 2 - Correctional Facilities[37]

County	Facility	Location	Population[38]	Staff
Hawaii	Hawaii Community Correctional Center (HCCC)	Hilo	247	171
	Kulani Correctional Facility (KCF)	Hilo	170	83
City and County of Honolulu	Federal Detention Center	Honolulu	167	?
	Oahu Community Correctional Center (OCCC)	Honolulu	862	501
	Women's Community Correctional Center (WCCC)	Kailua	220	159
	Waiawa Correctional Facility (WCF)	Waipahu	234	113
	Halawa Correctional Facility	Aiea	903	411
Kauai	Kauai Community Correctional Center (KCCC)	Lihue	170	86
Maui	Maui Community Correctional Center (MCCC)	Wailuku	254	187
	TOTAL SYSTEM[39]		3,227	2,785[40]

[35] Data from Hawaii association of independent schools
[36] The DCCA GeoMap is the Geographic Report shows the number of current licenses by license type, by island, and by type of entity. State and County workforce estimates 9 29 2020.1
[37] http://dps.hawaii.gov/about/divisions/corrections/
[38] https://dps.hawaii.gov/wp-content/uploads/2019/11/PSD-ANNUAL-REPORT-2019.pdf
[39] http://dps.hawaii.gov/wp-content/uploads/2015/06/PSD-ANNUAL-REPORT-2014.pdf
[40] NOTE: Includes staffing for all of PSD

Table C-15: Demographic Profile of Shelter Program Clients, FY 2017[41]

ALL INDIVIDUALS	Hawaii County		Kauai County		Maui County		C&C of Honolulu		Total	
	#	%	#	%	#	%	#	%	#	%
Total	1444	100%	654	100%	2817	100%	10,712	100%	15,627	100%
Gender										
Male	755	52.30%	332	50.80%	1,695	60.20%	5,592	52.20%	8,374	53.60%
Female	684	47.40%	322	49.20%	1,111	39.40%	4,114	38.40%	6,231	39.90%
Other/Unknown	5	0.30%	0	0.00%	11	0.40%	1,006	9.40%	1,022	6.50%
Age										
Birth to 5 years	182	12.60%	76	11.60%	255	9.10%	1,109	10.40%	1,622	10.40%
6 to 17 years	218	15.10%	96	14.70%	295	10.50%	1,315	12.30%	1,924	12.30%
18 to 24 years	113	7.80%	50	7.60%	222	7.90%	671	6.30%	1,056	6.80%
25 to 39 years	346	24.00%	154	23.50%	801	28.40%	2,320	21.70%	3,621	23.20%
40 to 59 years	408	28.30%	224	34.30%	953	33.80%	3,210	30.00%	4,795	30.70%
60 years and over	177	12.30%	54	8.30%	253	9.00%	902	8.40%	1,386	8.90%
Unknown	0	0.00%	0	0.00%	38	1.30%	1,185	11.10%	1,223	7.80%
Ethnicity										
Caucasian	527	36.50%	226	34.60%	973	34.50%	2,053	19.20%	3,779	24.20%
Hawaiian/part Hawaiian	457	31.60%	220	33.60%	650	23.10%	2,871	26.80%	4,198	26.90%
Marshallese	110	7.60%	64	9.80%	93	3.30%	398	3.70%	665	4.30%
Micronesian	48	3.30%	7	1.10%	77	2.70%	916	8.60%	1,048	6.70%
Other Pacific Islander	49	3.40%	13	2.00%	62	2.20%	686	6.40%	810	5.20%
Filipino	47	3.30%	44	6.70%	153	5.40%	470	4.40%	714	4.60%
Other Asian	44	3.00%	22	3.40%	63	2.20%	491	4.60%	620	4.00%
Black	52	3.60%	29	4.40%	117	4.20%	590	5.50%	788	5.00%
Native American	56	3.90%	12	1.80%	55	2.00%	129	1.20%	252	1.60%
Unknown	54	3.70%	17	2.60%	574	20.40%	2,108	19.70%	2,753	17.60%
Prior Living Situation										
Sheltered settings	97	6.70%	78	11.90%	489	17.40%	1,278	11.90%	1,942	12.40%
Unsheltered	1,207	83.60%	541	82.70%	1,376	48.80%	5,187	48.40%	8,311	53.20%
Institutional settings	40	2.80%	4	0.60%	111	3.90%	477	4.50%	632	4.00%
Unsubsidized housing	23	1.60%	4	0.60%	71	2.50%	338	3.20%	436	2.80%
Subsidized housing	8	0.60%	2	0.30%	11	0.40%	216	2.00%	237	1.50%
Doubled up	30	2.10%	18	2.80%	195	6.90%	1,154	10.80%	1,397	8.90%
Other / Unknown	39	2.70%	7	1.10%	564	20.00%	2,062	19.20%	2,672	17.10%

[41] https://humanservices.hawaii.gov/wp-content/uploads/2020/07/DHS-Databook-2019-FINAL.pdf

Critical Population Contacts

HDOH maintains point of contact information for each organization COVID-19 project MS Teams. HDOH separated the POC lists into statewide and county level POCs with examples of organizations that can assist with outreach to the critical populations shown. Note that some organizations can assist with multiple groups but may only be listed in one area. This list is not all-inclusive.

Table C-16: Critical Population Contacts

Allocation Stage	Population Group	Examples of Organizations
Stage 1a	High-risk workers in health care facilities	Healthcare Association of Hawaii (HAH) Hawaii Department of Health (HDOH) Hawaii Department of Commerce Consumer Affairs (DCCA) Hawaii State Center for Nursing (HSCN) University of Hawaii John A Burns School of Medicine Hawaii/Pacific Basin Area Health Education Center (AHEC)
	First responders	HDOH (Emergency Medical Services) State Law Enforcement Coalition (SLEC) Hawaii Fire Fighters Association (HFFA)
Stage 1b	People of all ages with comorbid and underlying conditions that put them at significantly higher risk	CMS HDOH
	Adults aged 65 and older living in congregate or overcrowded settings	Centers for Medicaid and Medicare (CMS) HDOH (Office of Healthcare Assurance) HAH (Long-term care)
Stage 2	K-12 teachers and school staff	Department of Education Hawaii State Teachers Association (HSTA) Hawaii Government Employees Association (HGEA) Hawaii Association of Independent Schools (HAIS) Hawaii Keiki Health and Ready to Learn (HK Nursing)
	Critical risk workers in high-risk settings - workers who are both in industries essential to the functioning of society and at substantially high risk of exposure	Department of Labor and Industrial Relations (DLIR)
	People of all ages with comorbid and underlying conditions that put them at moderately higher risk	CMS, HDOH
	People in homeless shelters or group homes for individuals with physical or mental disabilities or in recovery and staff who work in those facilities	CMS, HDOH (Behavioral Health Division)
	People in prisons, jails, detention centers, and similar facilities, and staff who work in such settings	Department of Public Safety (DPS), Department of Corrections
	Adults aged 65 and older not included in Allocation Stage 1	CMS Hawaii Primary Care Association (HPCA) HDOH AARP Hawaii
Stage 3	Young adults (18-22)	HPCA, HDOH, DOE
	Children (0-17)	American Academy of Pediatrics – Hawaii Chapter (AAP-HI), Hawaii Keiki Health and Ready to Learn (HK Nursing), National Association of Pediatric Nurse Practitioners Hawaii (NAPNAP)
	Workers in industries essential to the functioning of society and at increased risk of exposure not included in Stages 1 or 2	Department of Labor and Industrial Relations (DLIR)
Stage 4	Everyone residing in Hawaii who did not have access to the vaccine in previous allocation stages	Multiple organizations to include media and social media
TBD	Pregnant women	Hawaii Society of Obstetricians and Gynecologists Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN Hawaii)

NOTE: As noted previously, the NASEM framework did not include pregnant women in the allocation stages, or infants <1 year of age due to uncertainty concerning vaccine testing on those groups. However, the COVID-19 Core Planning Team identified some initial organizations that could be leveraged for outreach.

Critical Population Mapping

To target vaccination at critical population groups, the COVID-19 Vaccination Program must ensure groups have access to vaccination services. To inform COVID-19 vaccination provider outreach efforts, the COVID-19 Vaccination Program needs to know where critical population groups and points of contacts are located by island. The COVID-19 Vaccination Program will create visual maps of these populations, including places of employment where feasible/appropriate, to assist in COVID-19 vaccination clinic planning, especially for satellite, temporary, or off-site clinics. In addition, the federal government will release a dashboard that includes a mapping tool that may assist the COVID-19 Vaccination Program with this task. Additional information on the dashboard will be shared when available.[42] The COVID-19 Vaccination Program will maintain this information on the COVID-19 MS Teams project site.

The below tables provide information drawn from census and Agency for Toxic Substances and Disease Registry (ATSDR). ATSDR's Geospatial Research, Analysis & Services Program (GRASP) created the CDC Social Vulnerability Index (CDC SVI or simply SVI, hereafter) to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event.[43]

SVI indicates the relative vulnerability of every U.S. Census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. SVI ranks the tracts on 15 social factors, including unemployment, minority status, and disability, and further groups them into four related themes. Thus, each tract receives a ranking for each Census variable and for each of the four themes, as well as an overall ranking. The color scale reflects higher numbers in darker colors.

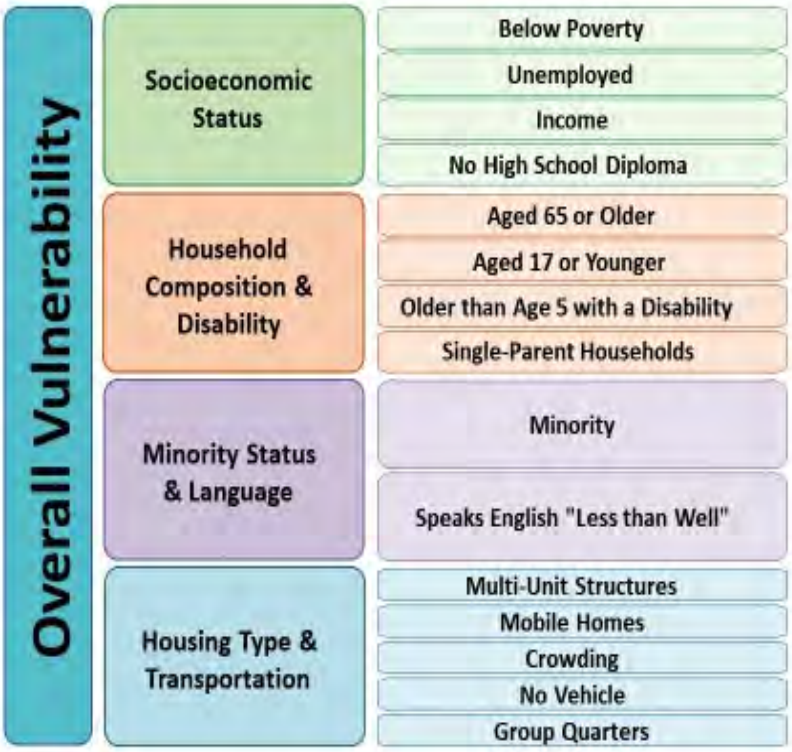

Figure C-8: Vulnerable Variables

[42] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.
[43] https://www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI_documentation_2018.html

Table C-17: Summary of Initial Criteria - Resident Population and Critical Populations with Highest Scores – By County

Resident Population and Critical Populations with Highest Scores – By County					
County	**Census ID**	**Populated Area**	**Critical Population Score (SVI+H)**	**Residential Population (2014-2018)**	**Total**
Kauai	406.03	Koloa-Poipu	13	3,105	3,887
	401.04	Haena-Hanalei	13	782	
Honolulu	93	Wahiawa Waena	14	4,530	66,662
	98.01	Makua Valley	14	2,598	
	80.01	Hale Mohalu Hospital	14	2,207	
	52	Chinatown	14	2,474	
	98.02	Makaha	14	7,146	
	9400.02	Nanakuli	14	7,107	
	97.03	Lualualei-Camp Waianae	14	6,892	
	96.08	Lualualei Transmitter	14	4,997	
	96.03	Maili	14	11,375	
	97.01	Waianae Kai	14	6,474	
	94	Wahiawa Makai	14	4,905	
	63.02	Kalena Drive	14	3,013	
	62.02	Linapuni Street	14	1,476	
	54	Mayor Wright Housing	14	1,468	
Maui	311.02	Central Kahului	14	6,155	19,304
	317	East Molokai	14	4,380	
	318.01	West Molokai	14	2,368	
	319	Spreckelsville	14	6,401	
Hawaii	212.02	Kau	15	9,473	36,115
	204	Hilo: Villa Franca-Kaikoo	15	3,522	
	203	Hilo: Puueo-Downtown	14	4,270	
	211.06	Pahoa	14	7,856	
	219.02	Honokaa-Kukuihaele	14	4,152	
	205	Hilo: University-Houselots	14	6,842	
				Total	125,968

Table C-18: Resident Population and Critical Populations - Oahu

Resident Population and Critical Populations - Oahu[44]			
Census ID	**Populated Area**	**Critical Population Score (SVI+H)**	**Residential Population (2014-2018)[45]**
93	Wahiawa Waena	14	4,530
98.01	Makua Valley	14	2,598
80.01	Hale Mohalu Hospital	14	2,207
52	Chinatown	14	2,474
98.02	Makaha	14	7,146
9400.02	Nanakuli	14	7,107
97.03	Lualualei-Camp Waianae	14	6,892
96.08	Lualualei Transmitter	14	4,997
96.03	Maili	14	11,375
97.01	Waianae Kai	14	6,474
94	Wahiawa Makai	14	4,905
63.02	Kalena Drive	14	3,013
62.02	Linapuni Street	14	1,476
54	Mayor Wright Housing	14	1,468
48	Kamehameha Heights	13	6,990
50	Kuakini	13	4,542
53	Aala	13	4,149
49	Lanakila	13	3,398
97.04	Lualualei: Halona Road	13	3,538
11	Central Palolo	13	3,415
86.17	Ewa Villages	13	10,324
56	Kapalama	13	7,280
75.04	Aloha Stadium	13	3,366
58	Waiakamilo Road	13	3,199
57	Iwilei-Anuenue	13	2,541
87.03	West Loch	13	7,313
62.01	Kam IV Road	13	6,372
89.14	Honowai School	13	5,412
9400.01	Waimanalo Beach-Homesteads	12	3,826
107.02	Mokulele Drive	12	3,615
39	Civic Center	12	261
34.07	Maryknoll School	12	920
89.13	Robinson Heights	12	4,232

[44] Based on a sample and subject to sampling variability. Figures displayed are the average values over the 5-year period of 2014 to 2018. Includes information with Critical Population Scores of 10 and higher.
[45] U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates, Tables DP02; https://data.census.gov accessed April 29, 2020; and calculations by the Hawaii State Department of Business, Economic Development & Tourism.

Resident Population and Critical Populations - Oahu[44]			
Census ID	**Populated Area**	**Critical Population Score (SVI+H)**	**Residential Population (2014-2018)[45]**
35.02	Upper Pawaa	12	3,963
18.03	Tusitala Street	12	2,730
105.03	Kaneohe District Park	12	1,767
18.01	Koa Avenue	12	1,042
84.02	Ewa Beach	12	7,809
99.04	Kaena Point	12	5,683 [46]
102.01	Hauula-Kaaawa	12	5,411
27.02	Punahou School	12	5,360
86.22	Lower Makakilo	12	4,490
89.07	Mililani High School	12	4,204
36.03	Ahana Street	12	2,958
113	Waimanalo	12	6,135
26	Bingham Tract	12	4,378
22.01	Kamoku Street-Iolani School	12	3,585
88	Managers Drive	12	8,917
87.01	Leeward Community College	12	8,232
87.02	St. Joseph School	12	5,772
80.03	Manana	12	4,387
78.08	Pearlridge Center	12	3,615
91	Kaukonahua Road	12	5,083
61	Kalihi Waena	12	4,053
24.01	Lower McCully	12	3,412
85.02	Kalaeloa	12	2,666
60	Umi Street	12	6,858
59	Mokauea Street	12	3,588
55	Palama	12	2,162
44	Pauoa	11	5,634
92	Wahiawa Mauka	11	8,001
45	Dowsett Highlands	11	6,007
109.05	Ulupaina Street	11	2,428
1.06	Hahaione-Mariners Ridge	11	7,997
80.07	Pearl City Highlands	11	5,783
78.11	Pearl Country Club	11	4,608
105.04	Waikalua Road	11	4,561
41	Queen's Hospital	11	4,287

[46] File source Name: Critical Population List by Census Tract Analysis.

Resident Population and Critical Populations - Oahu[44]			
Census ID	**Populated Area**	**Critical Population Score (SVI+H)**	**Residential Population (2014-2018)[45]**
80.06	Pearl City	11	4,237
19.03	Ena Road	11	2,925
9.01	Waialae Nui Valley	11	2,631
4.01	Waialae Nui Ridge-Ainakoa	11	2,441
40	Financial District	11	1,245
75.05	Foster Village	11	5,908
78.05	Waiau Townhouses	11	4,724
34.04	Makiki Fire Station	11	4,612
89.29	Mililani Mauka-Meheula Parkway	11	3,996
99.02	Haleiwa	11	3,884
109.03	Oneawa Street-Kawainui	11	3,706
34.05	Poki Street	11	3,522
35.01	Academy of Arts	11	2,475
20.06	Ala Wai-Olohana Street	11	1,713
68.02	Aliamanu	11	8,453
83.02	Campbell High School	11	6,908
64.02	Kamanaiki Street	11	6,630
34.06	Lower Makiki	11	5,859
63.01	Kalihi Valley Park	11	4,413
25	Lower Pawaa	11	4,033
21	Olokele Avenue	11	3,494
10	Upper Palolo	11	3,443
80.02	Lower Waiau	11	3,092
20.05	Ala Wai-Niu Street	11	1,658
20.04	International Market Place	11	1,220
89.12	August Ahrens School	11	2,968
23	Moiliili	11	5,578
27.01	UH Manoa Campus	11	5,554
24.02	Upper McCully	11	3,266
67.02	Red Hill	11	2,641
106.01	Puohala	10	3,361
111.04	Enchanted Lakes	10	4,579
1.12	Koko Marina	10	5,398
106.02	Castle High School-Halekou Road	10	5,324
77.02	Aiea Heights	10	5,071

Resident Population and Critical Populations - Oahu[44]			
Census ID	**Populated Area**	**Critical Population Score (SVI+H)**	**Residential Population (2014-2018)[45]**
47	Alewa-Kawananakoa	10	4,857
46	Puunui-Waokanaka Street	10	4,018
103.03	Kahaluu-Waikane	10	3,965
3.02	Wailupe	10	2,920
89.08	Mililani Marketplace	10	5,907
38	Kakaako	10	5,775
2	Kuliouou	10	5,364
75.03	Halawa Heights	10	5,222
30	Judd Hillside-Lowrey Avenue	10	4,719
9.02	Maunalani Heights	10	4,171
89.09	Mililani District Park	10	4,132
19.04	Hobron Lane	10	2,964
78.04	Lower Pearl City	10	2,280
37	Ala Moana	10	6,569
67.01	Tripler-Moanalua	10	6,236
43	Punchbowl	10	5,630
34.03	Thurston Street	10	5,426
42	Queen Emma Gardens	10	3,262
7	Kaimuki: 22nd Avenue	10	3,171
86.09	Ko Olina-Honokai Hale	10	2,022
18.04	Jefferson School	10	1,371
115	Kapolei	10	9,457
78.10	Royal Summit	10	5,840

1

Table C-19: Resident Population and Critical Populations – Hawaii County

Resident Population and Critical Populations – Hawaii County[47]			
Census ID	**Populated Area**	**Critical Population Score (SVI+H)**	**Residential Population (2014-2018)**
212.02	Kau	15	9,473
204	Hilo: Villa Franca-Kaikoo	15	3,522
203	Hilo: Puueo-Downtown	14	4,270
211.06	Pahoa	14	7,856
219.02	Honokaa-Kukuihaele	14	4,152
205	Hilo: University-Houselots	14	6,842
218	North Kohala	13	6,045
201	Paukaa-Wailea	13	4,162
214.02	Konawaena	13	3,791
217.02	Waimea-Puu Anahulu	13	11,832
206	Hilo: Keaukaha-Panaewa	13	5,792
215.02	Hualalai	13	4,220
220	Paauhau-Paauilo	13	2,520
215.09	Kaumalumalu-Keauhou	12	5,646
207.01	Hilo: Puainako	12	4,461
216.01	Kailua	12	9,943
210.11	Volcano-Mt. View	12	3,969
210.10	Upper Puna (Puna Mauka)	12	8,298
210.13	Keaau	12	4,969
210.03	Orchidland-Ainaloa	12	7,169
213	South Kona	11	6,977
211.01	Kalapana-Kapoho	11	3,359
221.02	North Hilo	11	1,510
216.04	Holualoa	11	8,658
207.02	Hilo: Kawailani	11	4,864
215.07	Kalaoa	11	10,044
215.04	Kealakehe	11	5,120
202.02	Hilo: Upper Waiakea Forest Reserve	11	2,565
209	Hilo: Haihai	10	4,769
210.05	Hawaiian Paradise Park	10	11,148
217.04	Kawaihae-Waikoloa	10	8,023
208.02	Hilo: Piihonua-Kaumana	9	6,507
208.01	Hilo: Kahuku-Kaumana	9	5,182

[47] Based on a sample and subject to sampling variability. Figures displayed are the average values over the 5-year period of 2014 to 2018.

Table C-20: Resident Population and Critical Populations - Maui

Resident Population and Critical Populations - Maui[48]			
Census ID	**Populated Area**	**Critical Population Score (SVI+H)**	**Residential Population (2014-2018)**
311.02	Central Kahului	14	6,155
317	East Molokai	14	4,380
318.01	West Molokai	14	2,368
319	Spreckelsville	14	6,401
315.03	Honokowai	13	2,339
309.01	West Central Wailuku	13	2,719
311.01	West Kahului	13	9,373
310	South Wailuku	12	9,373
304.03	Makawao	12	4,068
309.02	East Central Wailuku	12	3,619
314.05	Lahainaluna	12	6,316
307.10	Keawakapu	11	2,069
307.08	Halama	11	2,983
304.04	Haliimaile	11	5,552
316.01	Lanai	11	2,826
314.04	Lahaina	11	3,855
311.03	Southeast Kahului	11	10,679
301	Hana	10	1,642
319	Kalawao	10	75
307.09	Kamaole	10	3,359
314.02	Kahoma	10	2,932
315.01	Kapalua	10	2,215
309.03	North Wailuku	10	7,071
307.05	Kihei Mauka	10	4,179
303.01	Kula	9	9,776
303.03	Wailea	9	3,701
302.01	Huelo	9	2,173
315.02	Honokahua	9	4,947
307.07	Waipuilani	9	8,752
308	Waihee-Waikapu	9	7,427
320	Launiupoko	8	850
304.02	Pukalani	8	8,390
307.06	Kealia	8	2,606
305.01	Paia	8	2,426
302.02	Haiku	7	7,760

[48] Based on a sample and subject to sampling variability. Figures displayed are the average values over the 5-year period of 2014 to 2018.

Table C-21: Resident Population and Critical Populations - Kauai

Resident Population and Critical Populations - Kauai[49]			
Census ID	**Populated Area**	**Critical Population Score (SVI+H)**	**Residential Population (2014-2018)**
406.03	Koloa-Poipu	13	3,105
401.04	Haena-Hanalei	13	782
406.04	Omao-Kukuiula	12	3,469
405	Lihue	12	7,212
404	Puhi-Hanamaulu	12	11,060
402.04	Wailua Houselots	11	6,129
409	Kekaha-Waimea	11	5,524
402.05	Wailua Homesteads	11	4,087
401.03	Princeville-Kilauea	10	5,450
407	Eleele-Kalaheo	10	9,246
9400	Anahola	10	3,338
408	Kaumakani-Hanapepe	10	4,049
403	Kapaa	10	7,926
412	Niihau-Kaula	2	

[49] Based on a sample and subject to sampling variability. Figures displayed are the average values over the 5-year period of 2014 to 2018.

Critical Population Mapping by County

To target vaccination at critical vulnerable population groups, the COVID-19 Vaccination Program must ensure groups have access to vaccination services. To inform COVID-19 vaccination provider outreach efforts, the COVID-19 Vaccination Program needs to know where critical vulnerable population groups and points of contacts are located by island. The COVID-19 Vaccination Program will create visual maps of these populations, including places of employment where feasible/appropriate, to assist in COVID-19 vaccination clinic planning, especially for satellite, temporary, or off-site clinics. In addition, the federal government will release a dashboard that includes a mapping tool that may assist the COVID-19 Vaccination Program with this task. Additional information on the dashboard will be shared when available.[50] The COVID-19 Vaccination Program will maintain this information on the COVID-19 MS Teams project site. See examples below using the Social Economic Health Vulnerability Index scores mentioned previously, as well as Location of Nurse (RN, LPN, ARPN) Employment (orange) versus Residential Population (green-blue).

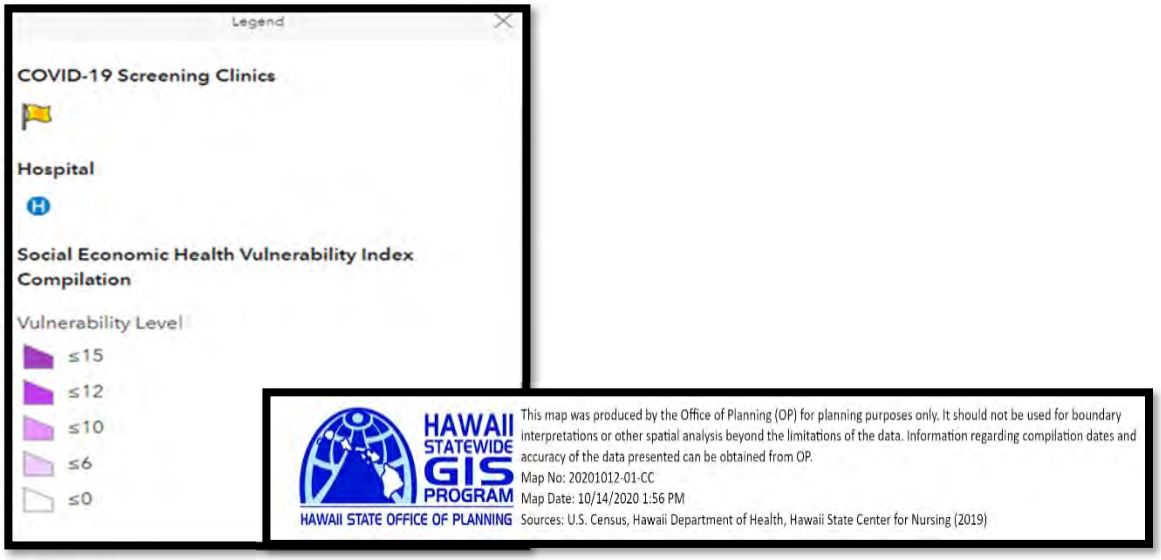

Figure C-9: Example Key of COVID-19 Critical Population Mapping for Maps Shown Below

[50] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

Kauai County

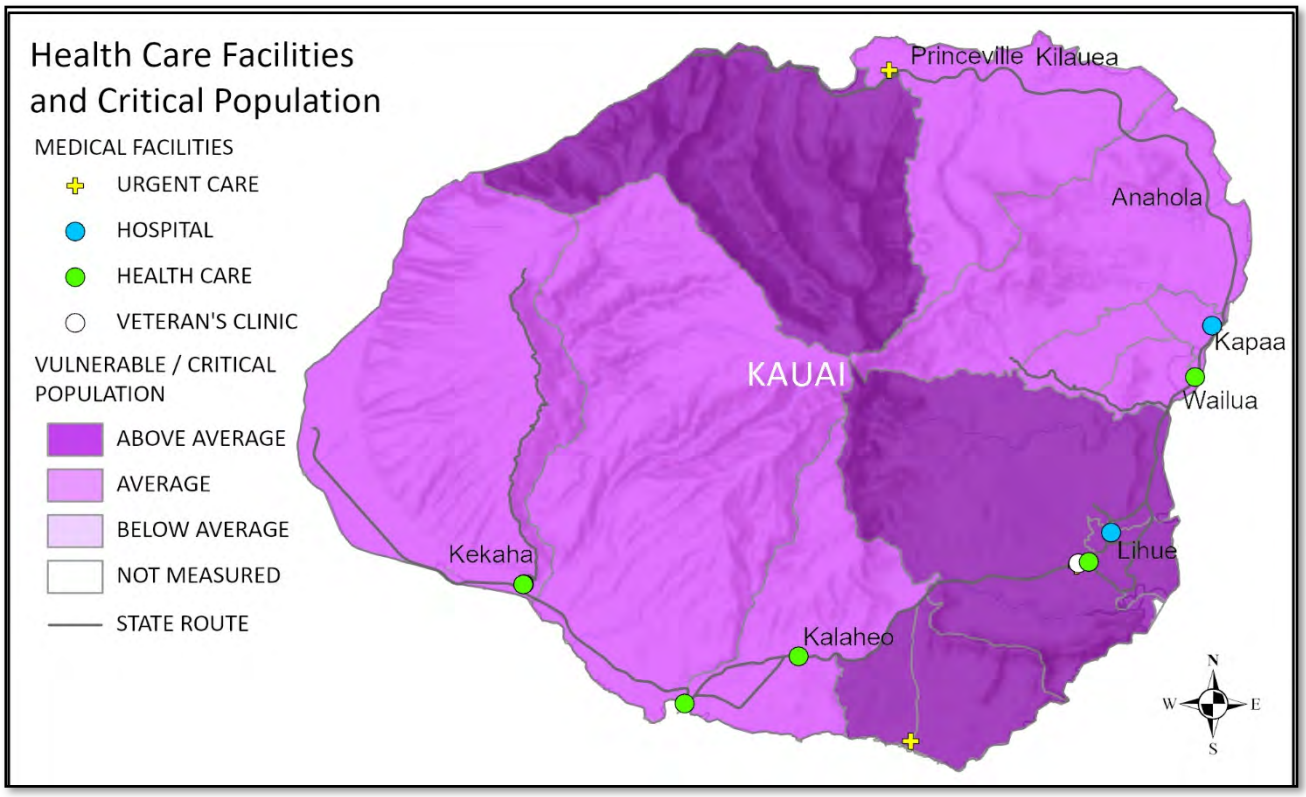

Figure C-10: Kauai County Health Care Facilities and Critical Vulnerable Population Mapping Example[51]

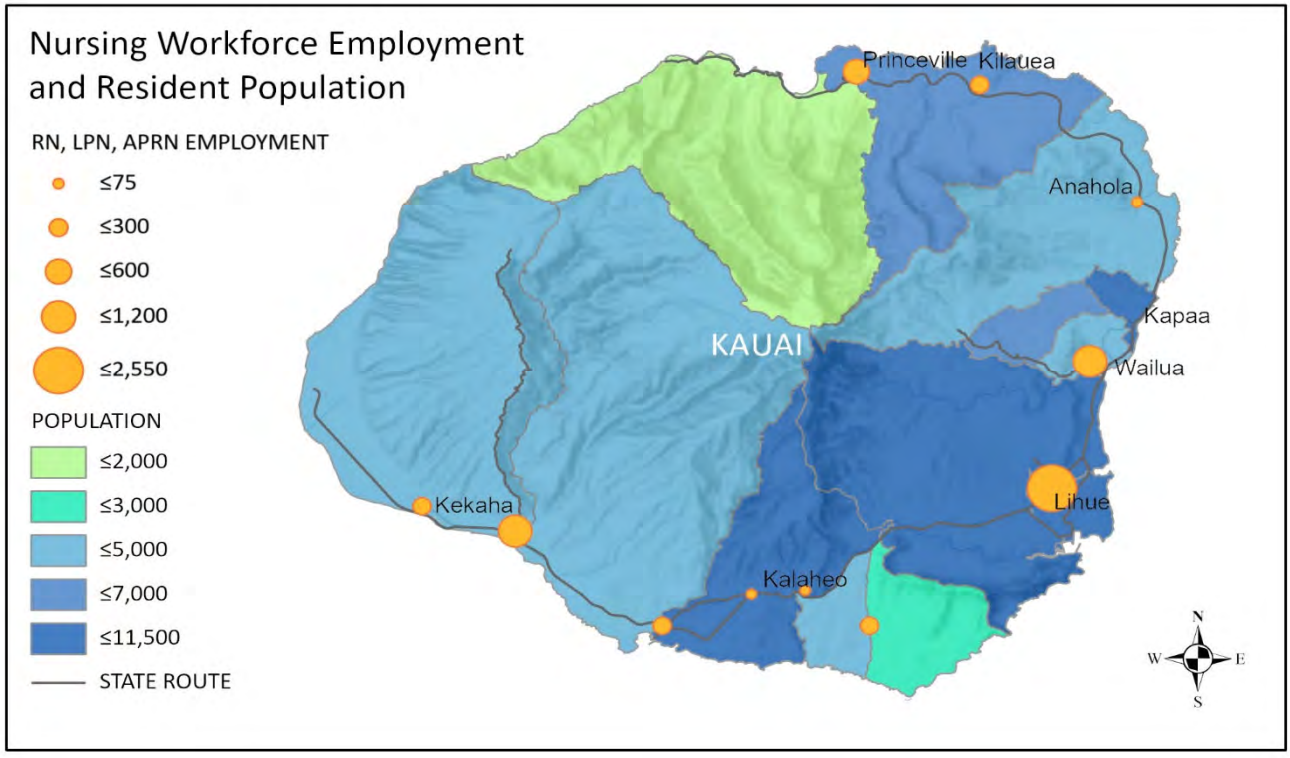

Figure C-11: Location of RN Employment (orange) versus Residential Population (blue) for Kauai County[52]

City and County of Honolulu

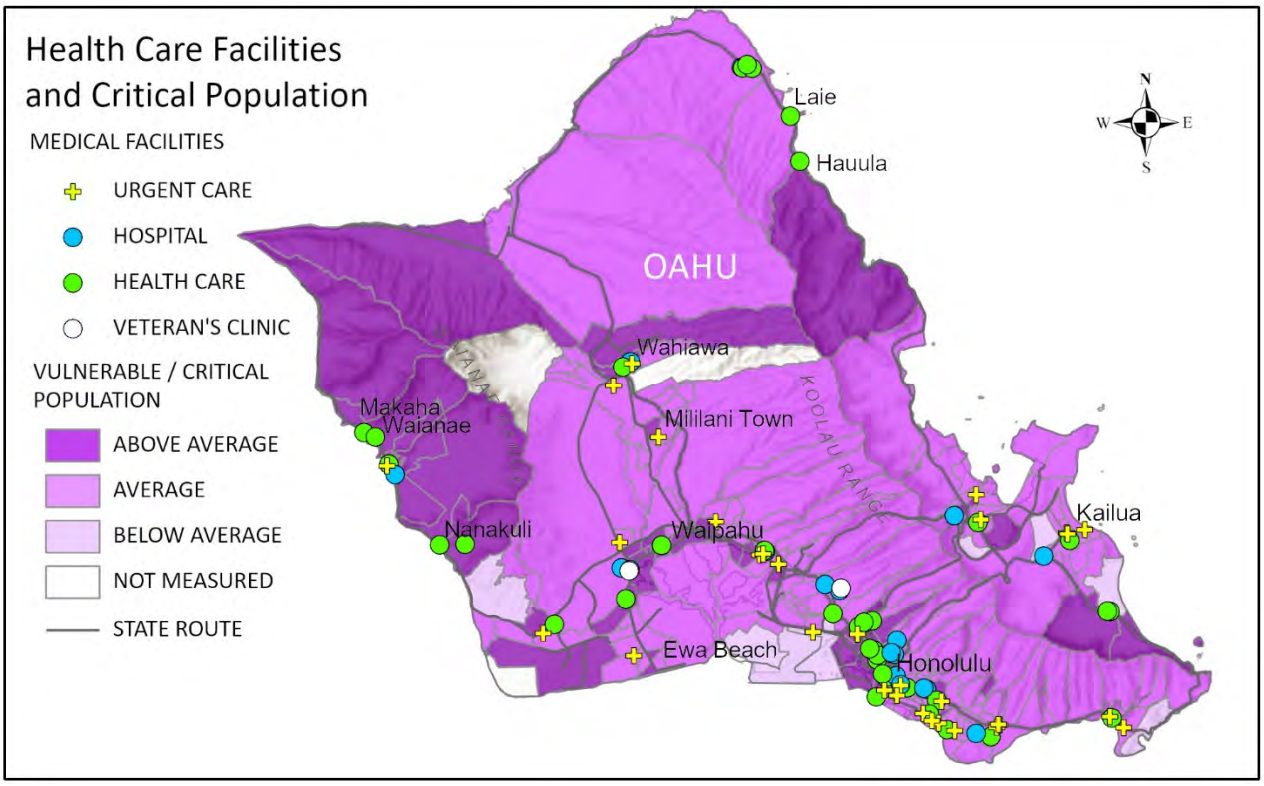

Figure C-12: City and County of Honolulu Health Care Facilities and Critical Vulnerable Population Mapping Example[53]

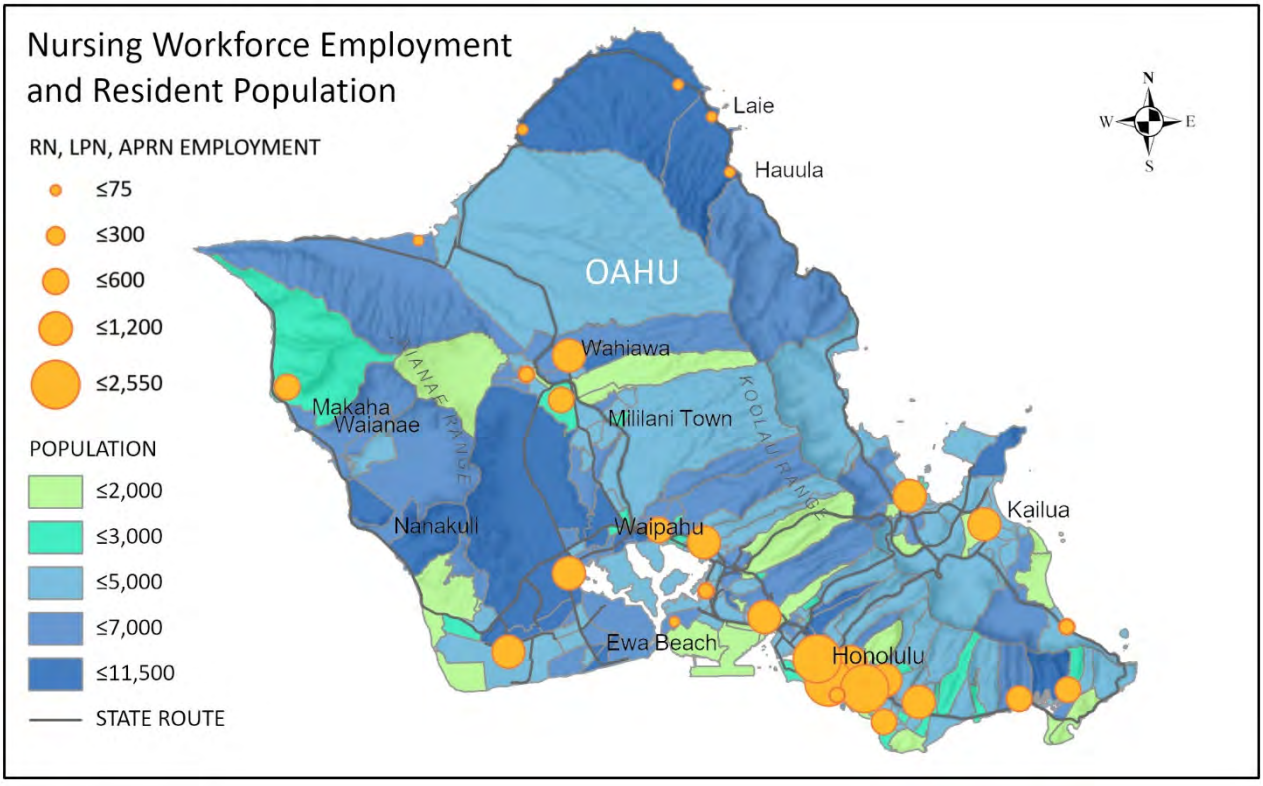

Figure C-13: Location of RN Employment (orange) versus Residential Population (blue) for Honolulu City & County[54]

Maui County

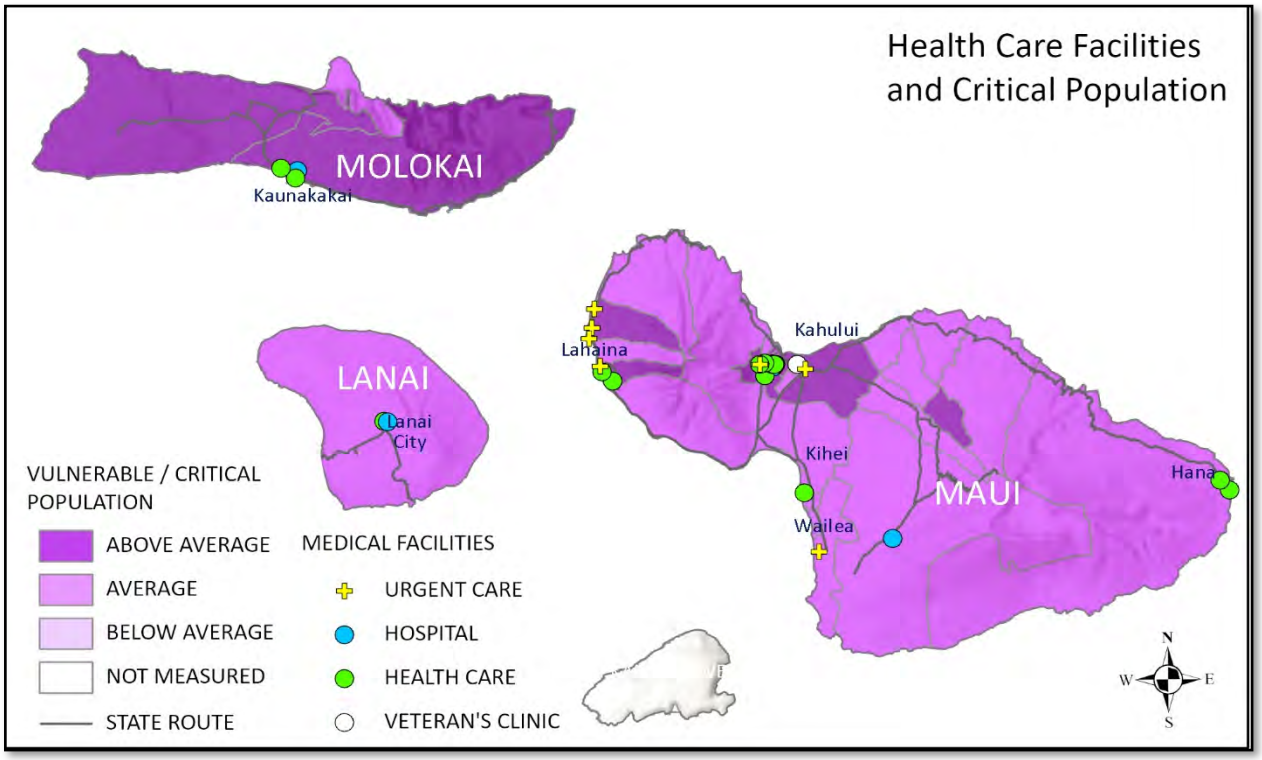

Figure C-14: Maui County Health Care Facilities and Critical Vulnerable Population Mapping Example[55]

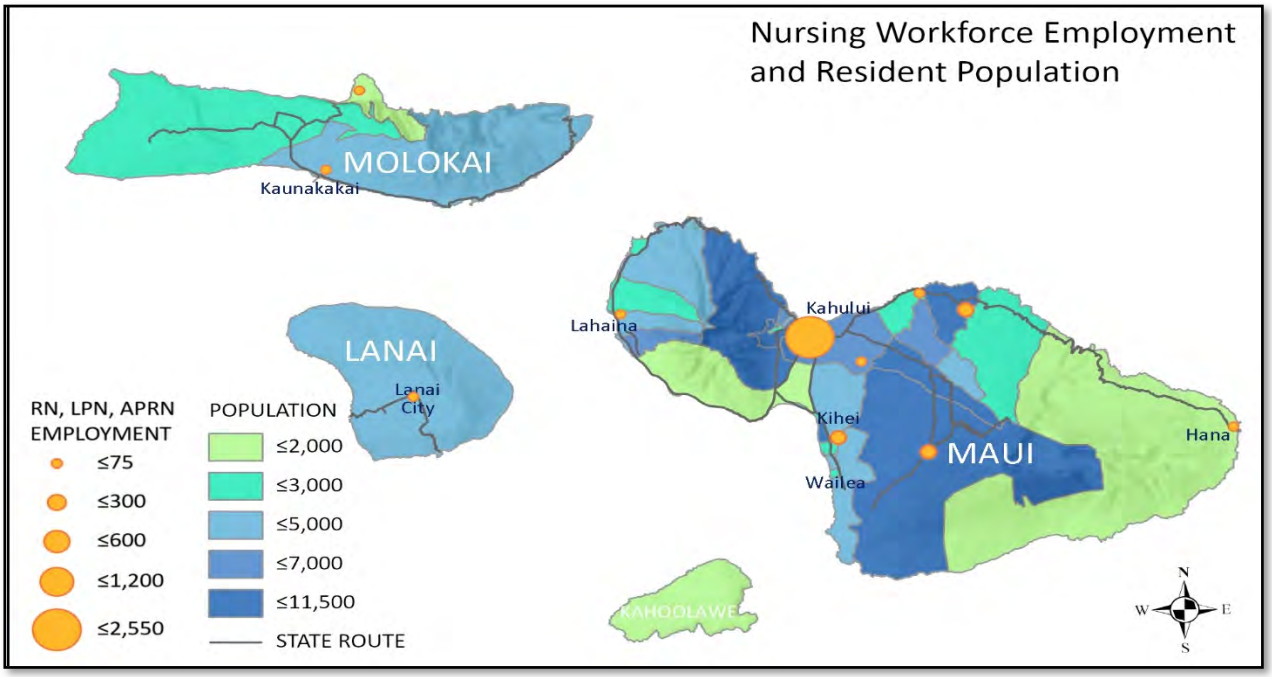

Figure C-15: Location of RN Employment (orange) versus Residential Population (blue) for Maui County[56]

[55] https://histategis.maps.arcgis.com/apps/webappviewer/index.html?id=cf2dd78ac4ca4223aabbafe9db6ad46b, accessed on October 8, 2020.
[56] Hawaii State Center for Nursing (2019). Hawaii's Nursing Workforce Supply 2019. Retrieved from: hawaiicenterfornursing.org

Hawaii County

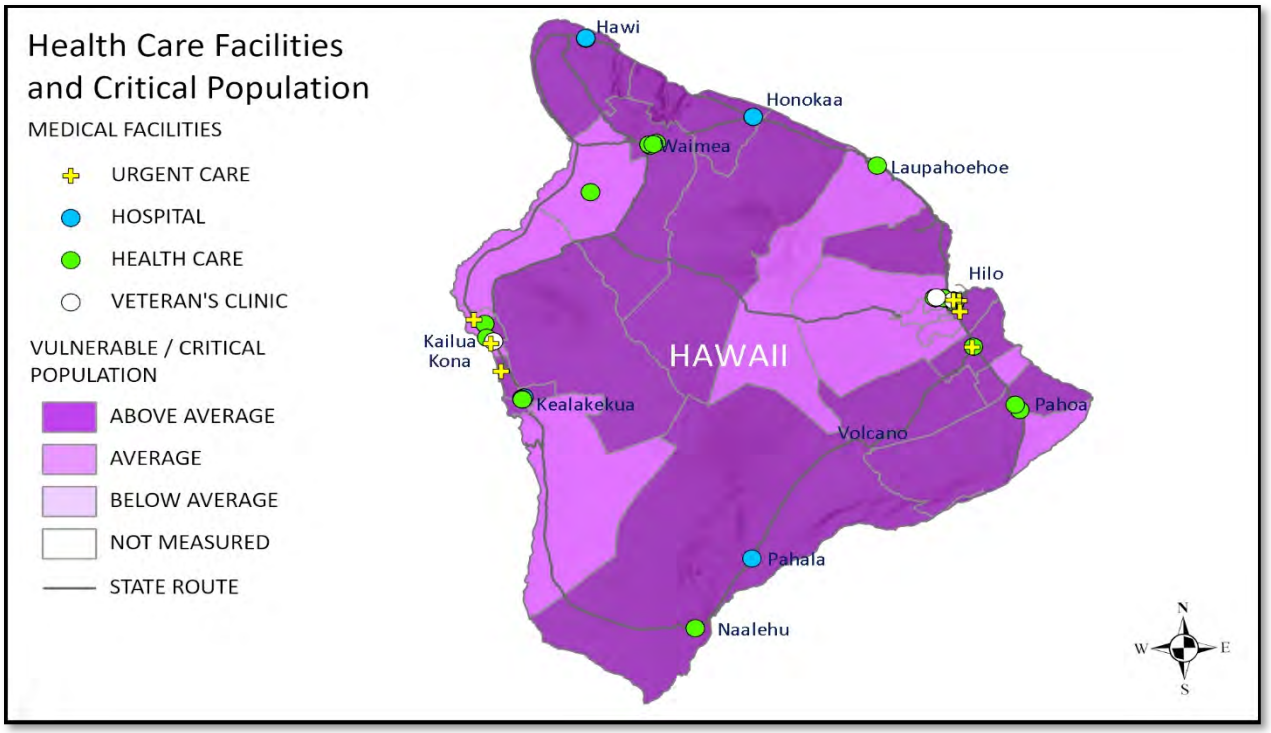

Figure C-16: Hawaii County Health Care Facilities and Critical Vulnerable Population Mapping Example[57]

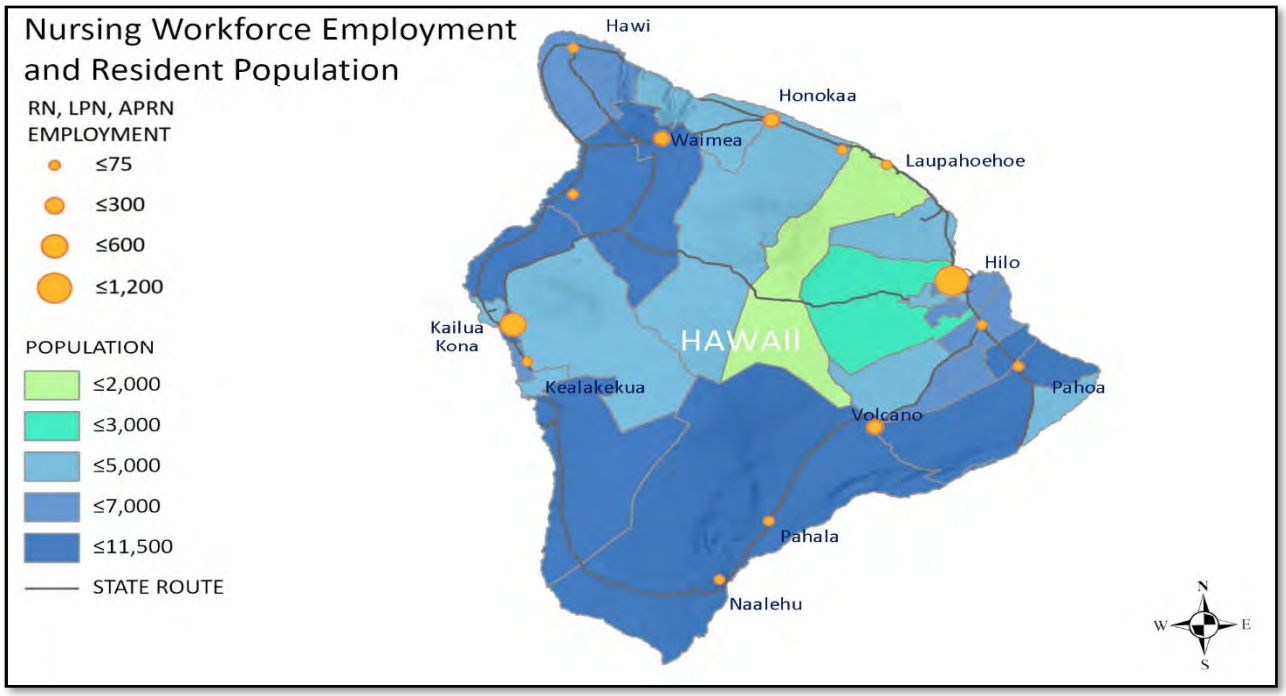

Figure C-17: Location of RN Employment (orange) versus Residential Population (blue) for Hawaii County[58]

[57] https://histategis.maps.arcgis.com/apps/webappviewer/index.html?id=cf2dd78ac4ca4223aabbafe9db6ad46b, accessed on October 8, 2020.
[58] Hawaii State Center for Nursing (2019). Hawaii's Nursing Workforce Supply 2019. Retrieved from: hawaiicenterfornursing.org

Tab 1 - Key Data on the Impact of COVID-19 on Certain Populations

Table C-22: Key Data on the Impact of COVID-19 on Certain Populations

Population (Order as listed in the source document)	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total[59]	Key Impact Data
Black	1,487	1,022	55	118	25,504	127	24,472	• Compared to non-Hispanic White populations, this group has a case rate that is 2.6 times higher, a hospitalization rate that is 4.7 times higher, and a death rate that is 2.1 times higher (United States).
Hispanic/Latinx	25,014	12,582	257	161	96,562	7,802	147,962	• Compared to non-Hispanic White populations, this group has a case rate that is 2.8 times higher, a hospitalization rate that is 4.7 times higher, and a death rate that is 1.1 times higher (United States).
American Indian and Alaska Native	411	202	119	17	1,018	244	1,877	• Compared to non-Hispanic White populations, this group has a case rate that is 2.8 times higher, a hospitalization rate that is 4.6 times higher, and a death rate that is 1.4 times higher (United States).
Native Hawaiian and Pacific Islander	22,062	17,266	3,847	578	87,614	5,622	132,583	• Group has experienced mortality from COVID-19 at a rate up to five times its proportion of the population compared to the general population (United States).[Includes residents from three major sub-regions of Oceania (Micronesia, Melanesia, and Polynesia)]
Older adults (≥65 years to 79 years)[60]	29,561	19,727	1,118	485	116,511	10,305	177,711	• Group accounts for approximately 80 percent of reported deaths related to COVID-19 (United States). • Population-level COVID-19 mortality risk is estimated to be 16- to 52-fold higher (United States) and 30- to 100-fold higher (worldwide) for this group than for younger people.
Older adults (>80 years)	8,652	5,940	416	174	49,921	3,133	68,244	• Group is experiencing a mortality rate 5-fold greater than average (United States). • Group is experiencing an "overwhelming percentage" of severe outcomes due to COVID-19 (worldwide).
Adults with 2 or more underlying or comorbid conditions[61]	59,700	42,800	2,900	900	268,500	19,600	400,700	• Group is 6-fold more likely to be hospitalized and 12-fold more likely to die from COVID-19 as people without underlying conditions (United States). • Group is at a greater risk of SARS-CoV-2 infection.
People with 3 or more underlying or comorbid conditions	32,800	23,000	1,500	600	146,700	10,500	218,100	

[59] https://files.hawaii.gov/dbedt/economic/databook/db2019/section01.pdf

[60] 65-79 and 80+ data from ACS 2014-2018 Table S0101

[61] Data from CDC, File Name: cdc_90519_DS1, (BRFSS 2013, 2015, 2017)

Population (Order as listed in the source document)	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total[59]	Key Impact Data
Obesity[62]	38,000	25,000	2,600	800	168,300	12,500	254,300	**NOTE:** underlying conditions including high blood pressure, high cholesterol, heart attack, CHD, stroke, asthma, cancer, COPD, arthritis, depression, kidney disease or diabetes.
People who live and/or work in congregate settings	TBD	TBD	TBD	TBD	TBD	TBD	TBD	• Older adults living in senior living facilities are at high risk of severe COVID- 19. • Long-term care facility residents accounted for half of >10,000 COVID-19 deaths reported by April 2020 (United States).
Sex (Female)	99,382	82,844	3,457	1,371	489,992	36,002	708,257	• Men with COVID-19 are more at risk for worse outcomes and death than women, independent of age (China).
Sex (Male)	98,276	82,437	3,291	1,455	497,646	35,375	713,772	
Children (0-17)	43,220	34,318	1,691	508	211,029	15,731	306,501	• Children and adolescents account for 10 percent of COVID-19 cases and less than 0.3 percent of deaths (United States). • Among children with COVID-19, 1.8 percent of cases resulted in hospitalization (United States). • 78 percent of deaths among adolescents (under 21) reported to the Centers for Disease Control and Prevention between mid-February and the end of July 2020 were people from Black, Hispanic and Latinx, or American Indian and Native • Alaskan communities.
People who are pregnant[63]	2,300	1,800	92	33	12,700	800	17,600	• Group may be at an increased risk of developing severe COVID-19 disease that requires intensive care unit admission and mechanical ventilation. • Black and Hispanic women who are pregnant appear to be disproportionately at risk of severe disease and hospitalization (United States). • Babies born to women infected with SARS-CoV-2 during pregnancy appear to be more likely to be born preterm or require neonatal intensive care.
People who are breastfeeding[64]	1,800	1,300	70	25	10,000	700	13,900	

NOTE: This list is **not** in order of priority for vaccine allocation. Population terms and key impact data come directly from the source.[65]

[62] BRFSS 2016-2018

[63] http://ibis.hhdw.org/ibisph-view/query/result/prams/CountyCat/CountyCat_ST.html, accessed October 8, 2020. NOTE: Data is from 2016 for pregnancy only

[64] PRAMS 2014-2016. Maui, Molokai, and Lanai are estimated based on the rate for Maui County.

[65] National Academies: A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus, available at: https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus, accessed October 8, 2020.

Tab 2 – Facility and Employer Supporting Data

Table C-23: Facility Overview

	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total	Total Staff Estimate	Population Served or *Capacity* (if available)
1. Hospitals	6	2	1	1	15	3	28	23,312	TBD
2. Long-term care facilities	5	2			26	3	36	TBD	TBD
3. Assisted Living Facility	1	1			17	1	20	TBD	TBD
4. Adult Residential Care Homes (ARCH)	40	9	3		386	6	444	TBD	1,821
5. Community Health Clinics	21	12			36	8	77	TBD	TBD
6. Community Care Foster Family Home (CCFFH)	122	54	2		1021	22	1,221	TBD	*3,143*
7. Urgent Care Centers	6	6	None	None	21	3	37	TBD	TBD
8. Chain/Independent Pharmacies	36	34	2	0	131	13	216	TBD	N/A
9. Schools (High Schools)	6	4	1	0	20	3	34	TBD	TBD
10. Schools (Universities/ Colleges)	2	1			11	1	15	TBD	TBD
11. School-based health centers					4		4	TBD	TBD
12. Health care provider offices							1,099	TBD	TBD
13. Outpatient clinics							123	4,385	TBD
14. Worksite Clinics								TBD	TBD
15. Occupational Health Centers								TBD	TBD
16. Satellite Vaccination Clinics	TBD	TBD			TBD	TBD	TBD	TBD	TBD
17. Mobile Vaccination Clinics	TBD	TBD			TBD	TBD	TBD	TBD	TBD
18. Drive-Thru Vaccination Clinics	TBD	TBD			TBD	TBD	TBD	TBD	TBD

Table C-24: Hospitals

Facility	Staff	County	City	Address	Organization Type
Hilo Medical Center	1,350[66]	Hawaii	Hilo	1190 Waianuenue Ave, Hilo, HI 96720	Hospital - Type I, Full Capability
Kona Community Hospital	550	Hawaii	Kealakekua	79-1019 Haukapila St, Kealakekua, HI 96750	Hospital - Type I, Full Capability
Queen's North Hawaii Community Hospital	300	Hawaii	Kamuela	67-1125 Mamalahoa Hwy, Kamuela, HI 96743	Hospital - Type I, Full Capability
Hale Ho'ola Hamakua		Hawaii	Honoka'a	45-547 Plumeria St, Honoka'a, HI 96727	Hospital - Type II, Partial Capability
Ka'u Hospital		Hawaii	Pahala	1 Kamani St, Pahala, HI 96777	Hospital - Type II, Partial Capability
Kohala Hospital		Hawaii	Kapaau	54-383 Hospital Rd, Kapaau, HI 96755	Hospital - Type II, Partial Capability
Adventist Health Castle		Honolulu	Kailua	640 Ulukahiki St, Kailua, HI 96734	Hospital - Type I, Full Capability
Kaiser Foundation Hospital		Honolulu	Honolulu	3288 Moanalua Rd, Honolulu, HI 96819	Hospital - Type I, Full Capability
Kapiolani Medical Ctr. for Women & Children		Honolulu	Honolulu	1319 Punahou St, Honolulu, HI 96826	Hospital - Type I, Full Capability
Kuakini Health System		Honolulu	Honolulu	347 N Kuakini St, Honolulu HI 96817	Hospital - Type I, Full Capability
Pali Momi Medical Center		Honolulu	Aiea	98-1079 Moanalua Rd, Aiea, HI 96701	Hospital - Type I, Full Capability
Straub Medical Center		Honolulu	Honolulu	888 S King St, Honolulu, HI 96813	Hospital - Type I, Full Capability
The Queen's Medical Center - Punchbowl		Honolulu	Honolulu	1301 Punchbowl St, Honolulu, HI 96813	Hospital - Type I, Full Capability
The Queen's Medical Center - West		Honolulu	Ewa Beach	91-2141 Fort Weaver Rd, Ewa Beach, HI 96706	Hospital - Type I, Full Capability
Tripler Army Medical Center		Honolulu	Honolulu	1 Jarrett White Rd, Tripler AMC, HI 96859	Hospital - Type I, Full Capability
Wahiawa General Hospital		Honolulu	Wahiawa	128 Lehua St, Wahiawa, HI 96786	Hospital - Type I, Full Capability
Kahuku Medical Center		Honolulu	Kahuku	56-117 Pualalea St, Kahuku, HI 96731	Hospital - Type II, Partial Capability
Hawaii State Hospital		Honolulu	Kaneohe	45-710 Keaahala Rd, Kaneohe, HI 96744	Hospital - Type III, Support
Kahi Mohala		Honolulu	Ewa Beach	91-2301 Old Fort Weaver Rd, Ewa Beach, HI 96706	Hospital - Type III, Support
Rehabilitation Hospital of the Pacific		Honolulu	Honolulu	226 N Kuakini St, Honolulu, HI 96817	Hospital - Type III, Support
Shriner's Hospitals for Children		Honolulu	Honolulu	1310 Punahou St, Honolulu, HI 96826	Hospital - Type III, Support
Wilcox Memorial Hospital		Kauai	Lihue	3-3420 Kuhio Hwy, Lihue, HI 96766	Hospital - Type I, Full Capability
Kauai Veterans Memorial Hospital		Kauai	Waimea	4643 Waimea Canyon Dr, Waimea, HI 96796	Hospital - Type II, Partial Capability
Samuel Mahelona Memorial Hospital		Kauai	Kapaa	4800 Kawaihau Rd, Kapaa, HI 96746	Hospital - Type II, Partial Capability
Maui Memorial Medical Center		Maui	Wailuku	221 Mahalani St, Wailuku, HI 96793	Hospital - Type I, Full Capability
Kula Hospital		Maui	Kula	100 Keokea Pl, Kula, HI 96790	Hospital - Type II, Partial Capability
Lanai Community Hospital		Maui	Lanai	628 7th St, Lanai City, HI 96763	Hospital - Type II, Partial Capability
Molokai General Hospital		Maui	Kaunakakai	280 Home Olu Pl, Kaunakakai, HI 96748	Hospital - Type II, Partial Capability
Total					

[66] https://www.hilomedicalcenter.org/

Table C-25: Long Term Care Facilities

Facility	Population Served	Staff	County	City	Address
Hale Anuenue Restorative Care Center			Hawaii	Hilo	1333 Waianuenue Ave, Hilo, HI 96720
Legacy Hilo Rehab & Nursing Ctr			Hawaii	Hilo	563 Kaumana Dr, Hilo, HI 96720
Life Care Center of Hilo			Hawaii	Hilo	944 W Kawailani St. Hilo, HI 96720
Yukio Okutsu State Veterans Home			Hawaii	Hilo	1180 Waianuenue Ave, Hilo, HI 96720
Life Care Center of Kona			Hawaii	Kailua Kona	78-6957 Kamehameha III Rd, Kailua Kona, HI 96740
Kulana Malama			Honolulu	Ewa Beach	91-1360 Karayan St, Ewa Beach, HI 96706
Avalon Care Center			Honolulu	Honolulu	1930 Kamehameha IV Rd, Honolulu, HI 96819
Care Center of Honolulu			Honolulu	Honolulu	1900 Bachelot St, Honolulu, HI 96817
Hale Ho Aloha			Honolulu	Honolulu	2670 Pacific Heights Rd, Honolulu, HI 96813
Hale Malamalama			Honolulu	Honolulu	6163 Summer St, Honolulu, HI 96821
Hale Nani Rehabilitation and Nursing			Honolulu	Honolulu	1677 Pensacola St, Honolulu, HI 96822
Hale Ola Kino			Honolulu	Honolulu	1314 Kalakaua Ave, Honolulu, HI 96826
Islands Skilled Nursing & Rehabilitation			Honolulu	Honolulu	1205 Alexander St, Honolulu, HI 96826
Kuakini Geriatric Care			Honolulu	Honolulu	347 N Kuakini St, Honolulu HI 96817
Liliha Healthcare Center			Honolulu	Honolulu	1814 Liliha St, Honolulu, HI 96817
Maluhia			Honolulu	Honolulu	1027 Hala Dr, Honolulu, HI 96817
Maunalani Nursing & Rehab			Honolulu	Honolulu	5113 Maunalani Cir, Honolulu, HI, 96816
Nuuanu Hale			Honolulu	Honolulu	2900 Pali Hwy, Honolulu, HI 96817
Oahu Care Facility			Honolulu	Honolulu	1808 S Beretania St, Honolulu, HI 96826
Palolo Chinese Home			Honolulu	Honolulu	2459 10th Ave, Honolulu, HI 96816
The Ching Villas			Honolulu	Honolulu	2230 Liliha St, Ste 500, Honolulu, HI 96817
VA Center for Aging			Honolulu	Honolulu	459 Patterson Rd, Honolulu, HI 96819
Liliha Healthcare Center			Honolulu	Honolulu	1814 Liliha St, Honolulu, HI 96817
Manoa Cottage- Kaimuki			Honolulu	Honolulu	2035 Kamehameha Ave #2102, Honolulu, HI 96822
Leahi Hospital			Honolulu	Honolulu	3675 Kilauea Ave, Honolulu, HI 96816
Aloha Nursing & Rehab Centre			Honolulu	Kaneohe	45-545 Kamehameha Hwy, Kaneohe, HI 96744
Ann Pearl Rehabilitation & Healthcare			Honolulu	Kaneohe	45-181 Waikalua Rd, Kaneohe, HI 96744
Weinberg Care Center			Honolulu	Kaneohe	45-090 Namoku St, Kaneohe, HI, 96744
Ka Punawai Ola			Honolulu	Kapolei	575 Farrington Hwy, Kapolei, HI 96707
Pearl City Nursing Home			Honolulu	Pearl City	919 Lehua Ave, Pearl City, HI 96782
Pu'uwai 'O Makaha			Honolulu	Waianae	84-390 Jade St, Waianae, HI 96792
Hale Kupuna Heritage Home			Kauai	Koloa	4297 Oama Rd, Ste C, Koloa, HI 96756
Garden Isle Healthcare			Kauai	Lihue	3-3420 Kuhi Hwy, Lihue, HI 96766
Kauai Care Center			Kauai	Waimea	9611 Waena Rd, Waimea, HI 96796
Hale Makua-Kahului			Maui	Kahului	472 Kaulana St, Kahului, HI 96732
Hale Makua-Wailuku			Maui	Wailuku	1540 Lower Main St, Wailuku, HI 96793
Total					

Table C-26: Assisted Living Facilities

Facility	Capacity	Staff	County	City	Address
Regency at Hualalai			Hawaii	Kailua Kona	75-181 Hualalai Rd, Kailua Kona, HI 96740
Regency at Puakea			Kauai	Lihue	2130 Kaneka St, Lihue, HI 96766
Roselani Place			Maui	Kahului	88 S Papa Ave, Kahului, HI 96732
Aiea Heights Senior Living			Honolulu	Aiea	99-1657 Aiea Heights Dr, Aiea, 96701
15 Craigside			Honolulu	Honolulu	15 Craigside Pl, Honolulu, HI 96817
Arcadia Retirement Residence			Honolulu	Honolulu	1434 Punahou St, Honolulu, HI 96822
Hawaii Kai Assisted Living & Retirement Community			Honolulu	Honolulu	428 Kawaihae St, Honolulu, HI 96825
Hi'olani Care Center at Kahala Nui			Honolulu	Honolulu	4389 Malia St, Honolulu, HI 96821
One Kalakaua Senior Living			Honolulu	Honolulu	1314 Kalakaua Ave, Honolulu, HI 96826
The Plaza at Waikiki			Honolulu	Honolulu	1812 Kalakaua Ave, Honolulu, HI 96815
Hale Kuike*			Honolulu	Honolulu	95 Kawananakoa Pl, Honolulu, HI 96817
Hale Kuike Pali*			Honolulu	Honolulu	2627 Pali Hwy, Honolulu, HI 96817
Kalakaua Gardens Senior Living Community*			Honolulu	Honolulu	1723 Kalakaua Ave, Honolulu, HI 96826
Pohai Nani			Honolulu	Kaneohe	45-090 Namoku St, Kaneohe, HI 96744
Hale Kuike Bayside*			Honolulu	Kaneohe	45-212 Kaneohe Bay Dr, Kaneohe, HI 96744
Ilima at Leihano			Honolulu	Kapolei	739 Leihano Street, Kapolei, HI 96707
The Plaza at Mililani			Honolulu	Mililani	95-1050 Ukuwai St, Mililani, HI 96789
The Plaza at Moanalua			Honolulu	Moanalua	1280 Moanalualani Pl, Honolulu, HI, 96819
The Plaza at Pearl City			Honolulu	Pearl City	1048 Kuala St, Pearl City, HI 96782
The Plaza at Punchbowl			Honolulu	Punchbowl	918 Lunalilo St, Honolulu, HI 96822
Total					

*Also listed as a Long-Term Care Facility

Table C-27: Adult Residential Care Homes (ARCH)[67]

	Hawaii County	Maui	Molokai	Lanai	City and County of Honolulu	Kauai County	Total
Adult Residential Care Homes (ARCH)	40	9	3	N/A	386	6	444
Adult Residential Care Homes (ARCH) Current Population Served	77	49	8	N/A	1,672	15	1,821
Adult Residential Care Homes (ARCH) Capacity	180	57	15	N/A	2,205	26	2,483
Adult Residential Care Homes (ARCH) Staff Estimate	TBD	TBD	TBD	TBD	TBD	TBD	TBD

[67] https://health.hawaii.gov/ohca/files/2020/10/Combined-ARCH-Expanded-ARCH-Vacancy-Report-By-Area-8-2020.pdf, accessed October 12, 2020.

Table C-28: Community Health Clinics

Health Center Name	County	City	Total Patients	Children (< 18 years old)	Adult (18 - 64)	Older Adults (age 65 and over)	Racial and/or Ethnic Minority
1. Hamakua Health Center	Hawaii	Honokaa	5,604	19.38%	55.28%	25.34%	61.18%
2. The Bay Clinic, Inc.	Hawaii	Hilo	21,344	24.87%	59.47%	15.65%	64.54%
3. West Hawaii Community Health Center, Inc	Hawaii	Kailua Kona	17,199	41.39%	46.35%	12.26%	65.97%
4. Kalihi-Palama Health Center	Honolulu	Honolulu	22,395	31.92%	54.05%	14.03%	93.71%
5. Waikiki Health	Honolulu	Honolulu	9,225	4.89%	81.64%	13.47%	66.60%
6. Waimanalo Health Center	Honolulu	Waimanalo	4,901	28.10%	59.99%	11.92%	83.39%
7. Kokua Kalihi Valley Comprehensive Family Services	Honolulu	Honolulu	11,458	44.27%	44.48%	11.25%	97.63%
8. Ko'olauloa Community Health and Wellness Center, Inc.	Honolulu	Kahuku	5,832	42.13%	49.88%	7.99%	74.22%
9. Waianae District Comp Hlth & Hospital Board, Inc.	Honolulu	Waianae	38,699	36.87%	55.50%	7.63%	90.42%
10. Ho'ola Lahui Hawai'i	Kauai	Lihue	3,648	10.17%	58.94%	30.89%	73.02%
11. Hana Community Health Center, Inc.	Maui	Hana	1,905	24.30%	59.58%	16.12%	57.80%
12. Lana'i Community Health Center	Maui	Lanai City	2,159	31.08%	53.03%	15.89%	80.62%
13. Molokai Ohana Health Care, Inc	Maui	Kaunakakai	2,386	44.22%	42.20%	13.58%	87.55%
14. Community Clinic of Maui, Inc	Maui	Wailuku	12,363	37.61%	54.33%	8.06%	76.47%

Table C-29: Community Care Foster Family Homes (CCFFH)

Hawaii County		
#CCFFHs	TOWN	#BEDS
	East Hawaii	
50	Hilo	138
32	Kea'au	91
5	Honoka'a	14
4	Na'alehu	11
3	Pahoa	7
3	Mt. View	7
1	Pepeekeo	2
1	Papaikou	3
1	Pahala	2
1	Nanawale	2
	West Hawaii	
15	Kailua-Kona	41
2	Kealakekua	6
2	Captain Cook	4
1	Kona	2
1	Kamuela	2
122	TOTALS	332
City and County of Honolulu		
434	Waipahu	1118
189	Ewa Beach	479
85	Honolulu 96819 (Kalihi Valley)	
58	Pearl City	153
49	Wahiawa	122
48	Honolulu 96818 (Aliamanu, Salt Lake)	
39	Aiea	102
34	Kapolei	86
27	Honolulu 96817 (Kalihi Palama)	
19	Waianae	48
10	Kaneohe	24
9	Mililani	21
6	Honolulu 96816 (Kaimuki, Palolo)	
4	Kailua	10
3	Waimanalo	8
2	Waialua, O'ahu	4
2	Honolulu 96815 (Kapahulu)	
2	Honolulu 96822 (Manoa Makiki)	
1	Kahuku	2
	Honolulu-all Zip codes	435

Kauai County		
#CCFFHs	TOWN	#BEDS
13	Lihue	29
6	Kapa'a	15
1	Lawai	3
1	Hanapepe	2
1	Lawai	3
Maui		
39	Kahului	101
11	Wailuku	29
2	Kaunakakai	6
1	Makawao	2
1	Kula	3
1	Kihei	3
1	Haiku	3

Table C-30: Public Housing[68]

Project Name	Location	Studio	Bedrm 1	Bedrm 2	Bedrm 3	Bedrm 4	Bedrm 5	Total # Units
Hawaii County								
Hale Aloha O Puna (E)	Keeau District, Keeau	18	12	0	0	0	0	30
Hale Hauoli (E)	45-540 Kaniaka Pl., Honokaa	24	16	0	0	0	0	40
Hale Hookipa (E)	81-1038 Nani Kupuna Pl., Kealakekua	20	12	0	0	0	0	32
Hale Olaloa (E)	144 Kamana St., Hilo	20	30	0	0	0	0	50
Ka Hale Kahaluu	78-6725 Makolea St., Kailua-Kona	0	8	12	22	8	0	50
Kauhale O'Hanakahi	19 Pamala St., Hilo	0	0	0	0	20	0	20
Kaimalino	74-5060 Kealakaa St., Kailua-Kona	0	10	14	14	2	0	40
Kealakehe	74-991 Manawale'a St., Kailua-Kona	0	16	16	16	0	0	48
Ke Kumu Ekolu	68-3385 Ke Kumu Pl., Waikoloa	0	0	0	20	0	0	20
Ke Kumu Elua	68-3367 Ke Kumu Pl., Waikoloa	0	10	16	0	0	0	26
Lanakila I-1004	600 Wailoa St., Hilo	0	6	32	32	8	0	78
Lanakila II-1013	600 Wailoa St., Hilo	0	4	16	18	6	0	44
Lanakila III-1014	600 Wailoa St., Hilo	0	0	0	8	12	0	20
Lanakila IIIa-1105	600 Wailoa St., Hilo	0	4	12	4	0	0	20
Lanakila IV-1104	600 Wailoa St., Hilo	0	2	18	20	8	0	48
Lokahi	Lokahi Circle, Hilo	0	0	14	16	0	0	30
Nani Olu (E)	81-1011 Nani Kupuna Pl., Kealakekua	0	32	0	0	0	0	32
Noelani I	65-1191 Opelo Rd., Kamuela	0	7	12	0	0	0	19
Noelani II	65-1191 Opelo Rd., Kamuela	0	0	0	24	0	0	24
Pahala (E)	96-1169 Kou St., Pahala	16	8	0	0	0	0	24
Pomaikai Homes (E)	929 Ululani St., Hilo	10	10	0	0	0	0	20
Punahele Homes	Lokahi Pl., Hilo	0	0	30	0	0	0	30
City and County of Honolulu								
Hale Laulima	1184 Waimano Home Rd., Pearl City	0	0	20	16	0	0	36
Hale Po'ai (E)	1001 N. School St., Honolulu	80	126	0	0	0	0	206
Halia Hale (E)	851 N. School St., Honolulu	30	11	0	0	0	41	0
Hauiki Homes	Meyers St., Honolulu	0	0	20	16	10	0	46
Hookipa Kahaluu	47-330 Ahuimanu Rd., Kaneohe	0	8	32	16	0	0	56
Ho'olulu (E)	94-943 Kau'olu Pl., Waipahu	86	26	0	0	0	0	112
Kaahumanu Homes	Alokele & Kaiwiula St., Honolulu	0	0	116	36	0	0	152
Kalakaua Homes	1545 Kalakaua Ave., Honolulu	0	127	58	36	0	0	221
Kalanihuia (E)	1220 Aala St., Honolulu	60	90	0	1	0	0	151
Kalihi Valley Homes	2250 Kalena Dr., Honolulu	0	52	60	123	112	26	373
Kamalu (E)	94-941 Kau'olu Pl., Waipahu	85	24	0	0	0	0	109
Kamehameha Homes	1629 Haka Dr., Honolulu	0	62	123	36	0	0	221

[68] http://www.hpha.hawaii.gov/housingprograms/projects/proj_loc.html

Project Name	Location	Studio	Bedrm 1	Bedrm 2	Bedrm 3	Bedrm 4	Bedrm 5	Total # Units
Kaneohe Apartments	45-503 & 45-507 Pahia Rd., Kaneohe	0	5	19	0	0	0	24
Kauhale Nani	310 North Cane St., Wahiawa	0	14	16	20	0	0	50
Kauhale O'hana	41-1260 Kalanianaole Hwy., Waimanalo	0	0	0	25	0	0	25
Kau'iokalani	85-658 Farrington Hwy., Waianae	0	0	0	50	0	0	50
Koolua Village	Kamau Pl., Kaneohe	0	8	24	36	12	0	80
Kuhio Homes	Ahonui St., Honolulu	0	20	32	37	37	8	134
Kuhio Park Terrace Lowrise	Ahonui St. & Linapuni St, Honolulu	0	0	0	0	40	0	40
Kuhio Park Towers	1475 Linapuni St., Honolulu	0	19	273	55	0	0	347
Kupuna Home O'Waialua (E)	67-088 Goodale Ave., Waialua	24	16	0	0	0	0	40
La'iola (E)	1 & 15 Ihoiho Pl., Wahiawa	60	48	0	0	0	0	108
Makamae (E)	21 S. Kuakini St., Honolulu	108	16	0	0	0	0	124
Makua Alii (E)	1541 Kalakaua Ave., Honolulu	0	210	0	1	0	0	211
Maili I	Maliona St., Maili	0	0	7	13	0	0	20
Maili II	Keliikipi St., Maili	0	0	12	0	12	0	24
Mayor Wright Homes	521 N. Kukui St., Honolulu	0	24	114	168	50	8	364
Nanakuli	Lualei Pl. & Farrington Hwy., Nanakuli	0	0	0	36	0	0	36
Palolo Valley Homes	1035 Spencer St., Honolulu	0	8	34	40	32	4	118
Paoakalani (E)	1583 Kalakaua Ave., Honolulu	90	60	0	1	0	0	151
Puahala Homes I	Ahiahi Pl. & Hala Dr., Honolulu	0	0	0	0	14	14	28
Puahala Homes II	Ahiahi Pl., Honolulu	0	0	12	8	0	0	20
Puahala Homes III	Ahiahi Pl., Honolulu	0	10	14	16	0	0	40
Puahala Homes IV	School St. & Lanakila Ave, Honolulu	0	4	32	4	0	0	40
Pumehana (E)	1212 Kinua St., Honolulu	98	40	1	0	0	0	139
Punchbowl (E)	730 Captain Cooke Ave., Honolulu	0	97	58	1	0	0	156
Puuwai Momi	99-132 Kohomua St., Aiea	0	48	86	88	38	0	260
Salt Lake	2907 Ala Ilima St., Honolulu	0	28	0	0	0	0	28
Spencer House	1035 Spencer St., Honolulu	0	0	1	16	0	0	17
Wahiawa Terrace	Palm St., Wahiawa	0	12	16	24	8	0	60
Waimaha-Sunflower	85-186 McArthur St., Waianae	0	52	46	32	0	0	130
Waimanalo (a & b)	Humuniki St., & Humuna Pl., Waimanalo	0	0	20	24	6	0	50
Waipahu I	94-111 Pupupole St., Waipahu	0	0	12	7	0	0	19
Waipahu II	94-132 Pupupuhi St., Waipahu	0	0	15	5			

Project Name	Location	Studio	Bedrm 1	Bedrm 2	Bedrm 3	Bedrm 4	Bedrm 5	Total # Units
Maui								
David Malo Circle	Mill St., Lahaina	0	2	4	10	2	0	18
Kahale Mua - Federal	Maunaloa, Molokai	0	0	0	25	0	0	25
Kahale Mua- State	Maunaloa, Molokai	0	12	20	0	0	0	32
Kahekili Terrace (A & B)	2015 Holowai Pl., Wailuku	0	12	22	36	12	0	82
Makani Kai Hale I	35 Koapaka Ln., Waiehu	0	0	0	25	0	0	25
Makani Kai Hale II	35 Koapaka Ln., Waiehu	0	0	0	4	0	0	4
Piilani Homes	1028 Wainee St., Lahaina	32	10	0	0	0	0	
Kauai								
Eleele Homes	Ahe St., Eleele	0	2	6	10	6	0	24
Hale Hoolulu (E)	4264 Ala Muku Pl., Kilauea	8	4	0	0	0	0	12
Hale Hoonanea (E) Port Allen	4401 Waialo Rd., Eleele	24	16	0	0	0	0	40
Hale Nana Kai O Kea (E)	4850 Kawaihau Rd., Kapaa	20	18	0	0	0	0	38
Home Nani (E)	Maoana & Laau Rd., Waimea	10	4	0	0	0	0	14
Hui O Hanamaulu	Laukona St., Hanamaulu	0	6	12	16	12	0	46
Kalaheo	Puu Rd., Kalaheo	0	0	2	4	2	0	8
Kapaa	4276 Malu Rd., Kapaa	0	6	8	12	10	0	36
Kawailehua - Federal	5230 Paanau Rd., Koloa	0	0	0	25	0	0	25
Kawailehua - State	5220 Paanau Rd., Koloa	0	6	20	0	0	0	26
Kekaha Ha'aheo	8238 Iwipolena Rd., Kekaha	0	42	12	24	0	0	78

1

Table C-31: Urgent Care Centers

Center Name	Address 1	County	City
1. Hilo Urgent Care	670 Kekuanaoa St	Hawaii	Hilo
2. Hilo Urgent Care Center	45 Mohouli St	Hawaii	Hilo
3. Kauka Express Urgent Care Clinic	2100 Kanoelehua Ave	Hawaii	Hilo
4. Aloha Kona Urgent Care	75-5995 Kuakini Hwy	Hawaii	Kailua Kona
5. Kea'au Urgent Care Clinic	16612 Old Volcano Rd	Hawaii	Keaau
6. Keauhou Urgent Care Center	78-6831 Alii Dr	Hawaii	Keauhou
7. Queens Island Urgent Care Pearl Kai	98-199 Kamehameha Hwy	Honolulu	Aiea
8. Straub Clinic Walk-In Pearlridge	98-151 Pali Momi St	Honolulu	Aiea
9. Concentra Honolulu	545 Ohohia St	Honolulu	Honolulu
10. Kalihi-Kai Urgent Care	2070 N King St	Honolulu	Honolulu
11. Kuhio Walk-In Clinic	2310 Kuhio Ave	Honolulu	Honolulu
12. Queens Island Urgent Care Hawaii Kai	6600 Kalanianaole Hwy	Honolulu	Honolulu
13. Queens Island Urgent Care Kakaako	400 Keawe St	Honolulu	Honolulu
14. Queens Island Urgent Care Kapahulu	449 Kapahulu Ave	Honolulu	Honolulu
15. Straub Clinic Walk-In Hawaii Kai	7192 Kalanianaole Hwy	Honolulu	Honolulu
16. Straub Clinic Walk-In Honolulu	888 S King St	Honolulu	Honolulu
17. Urgent Care Clinic of Waikiki	2155 Kalakaua Ave	Honolulu	Honolulu
18. Urgent Care Hawaii - Waikiki	1860 Ala Moana Blvd	Honolulu	Honolulu
19. Braun Urgent Care Kailua	130 Kailua Rd	Honolulu	Kailua
20. Urgent Care Hawaii - Kailua	660 Kailua Rd	Honolulu	Kailua
21. Windward Urgent Care	46001 Kamehameha Hwy	Honolulu	Kaneohe
22. Urgent Care Hawaii - Kapolei	890 Kamokila Blvd	Honolulu	Kapolei
23. Straub Clinic Walk-In Mililani	95-1249 Meheula Pkwy	Honolulu	Mililani
24. Urgent Care Hawaii - Pearl City	1245 Kuala St	Honolulu	Pearl City
25. Desmond T. Doss Health Clinic	3399 Glennan Street	Honolulu	Schofield Barracks
26. Waianae Coast Walk-In	86-120 Farrington Hwy	Honolulu	Waianae
27. Kunia Urgent Care	94-673 Kupuohi St	Honolulu	Waipahu
28. Urgent Care at Poipu	2829 Ala Kalanikaumaka St	Kauai	Koloa
29. Kauai Urgent Care	4484 Pahee St	Kauai	Lihue
30. Makana North Shore Urgent Care	4488 Hanalei Plantation Rd	Kauai	Princeville
31. Doctors on Call Hyatt Regency Maui	200 Nohea Kai Dr	Maui	Lahaina
32. Doctors on Call North Ka'anapali	3350 Lower Honoapiilani Rd	Maui	Lahaina
33. Minit-Medical Urgent Care	305 Keawe Street	Maui	Lahaina
34. Urgent Care West Maui	2580 Kekaa Dr	Maui	Lahaina
35. Urgent Care Wailea Makena	100 Wailea Ike Dr	Maui	Wailea
36. Maui Medical Wailuku Office Walk-In	2180 Main Street	Maui	Wailuku

Table C-32: Chain/Independent Pharmacies[69]

County	# of Pharmacies
Hawaii County	42
City and County of Honolulu	172
Kauai County	27
Maui County	33
Molokai	2
Lanai	1
Total	**277**

[69] https://cca.hawaii.gov/pvl/files/2020/08/WebGeo_072820.pdf

Table C-33: Schools (High Schools)[70]

School Name	County	city	address
1. Hilo High School	Hawaii	Hilo	556 Waianuenue Avenue
2. Keaau High School	Hawaii	Keaau	16-725 Keaau-Pahoa Road
3. Kealakehe High School	Hawaii	Kailua-Kona	74-5000 Puohulihuli Street
4. Kohala High School	Hawaii	Kapaau	54-3611 Akoni Pule Highway
5. Konawaena High School	Hawaii	Kealakekua	81-1043 Konawaena School Road
6. Waiakea High School	Hawaii	Hilo	155 W. Kawili Street
7. Aiea High School	Honolulu	Aiea	98-1276 Ulune Street
8. Campbell High School	Honolulu	Ewa Beach	91-980 North Road
9. Castle High School	Honolulu	Kaneohe	45-386 Kaneohe Bay Drive
10. Farrington High School	Honolulu	Honolulu	1564 North King Street
11. Kailua High School	Honolulu	Kailua	451 Ulumanu Drive
12. Kaimuki High School	Honolulu	Honolulu	2705 Kaimuki Avenue
13. Kaiser High School	Honolulu	Honolulu	511 Lunalilo Home Road
14. Kalaheo High School	Honolulu	Kailua	730 Iliaina Street
15. Kalani High School	Honolulu	Honolulu	4680 Kalanianaole Highway
16. Kapolei Charter School PCS	Honolulu	Kapolei	2140 Lauwiliwili Street
17. Kapolei High School	Honolulu	Kapolei	91-5007 Kapolei Parkway
18. Leilehua High School	Honolulu	Wahiawa	1515 California Avenue
19. McKinley High School	Honolulu	Honolulu	1039 South King Street
20. Mililani High School	Honolulu	Mililani	95-1200 Meheula Parkway
21. Moanalua High School	Honolulu	Honolulu	2825 Ala Ilima Street
22. Pearl City High School	Honolulu	Pearl City	2100 Hookiekie Street
23. Radford High School	Honolulu	Honolulu	4361 Salt Lake Blvd.
24. Roosevelt High School	Honolulu	Honolulu	1120 Nehoa Street
25. Waianae High School	Honolulu	Waianae	85-251 Farrington Highway
26. Waipahu High School	Honolulu	Waipahu	94-1211 Farrington Highway
27. Kapaa High School	Kauai	Kapaa	4695 Mailihuna Road
28. Kauai High School	Kauai	Lihue	3577 Lala Road
29. Waimea High School	Kauai	Waimea	9707 Tsuchiya Road
30. Baldwin High School	Maui	Wailuku	1650 Kaahumanu Avenue
31. Kekaulike High School	Maui	Pukalani	121 Kula Highway
32. Lahainaluna High School	Maui	Lahaina	980 Lahainaluna Road
33. Maui High School	Maui	Kahului	660 South Lono Avenue
34. Molokai High School	Molokai	Hoolehua	2140 Farrington Avenue

[70]

Table C-34: Schools (Colleges/Universities)

University/College	County	City	Address
Hawaii Community College	Hawaii	Hilo	200 W Kawili St
University of Hawaii at Hilo	Hawaii	Hilo	200 West Kawili Street
Hawaii Pacific University	Honolulu	Honolulu	1164 Bishop Street Suite 800
Brigham Young University - Hawaii	Honolulu	Laie	55-220 Kulanui Street
Chaminade University of Honolulu	Honolulu	Honolulu	3140 Waialae Ave
Hawaii Tokai International College	Honolulu	Honolulu	2241 Kapiolani Blvd.
Honolulu Community College	Honolulu	Honolulu	874 Dillingham Blvd
Kapi'olani Community College	Honolulu	Honolulu	4303 Diamond Head Rd
Leeward Community College	Honolulu	Pearl City	96-045 Ala Ike
University of Hawaii - West Oahu	Honolulu	Kapolei	91-1001 Farrington Highway
University of Hawaii at Manoa	Honolulu	Honolulu	2500 Campus Road, Hawaii Hall
Windward Community College	Honolulu	Kaneohe	45-720 Keaahala Rd
Kauai Community College	Kauai	Lihue	3-1901 Kaumualii Hwy
University of Hawaii Maui College	Maui	Kahului	310 Kaahumanu Ave

Table C-35: School-based health centers

To be published

Table C-36: Health Care Provider Offices

Health Care Provider Offices	Establishments	Number of employees[71]
Subject to federal income tax		
Ambulatory health care services	2,597	22,564
Offices of physicians	1,099	6,875
Offices of dentists	621	4,035
Offices of other health practitioners	596	2,607
Tax Exempt		
Ambulatory health care services	142	6,514
Total	5,055	42,595

Table C-37: Outpatient Clinics

Outpatient Clinics	Establishments	Number of employees
Subject to Federal Income Tax	123	3,909
Tax Exempt	102	4,385
Total	225	8,294

Table C-38: Government Employee Planning Estimates[72]

Organization	C&C Honolulu	Hawaii County	Maui County	Kauai County	Total
Federal Gov. Employees	24,800	75	75	50	25,000
Active Duty Military	50,700	50	50	200	51,000
*State Gov. Employees	71,538	250	250	100	72,138
*Local Gov. Employees	9,304	2,415	2,328	1,232	15,279
Total	156,342	2,790	2,703	1,582	163,417
Dependents (estimated based on 1.7 factor)	265,781	4,743	4,595	2,689	277,808
Total	422,123	7,533	7,298	4,271	441,225
					***Includes part time gov. state/local employees**

[71] U.S. Census Bureau, 2017 Economic Census, Table EC1762
[72] https://data.census.gov/

Table C-39: Top 25 Employers within Hawaii

Top 25 Employers in Hawaii		
Employer[73]	2019	
	Rank[74]	Employees
The Queen's Health Systems	1	7,479
Hawaii Pacific Health	2	7,273
Hawaiian Electric Industries Inc.	3	3,841
Kamehameha Schools	4	3,758
Hawaii Health Systems Corp.	5	2,553
Kaiser Foundation Health Plan	6	2,477
Securitas Security Services USA Inc.	7	2,302
Bank of Hawaii Corp.	8	2,083
Oahu Transit Services Inc.	9	2,026
First Hawaiian Bank	10	1,991
Aulani, A Disney Resort & Spa	11	1,800
Polynesian Cultural Center	12	1,500
Prince Resorts Hawaii Inc.	13	1,495
Hawaiian Telcom	14	1,115
Adventist Health Castle	15	1,054
Grand Hyatt Kauai Resort & Spa	16	906
Central Pacific Bank	17	851
Four Seasons Resort Lanai	18	850
Kamaaina Care Inc. dba Kamaaina Kids	19	782
Nan Inc.	20	736
Fairmont Orchid, Hawaii	21	700
Bayer U.S. - Crop Science	22	681
Waianae Coast Comprehensive Health Center	23	674
Ritz-Carlton, Kapalua	24	640
Pasha Hawaii	25	465

[73] Pacific Business News, "The List Employers - Statewide, Ranked by Number of Employees as of December 31, 2018" (July 5, 2019), page 18 https://www.bizjournals.com/pacific/subscriber-only/2019/07/05/employers-statewide.html accessed July 5, 2019; and Ibid. "As of December 31, 2019" (July 3, 2020), page 17 https://www.bizjournals.com/pacific/digital-edition?issue_id=14716 accessed July 6, 2020.
[74] All other agencies not ranked.

Appendix D: Logistics

Vaccine Allocation

The CDC will allocate COVID-19 vaccine(s) for use by the state of Hawaii[1] as COVID-19 vaccine(s) become available based on a variety of factors such as the following:

- COVID-19 vaccine production and availability
- Current local spread/prevalence of COVID-19
- Percentage of populations in Hawaii identified for initial allocation of vaccine as recommended by the Advisory Committee on Immunization Practices (ACIP)/ National Academies of Sciences, Engineering, and Medicine (NASEM)
- Overall population in Hawaii

The Vaccine Tracking System (VTrckS), a critical component of the Vaccine Management Business Improvement Project (VMBIP), is a secure, web-based information technology system that integrates the entire publicly-funded vaccine supply chain from purchasing and ordering through distribution to participating state, local, and territorial health departments (referred to as 'awardees') and health care providers.

Figure D-1: Vaccine Tracking System

The state of Hawaii HDOH Immunization Branch (IMB) will then need to order the vaccine from its CDC allotment through the CDC Vaccine Tracking System (VTrckS) system[2] in order for vaccine to be directly shipped to the designated vaccination provider. A HDOH led COVID-19 Prioritization/Allocation Working Group **(see Appendix C: Critical Populations for additional details)** will support vaccine allocation efforts as depicted in **Figure D-1**. The HDOH Director will have the final authority on allotment decisions.

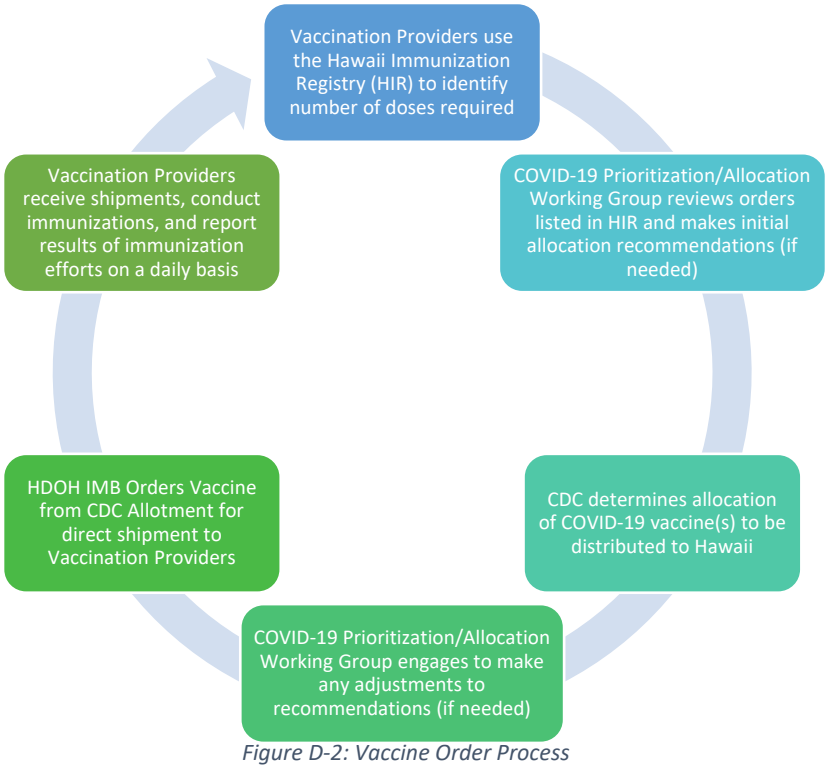

Figure D-2: Vaccine Order Process

[1] NOTE: Per CDC guidance, Federal agencies and additional commercial partners will also receive allocations directly from CDC once larger volumes of vaccine are available. CDC is currently developing procedures to ensure that jurisdictions have full visibility of COVID-19 vaccine supply and vaccination activities among these entities located within their boundaries.

[2] https://www.cdc.gov/vaccines/programs/vtrcks/index.html

The COVID-19 Prioritization/Allocation Working Group working with IMB will base allotment decisions on factors such as the following **(see Appendix C: Critical Populations for additional details)** with additional explanations provided below:

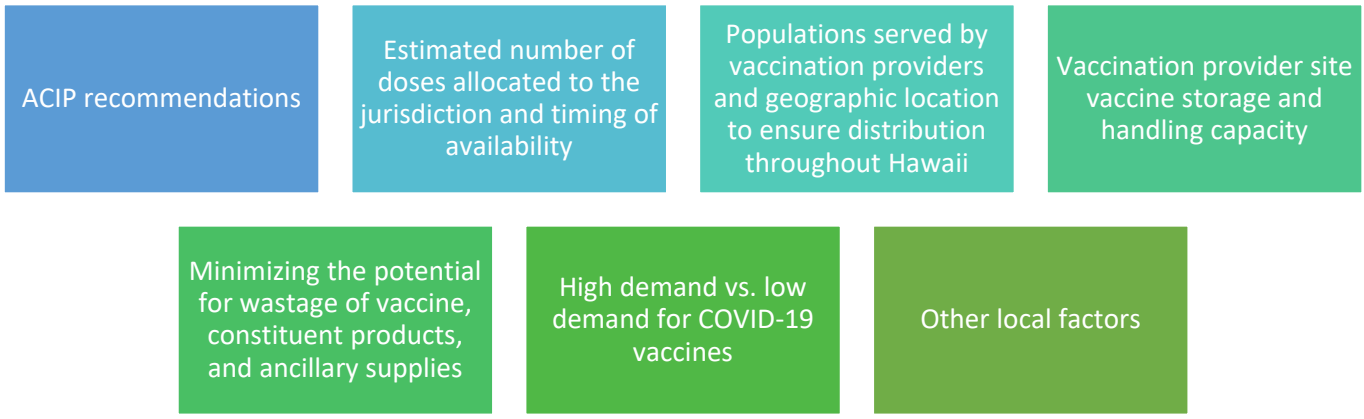

Figure D-3: Vaccine Allotment Decision Factors

Vaccination provider site vaccine storage and handling capacity

For initial allocation of vaccine(s) under Phase 1 of this plan **(see Section 3.0: Concept of Operations)** large healthcare systems and hospitals will likely have the most vaccine storage and handling capacity. Those organizations could be expected to vaccinate their own staff and stakeholders. This is especially critical, since current distribution, shipping, and ultra-cold storage requirements (-60°C to -80°C) for potential COVID-19 vaccines such as minimum ordering quantities will limit options to send vaccines directly to smaller vaccination providers. This could require large healthcare systems/hospitals to partner with smaller healthcare providers or other stakeholders to assist in distribution efforts for orders that are below the minimum ordering quantity.

High demand vs. low demand for COVID-19 vaccines

In situations where there is a high demand for COVID-19 vaccine(s), the COVID-19 Prioritization/Allocation Working Group may need to provide additional input to guide allocation decisions, and provide clear messaging for stakeholders on the process used to make those allocation decisions. If there is a low demand for COVID-19 vaccines, the COVID-19 Communications Working Group and the COVID-19 Medical Advisory Group will analyze the root causes of the lack of demand and provide recommendations for addressing those issues.

Vaccine Ordering

For every approved COVID-19 vaccination provider location, HDOH staff will create a Hawaii Immunization Registry (HIR) provider organization and populate the following:

- Provider/Facility Name
- Provider/Facility address
- Hours of operation
- Contact persons (Primary/Alternate)[3]
- Unique 5-digit PIN

[3] **NOTE:** Facilities should make sure providers are aware of their facility contact person for their orders – this is a lesson learned from H1N1 where some providers in large practices were not aware of their facility POC which hampered delivery efforts.

Every location approved to receive COVID-19 vaccine must have a HIR account and corresponding VTrckS account. Providers may access their HIR account via unique login and manage/update shipment information, including delivery days and times directly. HDOH will export provider information from HIR each time an order is processed for fulfillment and upload that information to VTrckS to ensure continuous harmonization between HIR and VTrckS for every COVID-19 vaccine order processed. Providers will only access HIR to place COVID-19 orders ("prebook requests"). Access to VTrckS is restricted to approved HDOH staff who have successfully completed the CDC Secure Access Management Services (SAMS)[4] and VTrckS onboarding Process.

The SAMS portal is a web site designed to provide centralized access to public health information and computer applications operated by the U.S. Centers for Disease Control and Prevention (CDC).

Figure D-4: SAMS Portal

HDOH Administrative Requirements for COVID-19 Vaccine Order Processing:

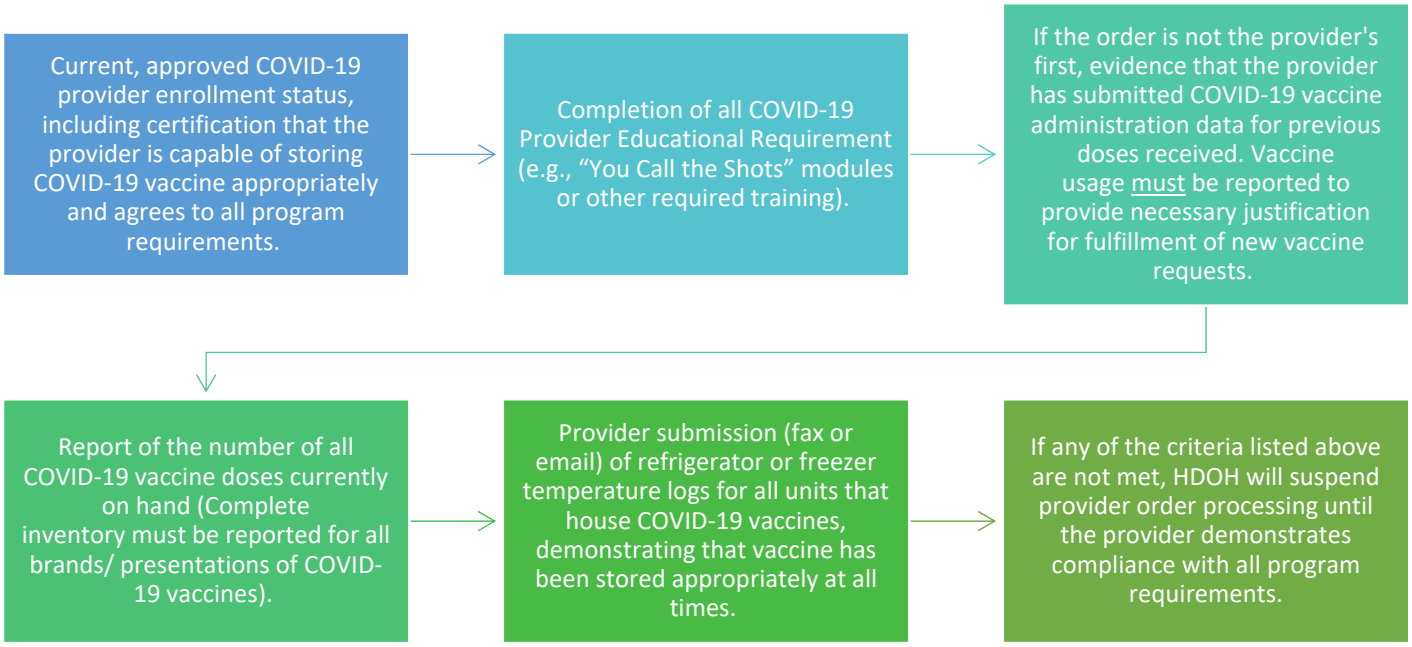

Figure D-5: HDOH Administrative Requirements for COVID-19 Vaccine Order Processing

[4] Secure Access Management Services

HIR Prebook procedures

If operational, HDOH will manage/fulfill provider requests for COVID-19 vaccine by leveraging existing HIR flu prebook functionality. Vaccination providers will submit orders for COVID-19 vaccine to HDOH IMB via the "manage flu-prebook"[5] HIR menu option **(see Figure D-6)** in quantities aligned with the minimum number of doses allowed per order based on vaccine type. At the micro, or user/provider level, HIR allows for partial fulfillment and tracking of limited-supply vaccines available only via CDC allocation.

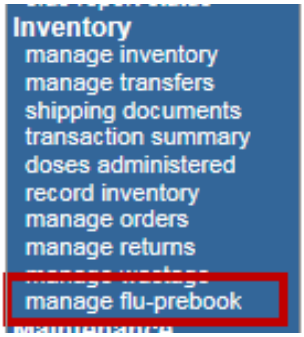

Figure D-6: Hawaii Immunizatio Registry (HIR) "Manage" Flu-Prebook Menu Option

At the macro, or state administrator level, IMB is able to coordinate overall provider order management, including rapid order allocation and fulfillment tracking for multiple providers. IMB also has visibility into orders shipped and received, including lot numbers of all supplied vaccines.

HDOH staff will manage CDC COVID-19 allocations and provider partial distributions to approved COVID-19 providers via "Manage Prebook Administration" functionality within HIR. This functionality allows for the creation of individual "Prebook Windows" which can include specific products, assigned by National Drug Code (NDC), which are viewable/accessible only to providers that have been granted permission to view specific prebook windows/vaccine formularies. Prebook window access permissions are controlled by HDOH IMB. Should a previously approved provider be found to be non-compliant with program requirements, HDOH IMB can suspend provider COVID-19 vaccine ordering privileges and HIR technical validations will not permit future orders/allocations to be completed/processed.

When Hawaii state vaccine allocations are available from the CDC, depending on supply and application of predetermined prioritization/allocation schema and the number of Phase I high priority patients/staff indicated by providers in their COVID-19 Provider Profile, HDOH IMB will review and approve the order made by a provider and enter appropriate vaccine shipment quantities into the provider's HIR account. The HIR account will then generate an export file (CSV format) via "Vtrcks flu file export" functionality **(see Figure D-7)**.

Figure D-7: HIR "VTrcks Flu File Export" Menu Option

Distribution will only occur to approved COVID-19 providers who serve prioritized populations and have the capacity to properly store and manage COVID-19 vaccine

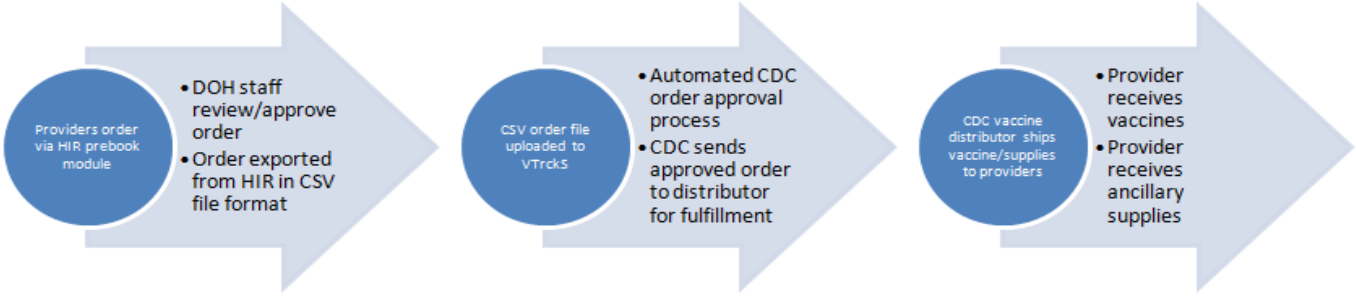

Figure D-8: Vaccine Order process

[5] **NOTE:** If HIR enhancement is possible, the HIR prebook module will be renamed "manage COVID-19 prebook" to avoid confusion with the Vaccines for Children (VFC) program provider influenza vaccine ordering process. HDOH IMB will update the Hawaii VFC program influenza prebook training presentation to reflect COVID-19-specific programmatic and technical requirements and processes. For a full description of HIR prebook functionality and provider order placement instructions refer to: https://health.hawaii.gov/docd/for-healthcare-providers/influenza-prebook/

inventory.[6] HDOH IMB will upload the CSV order file to VTrckS via the VTrckS External Information System (ExIS) interface for order fulfillment. CDC's automated approval process will then either forward the order information to the CDC vaccine/ancillary supply distributor or reject the order if insufficient supply is available in the State's allocation.

HIR Prebook Alternate (Back-up) Procedures

- Should HIR prebook functionality become inoperable, HDOH staff would revert to back-up manual, paper-based ordering systems (e.g., faxed or scanned orders from providers) to generate provider tracking spreadsheets which would record provider vaccine order amounts.
- As allocations are made available from the CDC, HDOH staff would manually generate CSV order files according to previously mentioned prioritization/allocation schema for upload to VTrckS and manually track provider order fulfillment until the provider's entire prebook request is fulfilled.
- In this time consuming and labor- intensive scenario, providers would not be able to manage inventory via HIR unless they enter the inventory records into the HIR inventory module themselves (i.e., shipment transfers will not be automatically created in HIR).
- HDOH IMB will notify impacted providers, as well as HDOH leadership.

Figure D-9: HIR Prebook Alternate (Back-up) Procedures

HDOH staff will download COVID-19 vaccine shipment information daily via VTrckS ExIS "shipment export" functionality and import into HIR via "Import VTrckS Vaccine Shipment Data" functionality. Once the HIR shipment import is complete, individual COVID-19 provider orders will populate with the number of doses they will receive. HIR will automatically generate "transfer" records which COVID-19 providers can accept into their HIR inventory module upon vaccine arrival, allowing providers to manage their COVID-19 vaccine inventory within HIR.

As CDC allocations of COVID-19 vaccine are made available and supply permits expansion of target populations/progression through Phase I and subsequent distribution Phases, HDOH staff will onboard and expand the number of providers able to access the HIR prebook module and will allocate vaccine to providers until their entire prebook amount is fulfilled. Upon total fulfillment, provider prebook request status will indicate "COMPLETE" and providers will no longer receive vaccine shipments. Should additional vaccine be required by the provider, a new prebook request must be entered into HIR.

[6] NOTE: Vaccine orders shall be fulfilled in a manner that equitably distributes vaccines to providers located statewide, inclusive of all islands **(see Appendix C: Critical Populations)**.

Minimum Order Requirements[7]

The minimum order size and increment for centrally distributed vaccines will be 100 doses per order; though early in the response, some ultra-cold (-60°C to -80°C) vaccine (if authorized for use or approved) may be shipped directly from the manufacturer in larger quantities (potentially 1000 dose minimum order). CDC will share more information on these shipments as it becomes available. Ancillary supplies will be packaged in kits and will be automatically ordered in amounts to match vaccine orders in VTrckS. Each kit will contain supplies to administer 100 doses of vaccine, including:

- Needles, 105 per kit (various sizes for the population served by the ordering vaccination provider)
- Syringes, 105 per kit
- Alcohol prep pads, 210 per kit
- 4 surgical masks and 2 face shields for vaccinators, per kit
- COVID-19 vaccination record cards for vaccine recipients, 100 per kit

NOTE:

- Ancillary supply kits will not include sharps containers, gloves, and bandages.
- Additional personal protective equipment (PPE) may be needed depending on vaccination provider site needs.
- HDOH IMB will provide additional information regarding these additional supplies to vaccination providers as needed.

Figure D-10: Ancillary Supply Kits

For COVID-19 vaccines that require reconstitution with diluent or mixing with adjuvant at the point of administration, mixing kits with syringes, needles, and other needed supplies will also be included.

As noted previously, facilities ordering outside of their jurisdiction's allocation (i.e., commercial, and federal entities with federal MOUs in place) will order directly from CDC, and CDC will be responsible for approval of those orders.

Vaccine Distribution[8]

COVID-19 vaccines and ancillary supplies will be procured and distributed by the federal government at no cost to enrolled COVID-19 vaccination providers. CDC will use its centralized distribution contract to fulfill orders for most vaccine products and associated ancillary supplies. Some vaccine products, such as those with ultra-cold temperature requirements, will be shipped directly from the manufacturer to the vaccination provider site. HDOH IMB will ensure accurate and complete shipping information (e.g., shipment address, provider contact information, shipping hours) is available in VTrckS for all vaccine shipments to enrolled vaccination providers.

- The CDC vaccine distributor has historically only shipped to Hawaii providers Monday - Wednesday of each week, so potential delays may be experienced for provider orders processed in the latter portion of the week.
- HDOH IMB staff will monitor provider deliveries to ensure the delivery timeframe is in alignment with CDC-specified delivery timeframes.

Figure D-11: Vaccine Distribution

COVID-19 vaccine (and diluent or adjuvant, if required) will be shipped to vaccination provider sites enrolled by HDOH IMB within 48 hours of order approval. Because of cold chain requirements, ancillary supply kits (and diluent, if applicable) will ship separately from vaccine but should arrive before or on the same day as vaccine **(see Figure D-12 below)**[9].

[7] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.
[8] Ibid.
[9] https://www.cdc.gov/flu/pandemic-resources/index.htm, accessed on October 13, 2020.

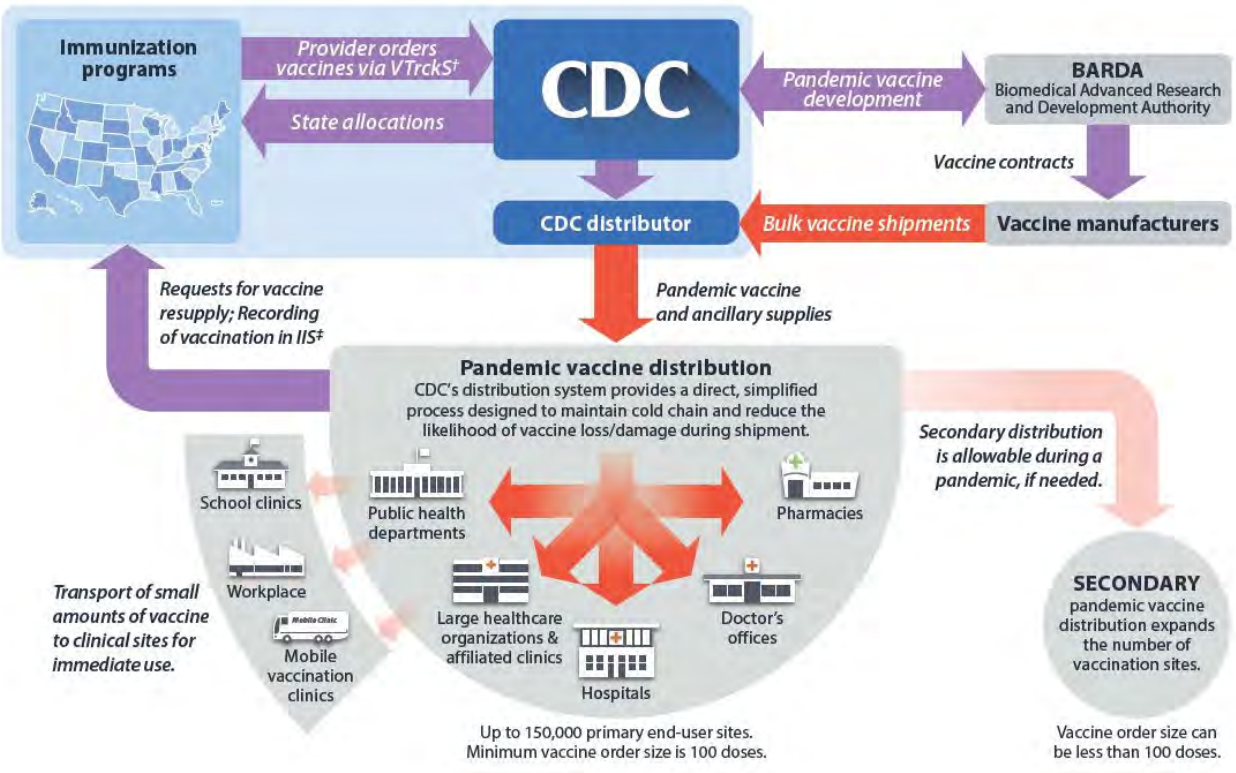

Figure D-12: Distribution of pandemic vaccine and supplies

The federally contracted vaccine distributor uses validated shipping procedures to maintain COVID-19 vaccine cold chain and minimize the likelihood of vaccine loss or damage during shipment. Once a vaccine product has been shipped to a COVID-19 vaccination provider site, the federal government will neither redistribute the product nor take financial responsibility for its redistribution.

Whenever possible, the CDC will ship vaccine to the location where it will be administered to minimize potential breaks in the cold chain. However, there may be circumstances where COVID-19 vaccine needs to be redistributed beyond the identified primary CDC ship-to sites (i.e., for orders smaller than the minimum order size or for large organizations whose vaccine is shipped to a central depot and requires redistribution to additional clinic locations). In these instances, vaccination provider organizations/facilities, third-party vendors, and other vaccination providers may be allowed, if approved by HDOH IMB, to redistribute COVID-19 vaccine, if validated cold-chain procedures are in place in accordance with the manufacturer's instructions and CDC's guidance on COVID-19 vaccine storage and handling. These entities must sign and agree to conditions in the CDC COVID-19 Vaccine Redistribution Agreement for the sending facility/organization and have a fully completed and signed CDC COVID-19 Vaccination Provider Profile form for each receiving location.

Prior to redistribution of COVID-19 vaccine, enrolled providers are required to submit their cold-chain procedures, in accordance with the manufacturer's instructions and CDC's guidance on COVID-19 vaccine storage and handling. The Vaccine Supply and Distribution Section (VSDS) Supervisor will be responsible for approving redistribution of COVID-19 vaccine between enrolled providers after reviewing submitted cold chain procedures.

Figure D-13: Cold Chain Requirements

HDOH IMB will be extremely judicious in allowing redistribution and limit any redistribution to refrigerated vaccines only. HDOH IMB may

occasionally allow local transport of vaccines from one location to another if adherence to cold chain and tracking requirements are maintained.

CDC does not pay for or reimburse jurisdictions, COVID-19 vaccination provider organizations, facilities, or other entities for any redistribution beyond the initial designated primary CDC ship-to location, or for any vaccine-specific portable refrigerators and/or qualified containers and pack-outs.

Scenario 1 Specific Distribution Guidance – Vaccine A[10]

The minimum order for Vaccine Candidate A is 1,000 doses so providers receiving this vaccine directly must demonstrate the ability to rapidly administer vaccines within the period of time vaccines may be stored in the ultra-cold shipment box (10 days) as well as sufficient high priority populations to vaccinate. According to CDC guidance, organizations receiving Vaccine Candidate A must repack the ultra-cold shipping cooler with dry ice within 24 hours of receipt and repack again within 5 days to maintain ultracold storage temperatures for the duration of the 10-day period. Providers anticipating receipt of Vaccine Candidate A must make arrangements for the procurement of sufficient quantities of dry ice prior to vaccine arrival. If large providers are approved to redistribute Vaccine Candidate A to affiliated satellite clinics/locations, the sending provider must complete and sign the CDC COVID-19 Vaccine Redistribution Agreement and the receiving provider must complete and sign a CDC COVID-19 Vaccination Provider Profile form.

All parties must strictly adhere to validated cold-chain procedures in accordance with vaccine manufacturer's instructions and CDC guidance on COVID-19 vaccine storage and handling. Vaccine redistributions shall be limited to refrigerated temperatures only so locations receiving redistributed doses of Vaccine Candidate A must administer doses within 24-48 hours of receipt. Equivalent vaccine administration ancillary supplies must accompany any redistributed vaccine doses.

For smaller COVID-19 providers, if only Vaccine Candidate A is available, HDHO located on each major island may serve as a vaccine depot site from which vaccination "strike teams"/mobile units will be deployed to rapidly administer Vaccine Candidate A to designated critical populations. Thawed vaccine (stored at 2°C - 8°C) must be administered within five days and reconstituted (room temperature) vaccine must be administered within 6 hours **(see Appendix G: Vaccine Characteristics for additional information)**.

Scenario 2 Specific Distribution Guidance – Vaccine B[11]

The minimum order for Vaccine Candidate B is 100 doses, so, if available, this vaccine could be deployed directly to smaller provider sites who have demonstrated sufficient storage space and have identified high priority populations to vaccinate.

If providers wish to redistribute Vaccine Candidate B to affiliated satellite clinics/locations, the sending provider must complete and sign the CDC COVID-19 Vaccine Redistribution Agreement and the receiving provider must complete and sign a CDC COVID-19 Vaccination Provider Profile form. All parties must strictly adhere to validated cold-chain procedures in accordance with vaccine manufacturer's instructions and CDC guidance on COVID-19 vaccine storage and handling. Vaccine redistributions shall be limited to refrigerated temperatures only so locations receiving redistributed doses of Vaccine Candidate B must administer doses within 7-14 days of receipt. Equivalent vaccine administration ancillary supplies must accompany any redistributed vaccine doses.

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[10] **NOTE:** This information is from the *COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020* and may change – HDOH IMB will distribute updated information/guidance as it becomes available.

[11] Ibid.

For COVID-19 providers requiring less than 100 doses, if only Vaccine Candidate B is available, HDHO offices located on each major island may serve as a vaccine depot site from which either vaccine redistribution will occur or vaccination "strike teams"/mobile units will be deployed to administer Vaccine Candidate B to designated critical populations. For ease of vaccine storage, providers receiving direct shipments of Vaccine Candidate B will be encouraged to use vaccines within the time period at which the vaccine can be stored at refrigerated temperatures (2°C - 8°C for 7-14 days).

Scenario 3 Specific Distribution Guidance – Vaccines A and B[12]

If both Vaccine Candidate A and Vaccine Candidate B are available, Candidate A vaccines will be directed to large provider organizations, such as local hospital systems or private sector networks such as chain pharmacies with established relationships with prioritized populations (e.g., Long Term Care facilities) to ensure rapid deployment of vaccines, given the storage limitations and handling requirements for that vaccine. Vaccine Candidate B will be directed to smaller COVID-19 provider sites with sufficient refrigerator storage capacity and the ability to rapidly administer vaccines (i.e., within 7-14 days).

Vaccine Shipment Arrival Procedures

- Providers should **never** refuse vaccine shipments under any circumstances including delivery after provider hours (i.e., suspected "warm"/spoiled vaccines) or damage to the exterior package.
- Upon arrival, providers must open the package **immediately**, check the temperature monitor reading (if available), inspect the vaccine, compare the vaccine received with the vaccine products indicated on the packing list, and store at the appropriate temperature.
- Vaccine storage units must be in secure locations and temperatures must be continually monitored via digital temperature data loggers.
- If providers suspect that vaccine viability has been compromised, vaccines must be separated from non-affected vaccine stock (e.g., placed in a paper or zip-top bag), labeled "Do Not Use," and stored at appropriate temperatures until vaccine viability is determined.
- Providers must be prepared to supply photos of the shipping container, packaging, and any activated temperature monitors. Photos must be taken for documentation purposes and avoid disposal of shipping boxes/packaging, packing slips, and temperature monitors of the vaccine(s) which may have been compromised until the situation is resolved.
- COVID-19 vaccine providers must contact HDOH IMB (DOH.Immunization@doh.hawaii.gov) on the **same day** that delivery has occurred to report any shipping incidents.
- HDOH IMB staff will work with providers, vaccine distributors, and vaccine manufacturers to determine if vaccine is viable, replace vaccines (if available), and arrange for the return of any spoiled vaccine.

Over Shipments and Mis-shipments

Over Shipments	Mis-shipments
•Defined as situations in which the vaccine quantity shipped to a provider exceeds the amount that was ordered.	•Defined as shipments that include at least one vaccine product that was not ordered by the provider.

Figure D-14: Over Shipments/Mis-Shipments

[12] Ibid.

- In each of the above-listed situations, vaccines which exceed a provider's immediate need have been shipped.
    - Providers must contact HDOH IMB to arrange for transfer to a COVID-19 provider in the near vicinity.
    - The HDOH IMB will arrange for pick-up of excess vaccine supplies and transfer to another COVID-19 provider.
    - Transport methods will constitute "redistribution" so vaccine will be maintained at refrigerated temperatures (2°C - 8°C) during transit.
    - Receiving organizations must agree to administer vaccinations within the window at which vaccine can be stored at 2°C - 8°C.

Delivery Shortage

- A delivery shortage has occurred if a product is listed on the packing slip but is not included in the vaccine shipment.
- If this occurs, providers must contact HDOH IMB to report the incident and request additional vaccine, if available. HDOH IMB staff will work with the CDC contracted vaccine distributor to arrange for the shipment of additional vaccine, if available.
- **Delivery shortage reports must be made on <u>the same day</u> that delivery has occurred.**
- Please be prepared to provide the following information and answer the following questions:

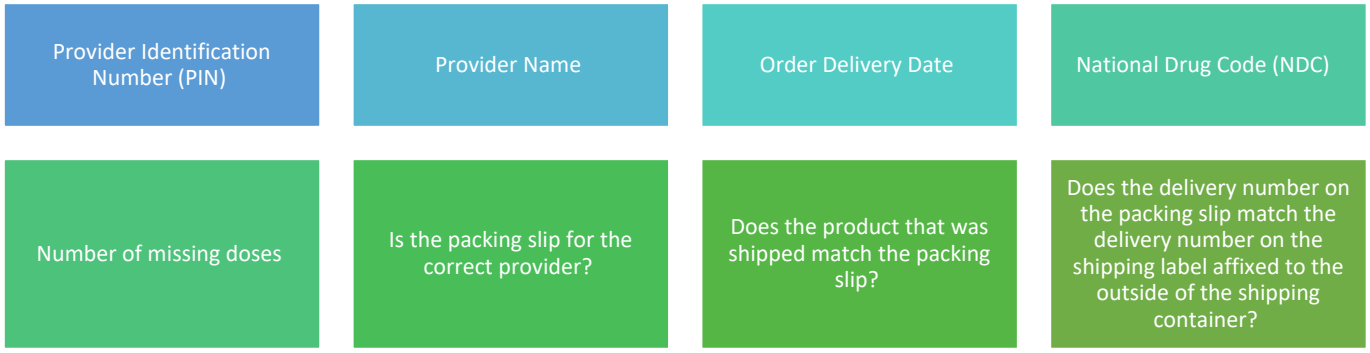


Figure D-15: Delivery Shortage Reporting Requirements

Concealed Shortage

- A concealed shortage is defined as product shortages that are found within the manufacturer's packaging. For example, after a new box of vaccine is opened, provider discovers that only 6 doses are included in the vial, rather than 10.
- Concealed shortage reports must be made as soon as the issue is discovered.

Diluent or Adjuvant Shortage

- For shipments of COVID-19 vaccine which requires the use of diluents or adjuvants, providers must ensure that they inventory the number of diluent and/or adjuvant doses supplied as soon as the shipment arrives to verify that the number supplied matches the number of vaccine doses received.
- **Requests for missing diluent and/or adjuvant must be made on <u>the same day</u> the shipment is received.**
- If there is a shortage, providers must contact HDOH IMB to report the incident and request additional diluent and/or adjuvant.

- HDOH staff will work with the CDC vaccine distributor or vaccine manufacturer to arrange for the shipment of additional diluent and/or adjuvant.
- Please note that diluent and/or adjuvant and vaccine may **not** have the same expiration dates.

Ancillary Supply Shortage

- Upon receipt of COVID-19 ancillary supplies, providers must ensure that supplies received matches the number of vaccine doses received or anticipated to be received if ancillary supplies are received prior to vaccine shipments. Each ancillary kit will contain supplies necessary to administer 100 doses of COVID-19 vaccine as noted above.
- If there is a shortage, providers must contact HDOH IMB to report the incident and request additional ancillary supplies to include sharps containers, etc.
- HDOH staff will work with the CDC ancillary supply distributor to obtain missing supplies.

Vaccine Inventory Management

COVID-19 vaccination providers shall maintain and report inventory of COVID-19 vaccines via the HIR "manage inventory" module. Vaccine inventory information **must** be submitted with each COVID-19 vaccine order.

Accessing the HIR "Manage Inventory " module will enable providers to view available inventory quantities and expiration dates as well as add new inventory, modify existing inventory entries, and view inventory transactions, including but not limited to, vaccines administered.

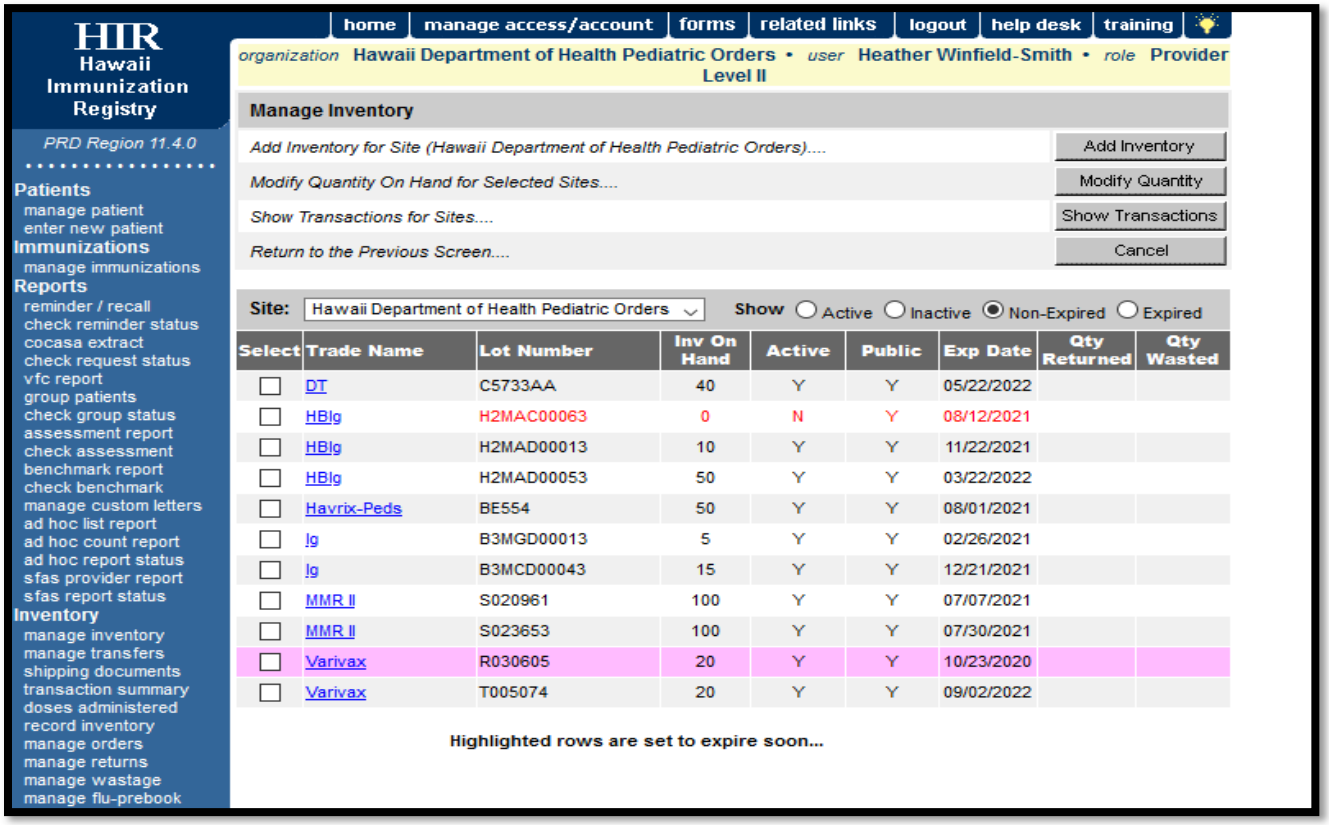


Figure D-16: HIR "Inventory" menu options (lower left side of screen shot) and "Manage Inventory" page which displays specific vaccines by lot number and expiration date.

Note:[13] It is anticipated COVID-19 vaccines will initially be authorized under an Emergency Use Authorization (EUA). Vaccines authorized under an EUA will contain slight variations from approved Food and Drug Administration (FDA) products, including:

- **Expiration Date:** The vaccine vials and cartons **will not contain a printed expiration date**. Expiration dates may be updated based on vaccine stability studies occurring simultaneously with COVID-19 vaccine distribution and administration. Current expiration dates by vaccine lots for *all authorized* COVID-19 vaccines will be posted on a US Department of Health and Human Services (HHS) website (**weblink pending**), accessible to all COVID-19 vaccination providers. To ensure that information systems continue to work as expected, CDC has worked with FDA and the manufacturers to include a two-dimensional (2D) barcode on the vaccine vial (if possible) and carton (required) labels that includes a National Drug Code (NDC), lot number, and a placeholder expiration date of 12/31/9999 to be read by a scanner. The placeholder 12/31/9999 expiration date is not visible on the vaccine packaging nor found anywhere else; it is only to facilitate information system compatibility. CDC is developing "beyond use date" (BUD) tracker labels to assist clinicians with tracking expiration dates at the point of vaccine administration. The label templates will be available on the CDC website.

COVID-19 vaccine providers may populate lot number-specific expiration dates in HIR for ease of tracking.

- Once vaccines are moved to refrigerated storage, vaccine expiration dates can be adjusted to reflect the length of time vaccines may be stored at refrigerated temperatures (e.g., Vaccine Candidate A: 24-48 hours; Vaccine Candidate B: 7-14 days).
- Vaccination Providers must rotate vaccine stock to ensure that vaccines expiring first are used first.

Figure D-17: Lot Number Tracking

- **Manufactured Date:** A manufactured date will be on the packaging and should not be used as the expiration date when documenting vaccine administration. This date is provided to help with managing stock rotations; however, expiration dates should also be considered **(see above)** as using manufactured date alone could have some limitations.
- **2D Barcode:** The 2D barcode available on the vaccine carton (also on the vials for some vaccines) will include NDC, lot number, and a placeholder expiration date of 12/31/9999.
- **QR Code:** Each vaccine manufacturer will include a Quick Response (QR) code on the vaccine carton for accessing FDA-authorized, vaccine product-specific EUA fact sheets for COVID-19 vaccination providers and COVID-19 vaccine recipients.

A list of authorized COVID-19 vaccine products with corresponding EUA fact sheets for healthcare providers and vaccine recipients, and up-to-date expiration information by vaccine lot will be available on an HHS website.

[13] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

Vaccine Recovery

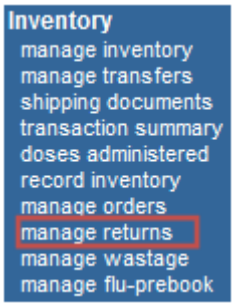


Figure D-18: HIR "Manage Returns" Inventory Module Option

All expired COVID-19 vaccines must be promptly reported to the HDOH IMB via the HIR "manage returns" menu option located within the HIR "Inventory" module. According to CDC guidance, details of COVID-19 vaccine recovery are still being finalized and will be communicated when available. Expired inventory must be removed from vaccine storage units and labeled "**Do Not Use**" to avoid the accidental administration of expired vaccine. Unused ancillary supplies may be returned to DHO offices on each respective island, or to HDOH if on Oahu, for possible redistribution to other COVID-19 vaccine providers. Procedures for ancillary supply return will be distributed at a later date, once CDC guidance is available. Any COVID-19 vaccine recovery involving unused viable vaccine must be coordinated and performed by HDOH IMB or DHO (neighbor islands).

HDOH IMB and DHO will utilize digital data logger (DDL) monitored, purpose-built, mobile, battery-powered refrigerators that have been prepositioned at all sites to recover and/or reposition any COVID-19 vaccines. DHOs must submit documentation of dates and times of any COVID-19 vaccine repositioning, sending, and receiving locations, lot numbers, expiration dates, and numbers of doses, and chain of custody documentation to HDOH IMB.

Additional details from CDC for COVID-19 vaccine recovery are still being finalized and will be communicated when available.[14]

[14] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

Strategies to Minimize Wastage of Vaccine, Constituent Products, and Ancillary Supplies

COVID-19 vaccines are temperature sensitive and must be stored and handled correctly to ensure efficacy and maximum shelf-life. COVID-19 vaccine providers must adhere to proper storage and handling practices critical to minimize vaccine loss and limit risk of administering COVID-19 vaccine with reduced efficacy. Vaccine providers should accurately identify needs for vaccine, constituent products, and ancillary supplies, and rapidly communicate with HDOH IMB regarding issues with over shipments or mis-shipments as noted previously.

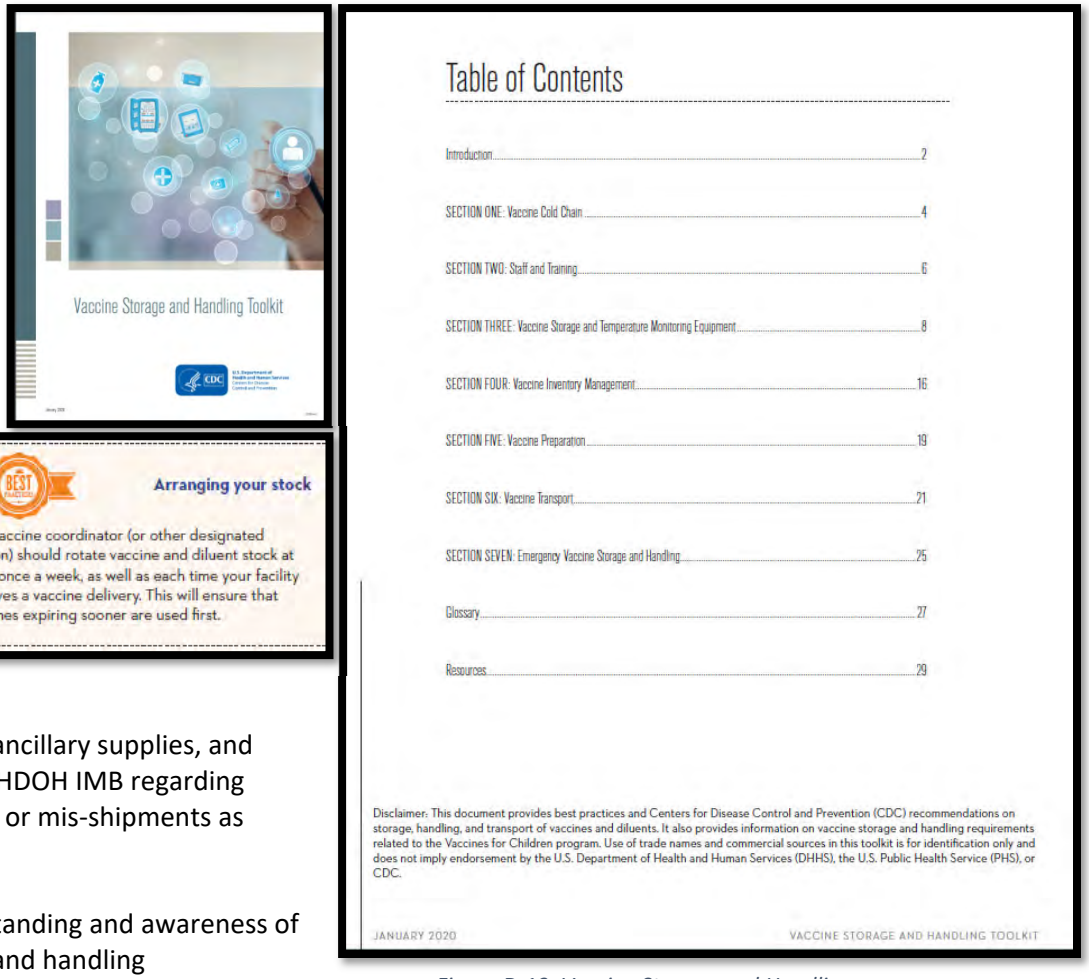


Figure D-19: Vaccine Storage and Handling

To ensure provider understanding and awareness of COVID-19 vaccine storage and handling requirements, providers and their staff must review and adhere to guidance in CDC-produced training materials, including but not limited to, COVID-19 specific updates to the **CDC Vaccine Storage and Handling Toolkit**, the CDC COVID-19 web based training module (currently under development), Vaccine Product Summary Sheets, and updated "You Call the Shots"[15] Vaccine Storage and Handling modules **(see: https://www.cdc.gov/vaccines/ed/youcalltheshots.html)**.

Figure D-20: Vaccine Storage and Handling

In addition, vaccination providers must ensure vaccine storage and temperature equipment reliably maintains and monitors vaccine storage and appropriate vaccine storage temperatures, and vaccination providers maintain accurate vaccine inventory records, including special attention to any changes to Beyond Use Dates

[15] https://www2a.cdc.gov/nip/isd/ycts/mod1/courses/sh/index.html

(BUD) necessitated by changes to vaccine storage temperatures (e.g., movement from frozen to refrigerated vaccine storage).

Biomedical Waste Handling

The state of Hawaii disposes of biomedical waste materials generated by medical materiel management operations according to Hawaii state statutes, policies, and protocols. HDOH will plan for and provide a comprehensive medical waste solution for expended vaccine related resources.

The Hawaii Rules for Management and Disposal of Infectious Waste establish minimum requirements for the management, treatment, transport, storage, and disposal of infectious waste and treated infectious waste, to protect the health and safety of persons living in Hawaii. The HDOH IMB will adhere to its written Infectious Waste Management Plan, which ensures compliance with Hawaii Statutes pertaining to infectious waste storage, transport, and disposal.

Infectious waste shall be incinerated, sterilized, or chemically disinfected by approved methods recommended for waste treatment. Infectious waste shall be segregated from all other waste at the point of generation. Facilities will transport and store infectious waste in accordance with approved policies and procedures both within their facilities, as well as away from the generating facility.

Each infectious waste generator and transporter of untreated infectious waste shall have a written plan that contains policies and detailed procedures for the safe and effective management of infectious waste in accordance with the regulations. A copy of this plan shall be kept in the respective administrative offices of the generator and the transporter. The plan shall also provide for contingencies in emergency situations. At a minimum, this shall include procedures to be used for a variety of circumstances such as spills, ruptures, and equipment failure.

INFECTIOUS WASTE

"Infectious waste" is defined as any waste that may contain pathogens capable of causing an infectious disease in humans and shall include, but not be limited to, the following wastes:

- Infectious isolation waste;
- Cultures and stocks of infectious agents;
- Blood, blood products and body fluids;
- Pathological waste;
- Contaminated sharps; and
- Contaminated animal carcasses, body parts, and bedding.

Figure D-21: Infectious Waste

Tab 1: Vaccine Administration Capacity[16]

"Vaccine administration capacity" is defined as the maximum achievable vaccination throughput regardless of public demand for vaccination. If HDOH has a good understanding of its COVID-19 vaccination providers and locations and their vaccine administration capacities, then planners can generate rough estimates of COVID-19 vaccine administration capacity and their ability to reach various COVID-19 vaccination coverage goals.

When estimating vaccination capacity, HDOH will consider these important elements:

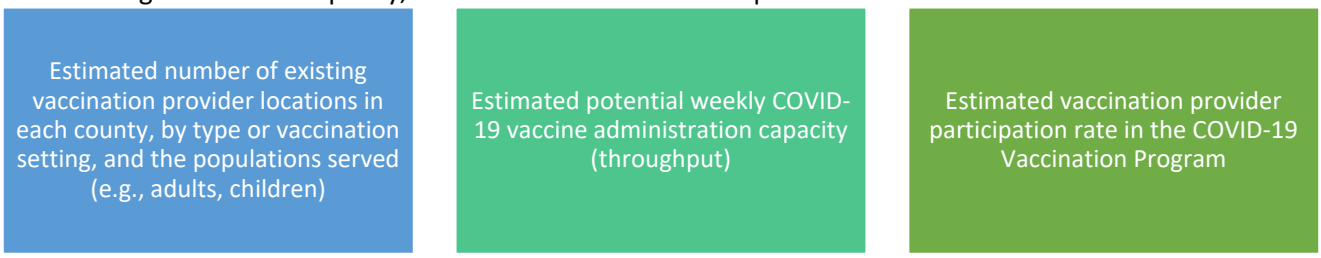


Figure D-22: Vaccination Estimation Elements

When assessing vaccine administration capacity, HDOH will consider the following factors:[17]

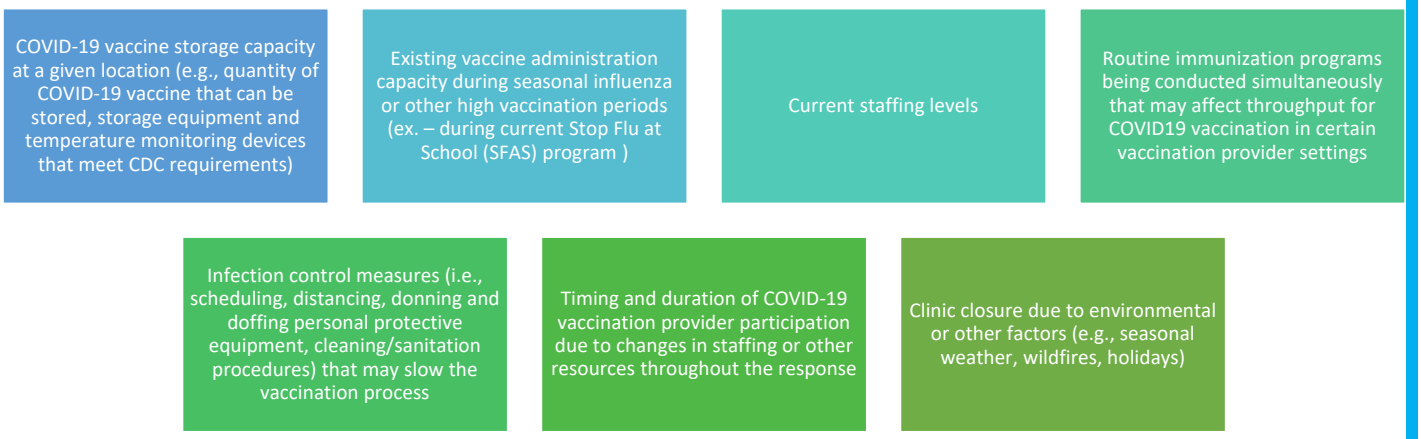


Figure D-23: Vaccine Administration Capacity Factors

HDOH IMB will maintain a dynamic list of current and potential COVID-19 Vaccination Providers through HIR and/or on its internal COVID-19 Vaccination Project MS Teams site (Contact DOH IMB for additional information). HDOH will track the following information at a minimum for each COVID-19 Vaccination Provider by county:

[16] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020

[17] For more information on the SFAS program **see:** https://health.hawaii.gov/docd/about-us/programs/stop-flu-at-school/

Vaccination Provider Information

- Name
- Vaccination Coordination POC (Primary/Alternate) Contact Information
- Location
- # of Individual Providers within Organization Provider
- Estimated Critical Population Served
- Estimated throughput capacity (Vaccinations per hour)
- Cold Chain Storage Capacity (refrigerated/frozen/ultra-cold temperature storage capacity)
- Completed provider enrollment to include any required inspections (Y/N)
- Completed required training (Y/N)
- Ready to receive COVID-19 Vaccine (Y/N)
- Able to potentially support satellite, mobile or drive-through clinics (Y/N)

Figure D-24: Vaccination Provider Information

Tab 2: Vaccination Provider Recruitment and Enrollment

HDOH IMB will immediately reach out to potential COVID-19 vaccination providers and target the appropriate settings so that COVID-19 vaccination services are accessible to the initial populations of focus when the first COVID-19 vaccine doses arrive. HDOH IMB will distribute a web-based pre-enrollment survey through existing organizations such as the Healthcare Association of Hawaii (HAH) to rapidly recruit potential vaccination providers.

HDOH IMB has prioritized identifying providers and settings that will maximize the number of people who can be vaccinated while considering social distancing and other infection control procedures. All providers/settings, especially those enrolled for Phase 1, must be able to meet CDC reporting requirements as defined in their provider agreements.

* 1. Name of Person Completing Survey
* 2. Title
* 3. Clinic/Facility Name
4. Facility Type

☐ Private Solo	☐ Private Group
☐ FQHC/RHC	☐ Hospital
☐ LTC	☐ SNF
☐ ALF	☐ ARCH
☐ Urgent Care Pharmacy	☐ Other (please specify)

* 5. Address 1
6. Address 2
* 7. City
* 8. Zip Code
* 9. Island
* 10. Telephone Number
* 11. Fax Number
* 12. Email Address:
* 13. Specialty:
* 14. Office Hours (e.g., M-F 8-5, etc.)
* 15. **Indicate Number of Personnel in Target Groups**
LTC/SNF/ALF Resident _____
Homebound _____
Healthcare Workers (direct contact) _____
Healthcare Workers (indirect contact) _____
Essential Workers (not included above) _____
* 16. Overall Patient Population
0 - 4 years _____
5 -18 years _____
19 - 49 years _____
50 - 64 years _____
65 and over _____
* 17. Total Overall Patient Population _____
* 18. Did you receive H1N1 vaccine from CDC/Department of Health in 2009-2010 for administration to your patients, healthcare workers, or others?
☐ Yes
☐ No
☐ Other (please specify) _____
19. Do you have a pharmaceutical refrigerator and freezer designed specifically for storage of biologics, including vaccines?
☐ Yes
☐ No
☐ Other (please specify)
20. Do you have a household-grade refrigerator unit capable of reliably maintaining vaccine storage temperatures (2°-8°C)?
☐ Yes
☐ No
21. Do you have a separate, stand-alone freezer unit for COVID-19 vaccines that may require frozen storage (must reliably maintain temperatures between -50°C and -15°C)?
☐ Yes
☐ No
22. Do you have or agree to purchase digital data logger (DDL) temperature monitoring devices with buffered temperature probes to actively monitor each refrigerator/freezer that houses COVID-19 vaccine?
DDL must feature:
1. An alarm for out-of-range temperatures
2. Current minimum and maximum temperature display
3. Recommended uncertainty of +/-0.5°C
4. Logging interval (or reading rate) that can be programmed by the user to measure and record temperatures at least every 30 minutes.
5. Certificate of Calibration Testing

Figure D-25: Draft of Pre-Enrollment Survey

Planning Considerations/Assumptions for Provider Recruitment/Enrollment

1. To receive COVID-19 vaccine and ancillary supplies, COVID-19 vaccination providers must enroll in the COVID-19 vaccination program through IMB by signing and agreeing to conditions outlined in the COVID-19 Vaccination Program Provider Agreement

   a. CDC will provide this agreement to HDOH IMB and HDOH IMB will be required to keep and maintain agreements on file for a minimum of three years

2. HDOH IMB will be required to collect and submit to CDC information on each enrolled vaccination provider/site, including provider type and setting, patient population (# and type of patients served), refrigerated/frozen/ultra-cold temperature storage capacity, and logistical information for receiving COVID-19 vaccine shipments

3. Some multijurisdictional vaccination providers will enroll directly with CDC to order and receive COVID-19 vaccine

   a. These direct partners will be required to report vaccine supply and uptake information back to HDOH IMB

4. The state of Hawaii may choose to partner with commercial entities to reach the initial populations of focus

5. Routine immunization programs will continue

Figure D-26: Planning Considerations/Assumptions for Provider Recruitment/Enrollment

Provider Outreach

As noted previously, HDOH will work through its COVID-19 Vaccine Program Implementation Committee to identify vaccinating providers **(see Table D-1 below)**. A database of survey respondents will serve to house contact information and core capacity data necessary for further outreach to potential vaccine providers as CDC-provided COVID-19 vaccine program Enrollment Agreements, training materials, and the COVID-19 vaccine itself become available.

HDOH IMB will recruit additional COVID-19 vaccination providers to expand equitable access to COVID-19 vaccination when vaccine supply increases. HDOH IMB will track enrollment activities so vaccination providers are not approached multiple times. HDOH will use a COVID-19 Vaccine Program Implementation Committee to assist in establishing and building upon existing relationships with community partners and collaborating with medical societies, state licensing boards, the state Medicaid agency, state rural health office, and health insurance issuers and plans in Hawaii to identify potential COVID-19 vaccination providers and the population groups they serve. HDOH IMB will consider engaging both traditional and nontraditional vaccination providers and settings, including professional organizations, professional boards, healthcare coalitions/groups, Insurer groups, professional organizations representing physician specialties such as OB/GYNs, Pediatrics, etc., as well as those listed in **Table D-1 below:**

Table D-1: Potential Vaccination Providers/Settings

In-patient healthcare facilities (Large hospitals and health systems)	In-home care provider organizations
Commercial partners, including chain pharmacies	Mobile vaccination providers
Long Term Care Facilities (LTCFs) (e.g., nursing home, assisted living, independent living, and skilled nursing facilities)	Federally Qualified Health Center (FQHC)s and Rural Health Clinics (RHCs)
Doctors' offices and other outpatient facilities (particularly those treating patients at higher risk of severe COVID-19 illness)	Organizations serving people at higher risk for severe illness from COVID-19 (e.g., dialysis centers, social service organizations)
Locations at which persons 65 years of age and older would gather, such as senior centers and food pantries	Homeless shelters
Occupational health settings for large critical infrastructure employers	Locations where people 65 years of age and older gather (e.g., senior centers, food pantries)
Colleges and universities	Congregate settings (e.g., correctional facilities)

Provider Enrollment Process Requirements

In order to participate in the COVID-19 Vaccination Program as a provider, the following requirements must be met:

1. Providers must complete and submit a CDC-supplied COVID-19 Vaccine Program Enrollment Agreement to HDOH IMB.
   a. A Chief Medical officer (or Equivalent), with prescriptive authority in the State of Hawaii, and the Organization's Chief Executive Officer (or Chief Fiduciary) must sign the enrollment agreement, indicating adherence with all program terms and conditions and agreement that all personnel, for which they are responsible, will adhere to all program terms and conditions.
2. HDOH IMB staff must review and approve the immunization provider's COVID-19 Vaccine Program Enrollment Form, including verification that provider credentials are in good standing **(see Provider Verification Process Below)**.
   a. Providers who are not in good standing will not be permitted to participate in the program.
   b. Missing/incomplete information will require follow-up by HDOH staff prior to Enrollment Agreement approval.
3. For providers with more than one location (e.g., Community Health Center with multiple satellite clinics) a completed enrollment form must be received for each site designated to receive vaccine.
   a. All individual locations affiliated with the Organization that will receive COVID-19 vaccine shipments must complete Section B, CDC COVID-19 Vaccination Program Provider Profile Information forms.
4. A COVID-19 Vaccine Coordinator and backup must be designated at each location.
   a.Coordinators and back-ups must be physically located at each receiving site to oversee program operations and ensure appropriate vaccine management practices at each site.
   b.Participating providers and Hawaii HDOH will retain all COVID-19 Enrollment and Profile forms for a minimum of 3 years, as specified by the CDC.
5. Additional Hawaii-specific requirements may be necessary, such as the use of HIR (if available) for vaccine ordering and patient vaccine administration reporting purposes.

Figure D-27: Provider Enrollment Process Requirements

Upon Enrollment Agreement approval, HDOH staff will either create or update provider information in HIR (if available) and the CDC Vaccine Tracking System (VTrckS), including shipping information and hours of operation. HDOH IMB will assign a five-digit identification code (PIN) to each provider for identification, tracking, and order processing purposes.
Participating providers and Hawaii HDOH will retain all COVID-19 Enrollment and Profile forms for a minimum of 3 years, as specified by the CDC.

In addition, HDOH/Disease Outbreak Control Division (DOCD) will complete an Enrollment Agreement with CDC to be a registered provider of COVID-19 vaccines and will agree to abide by all program terms and conditions. HDOH/DOCD COVID-19 vaccine will be administered to identified high risk/priority populations via vaccination "strike teams" (vaccine administration teams of appropriately trained, vetted, credentialed nurses or other designated HDOH personnel) to serve high risk/priority patients/healthcare personnel that may have no other means of receiving COVID-19 vaccines.

Provider Verification Process

Every facility location/organization provider that will administer COVID-19 vaccines must provide a listing of all individual providers practicing at their facility as a component of the mandatory Provider Profile form. The individual provider list must include the names of all individual providers designated to order/administer vaccines, title, and medical license number.

Individual Provider Verification

- HDOH staff will verify that all providers have active, valid licensure/credentials to possess and administer vaccine. Licensure verification will occur via Hawaii Department of Commerce and Consumer Affairs web interface:
  - Licensee Name Search: https://pvl.ehawaii.gov/pvlsearch/
  - Licensee Complaint History Search: https://web2.dcca.hawaii.gov/rico/#/search
- Individual providers that are identified as possessing inactive, invalid, or licenses not in good standing will not be permitted to order/administer COVID-19 vaccinations.
- Enrolling organizations will be notified of disqualification and vaccine administration records submitted by the organization will be audited to ensure disqualified providers are not permitted to order/administer vaccine.

Provider Organization Verification

- HDOH staff will utilize the Hawaii Department of Commerce and Consumer Affairs web interface to verify that all enrolling organizations have registered business names and are entities in good standing:
  - Business Name Search: https://hbe.ehawaii.gov/BizEx/home.eb
  - Business Complaint History Search: https://web2.dcca.hawaii.gov/ocp/#/search
- Organizations with inactive/expired business registration or are not in good standing (adjudicated complaints in which businesses were found to be negligent or at fault) will not be permitted to enroll at a COVID-19 vaccination provider organization.

Figure D-28: Provider Verification Process

CDC Direct Enrollment Processes and Procedures

According to CDC guidance, as noted previously, some multijurisdictional vaccination providers such as select large drugstore chains, Veterans Administration Clinics and Hospitals, and other Federal partners will enroll directly with the CDC to receive COVID-19 vaccines. CDC will notify HDOH of all "direct enrollees" located in Hawaii. CDC will be responsible for maintaining CDC COVID-19 Vaccination Program Provider Agreements,

Provider Profile Information, and Redistribution Agreements for direct enrollees. CDC must provide HDOH with direct enrollee contact persons and locations, so onboarding to the HIR can occur, including training and orientation to the system. All direct partners will be required to enroll in HIR and utilize the system to allow State visibility into inventory levels and serve as the mechanism for reporting doses administered at each location. Each physical location must have a separate HIR account to allow for visibility into location-specific inventory levels and vaccine administration data.

HDOH staff will explore partnerships with pharmacy chains to conduct PODs and serve as vaccination "strike teams" to provide vaccinations to organizations that may require less than the 100-dose ordering quantity and/or do not qualify for direct shipments of COVID-19 vaccines. Partnership with direct enrollees will aid in rapidly deploying COVID-19 vaccinations to smaller providers such as Long-Term Care Facilities who may lack capacity to store or administer vaccinations to their prioritized populations.

Provider Enrollment Process Overview

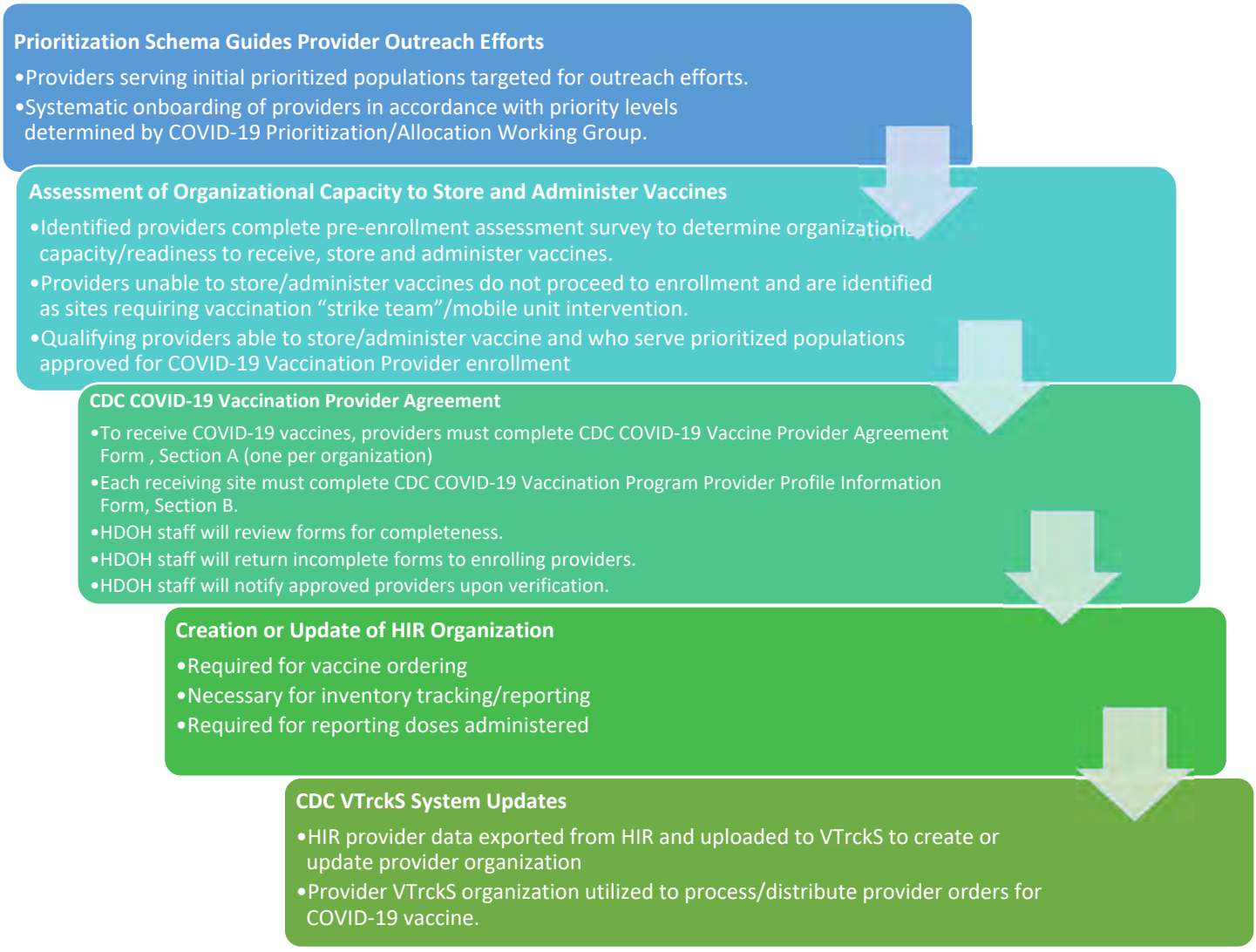


Figure D-29: Provider Enrollment Process Overview

Provider Recruitment Process by Phase

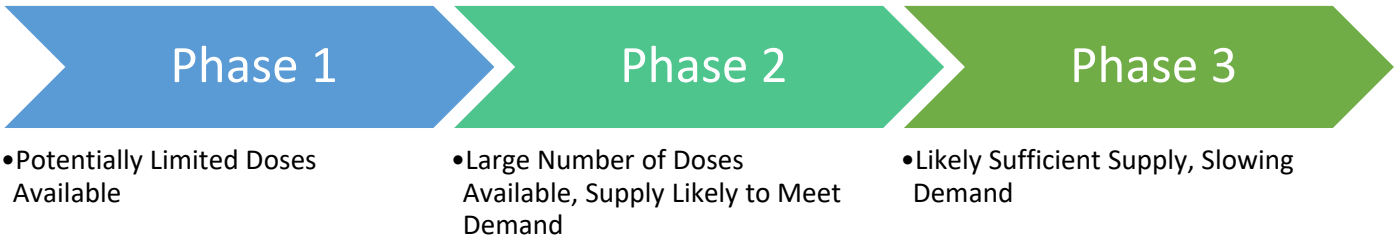


Figure D-30: Phased Approach of COVID-19 Vaccine Distribution

Based on prioritization recommendations by the Hawaii COVID-19 Vaccine Prioritization/Allocation Working Group, HDOH will conduct phased contacts via identified liaisons representing the organizations listed in **Table D-1** above that can reach the critical populations identified for each Allocation Stage. In addition, HDOH will target deployment of the COVID-19 Vaccine Provider Pre-Enrollment survey noted above initially on vaccination providers that can support Phase 1 efforts.

Providers not capable of meeting program requirements will be noted as requiring vaccination "strike team"/mobile unit services that could be deployed in Phase 1. Organizations able to meet program participation criteria will continue through the onboarding process, including completion of all agreement, profile, and redistribution forms (as appropriate/needed), enrollment in HIR, and completion of education/training requirements.

To ensure equitable access to COVID-19 vaccines throughout the state, DHO liaisons representing each county will coordinate with the centrally-located HDOH IMB to ensure appropriate representation and vaccine distribution to identified providers that serve critical populations.

Pharmacies capable of both conducting worksite vaccination clinics and vaccinating persons at individual pharmacy locations will be critical for the rapid deployment and provision of COVID-19 vaccinations to small organizations that serve critical populations. HDOH staff will coordinate with Hawaii Pharmacists Association liaisons and liaisons representing the Daniel K. Inouye College of Pharmacy to connect with and enroll pharmacy locations as COVID-19 vaccination providers.

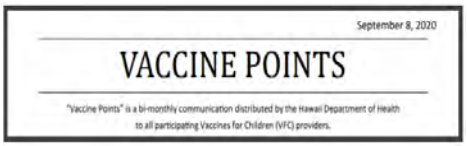
Provider Outreach

Medical Advisories

DOCD distributes Medical Advisories to healthcare personnel statewide via email on relevant topics, including outbreaks, immunization recommendations, and most recently, the COVID-19 pandemic. All Medical Advisories are posted on the DOCD website. Medical Advisories include links to the information posted on the DOCD or CDC websites. Information distributed through Medical Advisories will include:

- Advisory Committee on Immunization Practices (ACIP) COVID-19 vaccine recommendations
- Vaccine Product Summary Sheets
- Vaccine Information Statements (VIS)
- Emergency Use Authorization (EUA) Fact Sheets
- Procedures for reporting moderate to severe adverse events and vaccine administration errors to the Vaccine Adverse Event Reporting System (VAERS)

- Procedures for submitting facility information for COVID-19 vaccination clinics to CDC's Vaccine Finder
- COVID-19 Vaccine Information
    - Storage and Handling (including transportation requirements)
    - Procedures for ordering COVID-19 vaccine
    - Vaccine administration
    - Vaccine documentation and reporting
    - Vaccine inventory management
    - Reporting vaccine inventory
    - Managing temperature excursions
    - Documenting vaccine wastage/spoilage


September 8, 2020

VACCINE POINTS

"Vaccine Points" is a bi-monthly communication distributed by the Hawaii Department of Health to all participating Vaccines for Children (VFC) providers.

Figure D-31: Vaccine Points

Vaccine Points

Vaccine Points[18] is a bi-monthly communication distributed by the Hawaii Department of Health to all participating Vaccines for Children (VFC) providers. Its purpose is to provide timely information on immunization topics. Distribution of *Vaccine Points* will be expanded to include COVID-19 Vaccination Program enrolled providers, as a means of providing timely information regarding COVID-19 vaccination.

Provider Enrollment Training

HDOH IMB will use multiple approaches for provider training to ensure a well-trained, proficient, and competent cadre of immunization providers. For example, HDOH IMB currently requires providers to view CDC's web-based training modules biennially for participation in the Vaccines for Children (VFC) Program. Providers must then submit certification of completion of those web-based training modules to IMB. IMB will require the same process once CDC's COVID-19 Training Modules have been completed. COVID-19 Vaccination Program enrolled providers will be similarly required to submit proof of completion of the training modules to IMB.

Training

- HDOH, with the assistance of the COVID-19 Communications Working Group, will hold a series of video/webcast sessions to educate providers, including pharmacies, clinics, long term care facilities, hospitals, and DHO in each county.
- The trainings are to ensure all COVID-19 vaccinating providers are on the same page in regard to properly monitoring the storage and handling of vaccine to ensure its viability, the appropriate administration of vaccine, and the documentation of the administration of vaccine.

Figure D-32: Provider Enrollment Training

Provider Enrollment Data Collection/Reporting

The Vaccine Supply and Distribution Section (VSDS) of the HDOH IMB will be responsible for collection and review of COVID-19 Provider Agreement forms, including hard copy and electronic versions. HDOH IMB will accept COVID-19 Vaccine Provider Agreement Forms, COVID-19 Vaccine Provider Profile Forms, and COVID-19 Vaccine Distribution Redistribution Forms **(see examples below)** via email or fax submission.

HDOH will scan form as needed and maintain forms in a digital archive for a minimum of three years, per CDC requirements. HDOH plans to enter this data in HIR if the system is enhanced to collect and export this information. If HIR is not enhanced to capture this information, HDOH will use a database to digitally store information captured in the forms. HDOH will provide enrollment, profile, and redistribution data to VTrckS or other CDC systems developed to collect this information twice per week per CDC Program requirements.

[18] https://health.hawaii.gov/docd/for-healthcare-providers/vaccine-points/

CDC COVID-19 Vaccine Provider Agreement Form

The Centers for Disease Control and Prevention (CDC) requires that an organization's chief medical officer (or equivalent) and chief executive officer (or chief fiduciary)—must complete and sign the CDC COVID-19 Vaccination Program Provider Requirements and Legal Agreement **(see Section A of form)**. In addition, CDC COVID-19 Vaccination Program Provider Profile Information **(see Section B of form)** must be completed for each vaccination Location covered under the Organization listed in Section A.

HDOH IMB will distribute the eight-page CDC COVID-19 Vaccine Provider Agreement Form to organizations interested in becoming COVID-19 Vaccine Distributors.

CDC COVID-19 Vaccine Redistribution Agreement

The Centers for Disease Control and Prevention (CDC) plans to ship a minimum order size of COVID-19 vaccine, constituent products, and ancillary supplies at no cost directly to enrolled COVID-19 vaccination providers throughout the United States. The federally contracted vaccine distributor uses validated shipping procedures to maintain vaccine cold chain and minimize the likelihood of vaccine loss or damage during shipment. There may be circumstances where COVID-19 vaccine needs to be redistributed beyond the identified primary CDC ship-to sites (i.e., for orders smaller than the minimum order size or for large organizations whose vaccine is shipped to a central depot and requires redistribution to additional clinic locations). In these instances, vaccination provider organizations/facilities, third-party vendors, and other vaccination providers may be allowed to redistribute vaccine, if approved by the jurisdiction's immunization program and if validated cold-chain procedures are in place in accordance with the manufacturer's instructions and CDC's guidance on COVID-19 vaccine storage and handling. There must be a signed *CDC COVID-19 Vaccine Redistribution Agreement* ***(See Table D-2 below)*** for the facility/organization conducting redistribution and a fully completed *CDC COVID-19 Vaccination Provider Profile Information* form (Section B of the CDC COVID-19 Vaccination Program Provider Agreement) for each receiving vaccination location.

The parties to this agreement are CDC and healthcare organizations, third-party vendors, and vaccination providers that redistribute COVID-19 vaccine. CDC cannot reimburse costs of redistribution beyond the initial designated primary CDC ship-to site(s), nor for purchase of any vaccine-specific refrigerators or qualified containers. Therefore, organizations planning for redistribution of COVID-19 vaccine must carefully assess the associated risks and costs (e.g., vaccine loss due to temperature excursions, purchase of vaccine-specific portable refrigerators and/or containers) before planning this activity.

Table D-2: CDC COVID-19 Vaccine Redistribution Agreement

ORGANIZATION INFORMATION			
Organization/facility name:	*For official use only:* *VTrckS ID:* _____ *Unique COVID-19 Organization ID (from Section A):* _____		
PRIMARY ADDRESS and CONTACT INFORMATION OF COVID-19 VACCINATION ORGANIZATION			
Street:			
City:	County:	State:	ZIP:
Telephone:		Fax:	
RESPONSIBLE OFFICERS			
Medical Director (or Equivalent) Information			
Last name	First name	Middle initial	
Title	Licensure (state and number)		
Telephone number:	Email:		
Address:			
Chief Executive Officer (or Chief Fiduciary) Information			
Last name	First name	Middle initial	
Telephone number:	Email:		
Address:			

PRIMARY POINT OF CONTACT RESPONSIBLE FOR RECEIPT OF COVID-19 VACCINE (if different than medical director listed above)	
Last name, first name, middle initial:	
Telephone number:	Email:

SECONDARY POINT OF CONTACT FOR RECEIPT OF COVID-19 VACCINE	
Last name, first name, middle initial:	
Telephone number:	Email:

COVID-19 VACCINATION ORGANIZATION REDISTRIBUTION AGREEMENT REQUIREMENTS

To redistribute COVID-19 vaccine, constituent products, and ancillary supplies to secondary sites, this organization agrees to:

1.	Sign and comply with all conditions as outlined in the CDC COVID-19 *Vaccination Program Provider Agreement.*
2.	Ensure secondary locations receiving redistributed COVID-19 vaccine, constituent products, or ancillary supplies also sign and comply with all conditions in the *CDC COVID-19 Vaccination Program Provider Agreement.*
3.	Comply with vaccine manufacturer instructions on cold chain management and CDC guidance in CDC's Vaccine Storage and Handling Toolkit[1], which will be updated to include specific COVID-19 conditions for any redistribution of COVID-19 vaccine to secondary locations.
4.	Document and make available any redistribution records of COVID-19 vaccine to secondary sites to jurisdiction's immunization program as requested, including dates and times of redistribution, sending, and receiving locations, lot numbers, expiration dates, and numbers of doses. *Neither CDC nor state, local, or territorial health departments are responsible for any costs of redistribution or equipment to support redistribution efforts.*

By signing this form, I understand this is an agreement between my Organization and CDC, implemented and maintained by my jurisdiction's immunization program. I also certify on behalf of myself, my medical practice or other legal entity with staff authorized to administer vaccines, and all the practitioners, nurses, and others associated with this Organization that I have read and agree to the COVID-19 vaccine redistribution agreement requirements listed above and understand my Organization and I are accountable for compliance with these requirements. Non-compliance with the terms of this Redistribution Agreement may result in suspension or termination from the CDC COVID-19 Vaccination Program and criminal and civil penalties under federal law, including but not limited to the False Claims Act, 31 U.S.C. § 3729 et seq., and other related federal laws, 18 U.S.C. §§ 1001, 1035, 1347, 1349.

Organization Medical Director (or Equivalent)		
Last name	First name	Middle initial
Signature:		Date:

Chief Executive Officer (Chief Fiduciary Role)		
Last name	First name	Middle initial
Signature:		Date:

1

Emergency Use Authorization Fact Sheets

Initially available COVID-19 vaccines may be approved as licensed vaccines or may be authorized for use under an Emergency Use Authorization (EUA) issued by the Food and Drug Administration (FDA). If issued under an EUA, the EUA will outline how the COVID-19 vaccine should be used and any conditions that must be met to use the vaccine. The conditions of authorization are expected to include distribution requirements, reporting requirements, and safety and monitoring requirements. The provisions of an EUA require persons receiving the vaccine know that the vaccine has not completed full approval but is being offered due to an emergency. Potential recipients would need to know the risks and benefits of receiving the vaccine or of refusing the vaccine, any alternatives that they have to the vaccine, and an assurance of their right to refuse the vaccine. If this vaccine is being administered under an EUA, organizations should expect to receive substantial information from HDOH detailing the following:

- Target recipients
- FDA conditions for use
- Information regarding risk and benefit of use
- Additional information to be collected (in addition to contact information and information collected as part of the vaccination process for a non-EUA vaccine)
- Guidance regarding enhancements to adverse event reporting and case investigation which would need to be implemented as additional safeguards.

HDOH is responsible for providing training to all persons administering vaccines under an EUA. Product-specific EUA fact sheets for COVID-19 vaccination providers and for vaccine recipients, including information of the specific vaccine product and instructions for its use and are expected to be available on the FDA and CDC websites. When the EUA fact sheets are available, DOCD will issue a Medical Advisory to inform providers of:

- Websites where EUA fact sheets may be found
- Requirement for provision of recipient fact sheet to each potential vaccinee prior to administration

NOTE: IMB is in the process of procuring a software suite that will automate online consent, mass vaccinations, and clinic management. Once acquired, IMB will request that the EUA fact sheet be included with the online consent form, with a requirement for review prior to proceeding to completion of the consent form.

Copies of the EUA fact sheets will be included with the Medical Advisory and posted on the DOCD website[19].

Vaccine Information Sheets

Vaccine Information Statements (VISs)[20] are information sheets produced by the CDC that explain the benefits and risks of a vaccine to vaccine recipients. Federal law (National Vaccine Childhood Injury Act) requires that healthcare staff provide a VIS to a patient, parent, or legal representative if a vaccine is added to the Vaccine Injury Table.

Although it is not currently known if a VIS will be produced by CDC for the COVID-19 vaccines, in general, CDC encourages healthcare providers to use VISs prior to administration of a vaccine, even for vaccines not covered by the National Vaccine Childhood Injury Act. When VISs are provided, they must be given prior to the vaccination and must be given prior to each dose of a multi-dose series, regardless of the age of the recipient. VISs may be provided as:

[19] https://health.hawaii.gov/docd/category/docd/

[20] Additional information on VISs is located at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html.

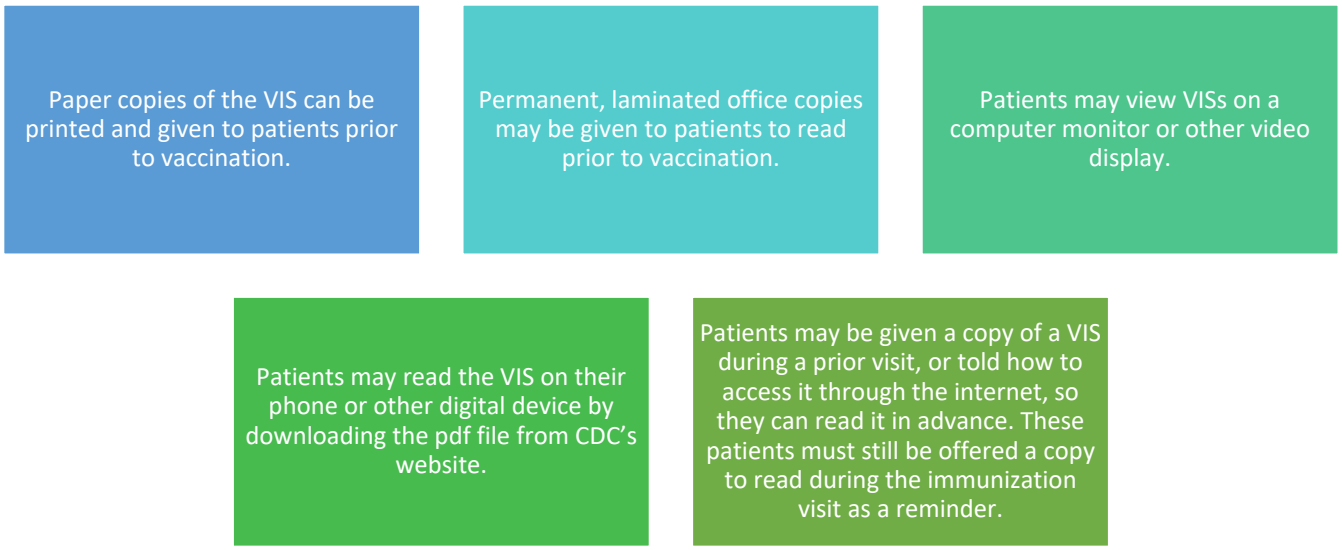


Figure D-33: Presentation of Vaccine Information Sheets

Patients must be offered a copy of the VIS to take away following the vaccination. The patient may decline. If VISs for COVID-19 vaccines are available, DOCD will issue a Medical Advisory to inform providers of:

- Websites where VISs may be found
- Recommendation/requirement for provision of VIS to each potential vaccinee prior to administration

Copies of the VIS forms will be included with the Medical Advisory and posted on the DOCD website[21].

The IMB is in the process of procuring a software suite that will automate online consent, mass vaccinations, and clinic management. Once acquired, the IMB will request that the VIS be included with the online consent form, with a requirement for review prior to proceeding to completion of the consent form.

Figure D-34: Status of Software to Support Vaccination Providers

[21] https://health.hawaii.gov/docd/category/docd/

Tab 3: Satellite, Temporary, and Off-Site Clinics

The state of Hawaii will determine the need for additional vaccination services such as satellite, temporary, or off-site clinics to meet demand/need not met by other enrolled COVID-19 vaccination providers. These clinics may operate as either closed or open PODs. It is important to consider infection control measures that are currently necessary when selecting COVID-19 vaccination clinic settings:

- Providing specific appointment times or other strategies to manage patient flow and avoid crowding and long lines
- Ensuring sufficient staff and resources to help move patients through the clinic flow as quickly as possible
- Limiting the overall number of clinic attendees at any given time, particularly for people at higher risk for severe illness from COVID-19
- Setting up a unidirectional site flow with signs, ropes, or other measures to direct site traffic and ensure physical distancing between patients
- When feasible, arranging a separate vaccination area or separate hours for people at increased risk for severe illness from COVID-19, such as older adults and people with underlying medical conditions
- Making available a point of contact for any reasonable accommodation needs for people with disabilities
- Ensuring vaccination locations are accessible to individuals with disabilities consistent with disability rights statutes such as the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973
- Selecting a space large enough to ensure a minimum distance of 6 feet between patients in line or in waiting areas for vaccination, between vaccination stations, and in postvaccination monitoring areas.
    - Note: ACIP recommends that providers consider observing patients for 15 minutes after vaccination to decrease the risk for injury should they faint. For mobile or drive-through vaccination clinics, it is important to assess parking to accommodate vaccine recipients as they wait after vaccination.

Infection Control Measures[22]

COVID-19 vaccination providers should ensure they are following all appropriate infection control procedures. The IMB will request a copy of infection control procedures from providers conducting satellite, temporary and off-site clinics, to include at minimum:

- Screening and triage of everyone outside the facility prior to entering the satellite, temporary or off-site clinic
- Ensuring adherence to source control measures and hand hygiene practices for both staff and patients
    Patients:
    - Required to wear face covering to enter the clinic

    Healthcare personnel:
    - Appropriate personal protective equipment (PPE) for clinic staff
        - Must wear, at minimum, medical masks and eye protection
    - Gloves must be worn if vaccinator has lesions on hands or if contact with patient's blood or body fluids anticipated.
        - If gloves are worn, they must be changed between each patient; after gloves are removed, wash hands or use alcohol-based hand sanitizer.

[22] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf

    - Must wash hands or use alcohol-based hand sanitizer between each patient
- Provision of alcohol-based hand sanitizer with a minimum of 60% alcohol
- Limited points of entry
- One-way flow through clinic
- Appointments to limit the number of patients at the facility concurrently
- Physical distancing (minimum 6 feet) between patients
- Clean/disinfect vaccination stations between each patient
- Planners should consider additional staff needed to assist with the following: Screening, maintaining physical distancing, cleaning/disinfection, and one-way flow through clinic

Mobile Clinic Procedures

IMB has 13 years of experience in conducting off-site clinics through the school-located influenza vaccination program, Stop Flu at School (SFAS). Procedures for the SFAS clinics are well established and refined each year, based on lessons learned and include:

- Clinic Set-up and flow
- Clinic operations
- Vaccine storage and handling
- Job Action Sheets for:
    - Registration
    - Line flow
    - Vaccinators
    - Clinic Manager
- Just-in-time Training
- Standing Orders
    - Administering vaccine
    - Responding to adverse events post-vaccination
- Procedures for responding to blood borne pathogen exposures
- Vaccination documentation

Figure D-35: Mobile Clinic Procedures

COVID-19 Vaccination providers conducting mobile clinics should refer to CDC's *Guidance for Planning Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations*.

SFAS will begin in mid-October 2020. The COVID-19 Vaccination Program will incorporate lessons learned/experience gained in conducting those mobile clinics with COVID-19 considerations such as mandatory face coverings and social distancing.

Drive-Thru Clinic procedures

With COVID-19, precautionary measures would need to be in place to minimize exposure as much as possible during a vaccination event. Efforts to vaccinate with COVID-19 vaccine will also need to ensure the appropriate recommendations on physical distancing and wearing masks. In addition, trying to not have individuals confined into possible tight spaces, utilizing drive-thru clinics is an option to vaccinate people wanting to get the COVID-19 vaccine. The Drive-thru clinics may be more utilized for mass vaccinations when there is a lot of vaccine product available. This is not a process utilized by HDOH, but HDOH could work with other entities who have experience performing Drive-thru vaccination clinics which make sense to perform to ensure safe physical distancing, but may have some logistical issues to deal with depending on the type of vaccine available.

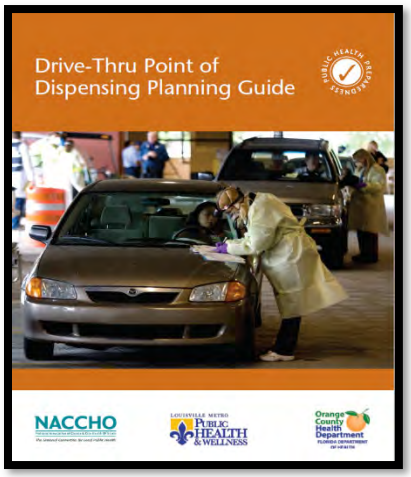


Figure D-36: Drive-Thru Planning Guide

Planning for the Clinic

There are a number of unknowns that make planning for a Drive-Thru POD site challenging such as which specific storage and handling procedures will need to be followed. Planners should review guidance documents such as the *Drive-Thru Point of Dispensing Planning Guide* and other resources available through the HHS ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE) site.[23] **See additional planning considerations below**.

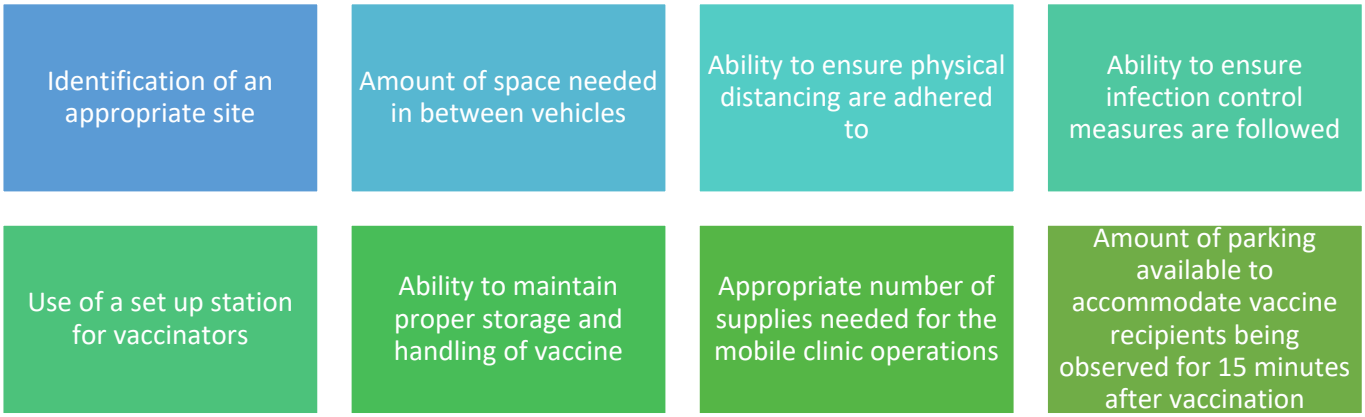


Figure D-37: Planning Considerations for a Drive-Thru Clinic Operation

[23] https://asprtracie.hhs.gov/technical-resources/67/mass-distribution-and-dispensing-of-medical-countermeasures/0

Medical Staff Recruitment/Management

IMB has 13 years of experience in conducting off-site clinics through the school-located influenza vaccination program, Stop Flu at School (SFAS). Medical staffing for the SFAS clinics consists of:

Figure D-38: Medical Staffing

SFAS clinics are staffed with:

- One Clinic Manager (Public Health Nurse); responsible for:
  - Overall operations of the clinic
  - Serving as primary decision-maker for clinic
  - Managing adverse reactions post-vaccination according to Standing Orders
- One Vaccine Group Supervisor (Public Health Nurse); responsible for:
  - Assuring proper administration of vaccines to participants according to Standing Orders
  - Managing storage and handling of vaccines
- Vaccinators (number based on SFAS formula – **see below**); responsible for:
  - Administration and documentation of vaccine according to Standing Orders

Medical personnel are required to have documentation of:

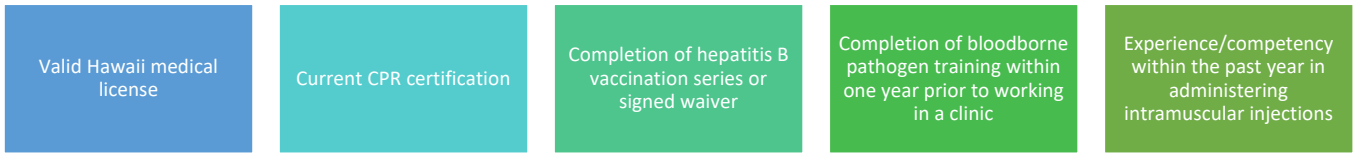


Figure D-39: Medical Documentation Requirements

Formula to Determine Number of Vaccinators per Clinic[24]

Total number of participants / (Clinic Hours) x 20 = number of vaccinators (ex. 1,000/(8x20) = 6)

SFAS are scheduled to begin in mid-October 2020. Lessons learned/experience gained regarding adequate staffing to conduct a clinic with restrictions due to the COVID-19 pandemic will be added to this plan.

[24] Due to the unique challenges of conducting a vaccination clinic during the COVID-19 pandemic, including physical distancing requirements and cleaning/disinfection of vaccination station between each patient, the formula may need to be adjusted. The number of additional staff needed has yet to be determined. See Assumptions in Section 1 for additional details.

Non-Medical Staff Recruitment/Management

Non-medical staffing for the SFAS clinics consist of:

Figure D-40: Non-Medical Staffing

See below for an estimate of the number of non-medical staff per clinic (for registration/line flow) used for SFAS clinics based on the number of vaccine recipients expected:

Table D-3: Number of Non-Medical Staff Needed based on Number of Participants[25]

Number of Vaccine Recipients Expected	Non-medical staff needed
≤25	1
26-50	2
51-150	3
151-200	4
201-300	5
>300	6

Security Requirements

Planners currently anticipate that the main security requirements for COVID-19 vaccination efforts will be to provide crowd control at mass clinic events. Since the CDC will distribute COVID-19 vaccine directly to vaccination providers, planners are currently assuming that those shipments will not need security escorts, and that there will be no need for security forces for guarding vaccine storage areas.

[25] Due to the unique challenges of conducting a vaccination clinic during the COVID-19 pandemic, including physical distancing requirements and cleaning/disinfection of vaccination station between each patient, the formula may need to be adjusted. The number of additional staff needed has yet to be determined.

Tab 4: Vaccine Storage and Handling

COVID-19 vaccine products are expected to be temperature-sensitive and must therefore be stored and handled correctly to ensure efficacy and maximize shelf life. Failure to store and handle vaccines properly can result in inadequate immune responses in patients, poor protection against disease, and thousands of dollars in wasted vaccine. Patients and the public can lose confidence in vaccines and immunization providers if they require revaccination because the vaccines they received may have been compromised.

It is expected that cold chain storage and handling requirements for COVID-19 vaccine products will vary in temperature from refrigerated (2°C to 8°C) to frozen (-15°C to -25°C) to ultra-cold (-60°C to -80°C) in specialized dry ice shipping containers. Ongoing stability testing may impact these requirements. Updated information will be communicated to enrolled COVID-19 Vaccination Program providers, as information becomes available.

COVID-19 vaccines must be stored properly from the time they are manufactured until they are administered. Potency is reduced every time a vaccine is exposed to an improper condition. This includes overexposure to heat, cold, or light at any step of the cold chain. Once lost, potency cannot be restored **(see Figure D-41: Cold Chain Flowchart)**[26].

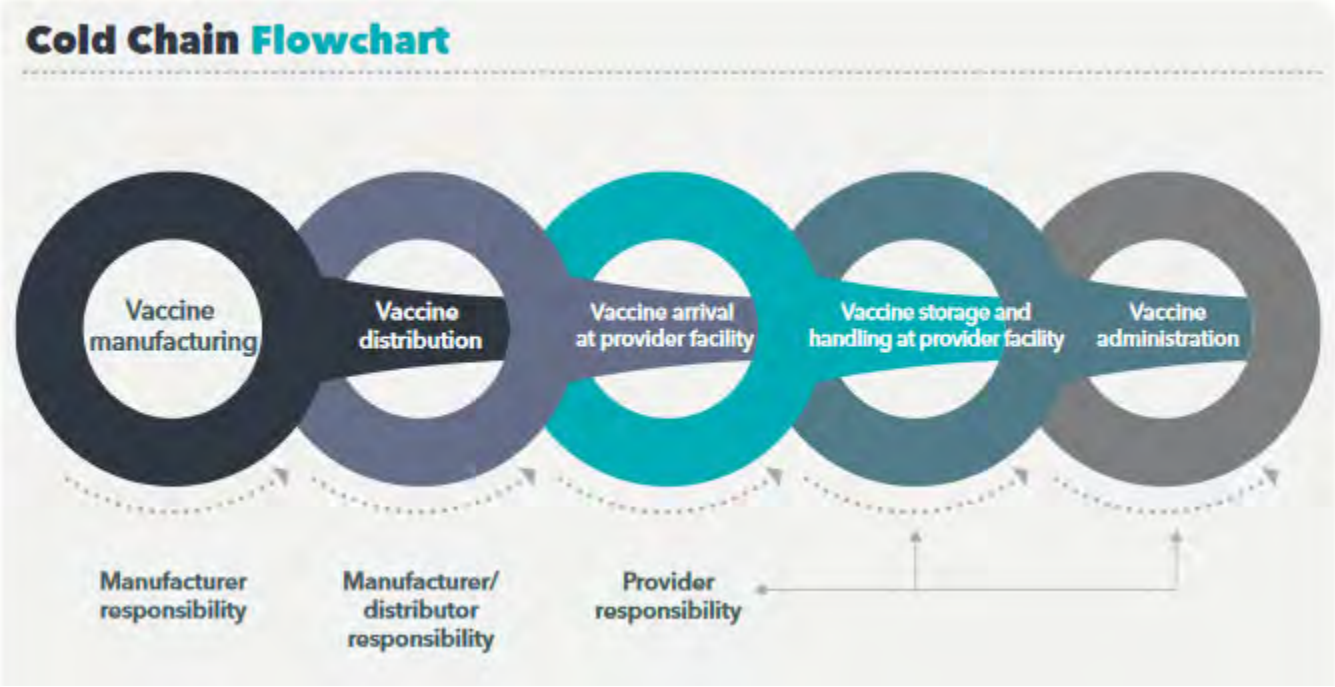


Figure D-41: Cold Chain Flowchart

Effective cold chain management is critical to secure the potency and life span of vaccines. Validated cold chain packing protocols, temperature monitoring devices, and specialized shipping containers also ensure vaccines to remain at the proper temperature throughout the packing and shipping processes. There are four main

[26] https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit-2020.pdf

elements to cold chain storage that need to be monitored:

Figure D-42: Cold Chain Storage Elements

Individual Provider Locations

Each site designated to receive COVID-19 vaccine must develop and maintain clearly written, detailed, and up-to-date storage and handling Standard Operating Procedures (SOPs) specific to the COVID-19 Vaccine they are designated to receive. All staff must review SOPs that have been updated by the location's COVID-19 Vaccine Coordinator as needed. SOPs must address three major areas[27]:

Figure D-43: Standard Operating Procedures

Additional information and worksheets to assist providers in developing routine and emergency SOPs can be found in the CDC Vaccine Storage and Handling Toolkit.[28]

All staff members who receive COVID-19 vaccine deliveries as well as those who handle or administer vaccines must be trained in COVID-19 vaccine related storage and handling practices and be familiar with facility/organization-specific storage and handling SOPs. Ensure staff are able to locate SOPs when needed. COVID-19 storage and handling training shall consist of a review of CDC produced materials, including but not limited to, a COVID-19-specific addendum to the CDC Vaccine Storage and Handling Toolkit, completion of a CDC COVID-19 Training Module, review of vaccine product summary sheets, completion of CDC "You Call the Shots" web-based training modules, and review of any additional guidance materials. Certificates of completion for both CDC training modules (COVID-19 and "You Call the Shots") for each individual provider are also required.

As a condition of enrollment in the COVID-19 Vaccination Program, SOPs and staff training logs must be provided to the HDOH IMB via fax or email. Receipt of provider documentation will be required for COVID-19

[27] https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit-2020.pdf
[28] Ibid.

vaccine orders to be approved and processed. Provider SOPs will be digitally maintained by the HDOH IMB along with completed Enrollment, Profile, and Redistribution Forms for a minimum of three years.

Vaccine Storage and Temperature Monitoring Equipment

Each facility/organization receiving COVID-19 vaccine must have proper storage and temperature monitoring equipment that is set up correctly, maintained appropriately, and repaired as needed. Purpose-built or pharmaceutical grade units designed specifically for the storage of biologics, including vaccines are the preferred storage units. Household-grade units can be an acceptable alternative for refrigerated vaccines. For frozen storage, a separate freezer unit is required.

For all unit types, COVID-19 Vaccine Providers must utilize a "digital data logger" (DDL) continuous temperature monitoring device. A DDL provides the most accurate storage unit temperature information, and in the event of a temperature excursion, will provide detailed information on how long a unit has been operating outside the recommended temperature range. DDLs are relatively easy to obtain and must be used in each vaccine storage unit and each transport unit (emergency or non-emergency).

DDLs must also possess the following features:

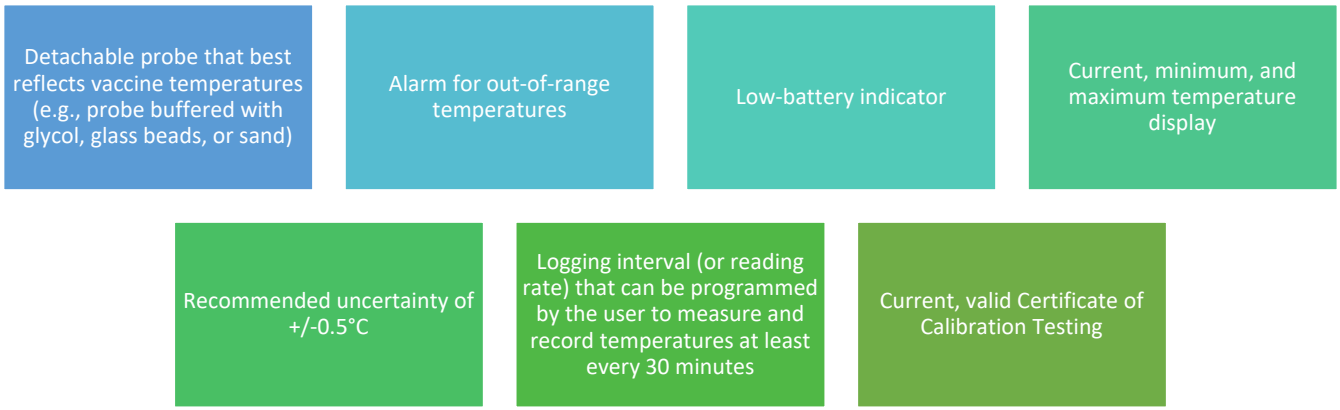


Figure D-44: Digital Data Logger Features

Any identified temperature excursions must be acted upon immediately. Any vaccines exposed to temperatures outside of recommended ranges must be labeled "DO NOT USE" and physically separated from other vaccines until viability is determined.

Provider temperature data must be reviewed at least twice daily (one AM and one PM check), and temperature logs must be submitted to the HDOH IMB when COVID-19 vaccine orders are placed. Any temperature excursions not previously reported will result in the suspension of provider ordering privileges and possible disenrollment from the COVID-19 Vaccination Program.

Satellite, Temporary, or Off-Site Settings

Satellite, temporary, or off-site clinics conducted in collaboration with community or mobile vaccinators may assist in providing equitable access for COVID-19 vaccination. However, these situations require additional oversight and enhanced storage and practices, including:

- The quantity of COVID-19 vaccine transported should be based on the anticipated number of COVID-19 vaccine recipients and the ability to store, handle, and transport the vaccine appropriately. To avoid vaccine wastage, do not transport more vaccine than needed.
- Vaccine should be transported in either a portable vaccine refrigerator or "qualified container and packout" continuously monitored with a DDL, as specified by the CDC Vaccine Storage and Handling Toolkit **(see: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit-2020.pdf)**.
- Providers administering COVID-19 vaccines at satellite, temporary, or off-site settings must develop an emergency plan and SOPs for transporting vaccines and include procedures and protocols for COVID-19 vaccine packing and transport. **See the CDC Vaccine Storage and Handling Toolkit, Section 6 for detailed guidance regarding vaccine transport (see: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit-2020.pdf)**
- Providers must complete the Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations each time a satellite, temporary, or off-site clinic is conducted and submit checklists to the HDOH IMB along with temperature logs. The checklist may be obtained at: https://www.izsummitpartners.org/content/uploads/2017/02/NAIIS-Vaccination-Clinic-Checklist_v2.pdf. Per CDC guidelines, checklists must be maintained for a minimum of 3 years. If "No" is checked in one or more boxes that contain a "STOP" indicator, contact the HDOH IMB before proceeding with the clinic. Do not administer any vaccine until confirmation is received to proceed with the clinic.
- Providers must adhere to temperature review and documentation requirements specified in any addendums to the CDC's Vaccine Storage and Handling Toolkit (addendum not yet released).
- For any vaccines exposed to temperature excursions at any time, the temperature excursion must be documented and reported to the HDOH IMB. Vaccines exposed to out-of-range temperatures must be labeled "DO NOT USE" and stored at required temperatures until vaccine viability can be determined or further instructions regarding disposal or recovery is provided.
- SOPs, staff training logs, and temperature logs must be provided to the HDOH IMB via fax or email. Receipt of provider documentation will be required for COVID-19 vaccine orders to be approved and processed. Provider documentation will be digitally maintained by HDOH IMB along with completed Enrollment, Profile, and Redistribution Forms for a minimum of three years.
- Failure to submit required documentation may result in the suspension of satellite, temporary, or off-site clinics, provider ordering privileges or possible disenrollment from the COVID-19 Vaccination Program.

Additional guidance for planning vaccination clinics held at Satellite, Temporary, or Off-Site locations can be found at: https://www.cdc.gov/vaccines/hcp/admin/mass-clinic-activities/index.html .

Planning Redistribution to Individual Locations

Due to minimum order sizes of COVID-19 vaccine (Vaccine Candidate A: 1,000 doses; Vaccine Candidate B: 100 doses), constituent products, and ancillary supplies, there may be circumstances in which COVID-19 vaccine must be redistributed beyond the identified primary CDC ship-to site. In these instances, vaccination provider organizations/facilities, third-party vendors, and other vaccination providers may be permitted to redistribute vaccine if validated cold-chain Standard Operating Procedures (SOPs) are established in accordance with the manufacturer's instructions and CDC's guidance on COVID-19 vaccine storage and handling and approval is received from the HDOH IMB to engage in planned redistribution. To apply, approved COVID-19 providers must:

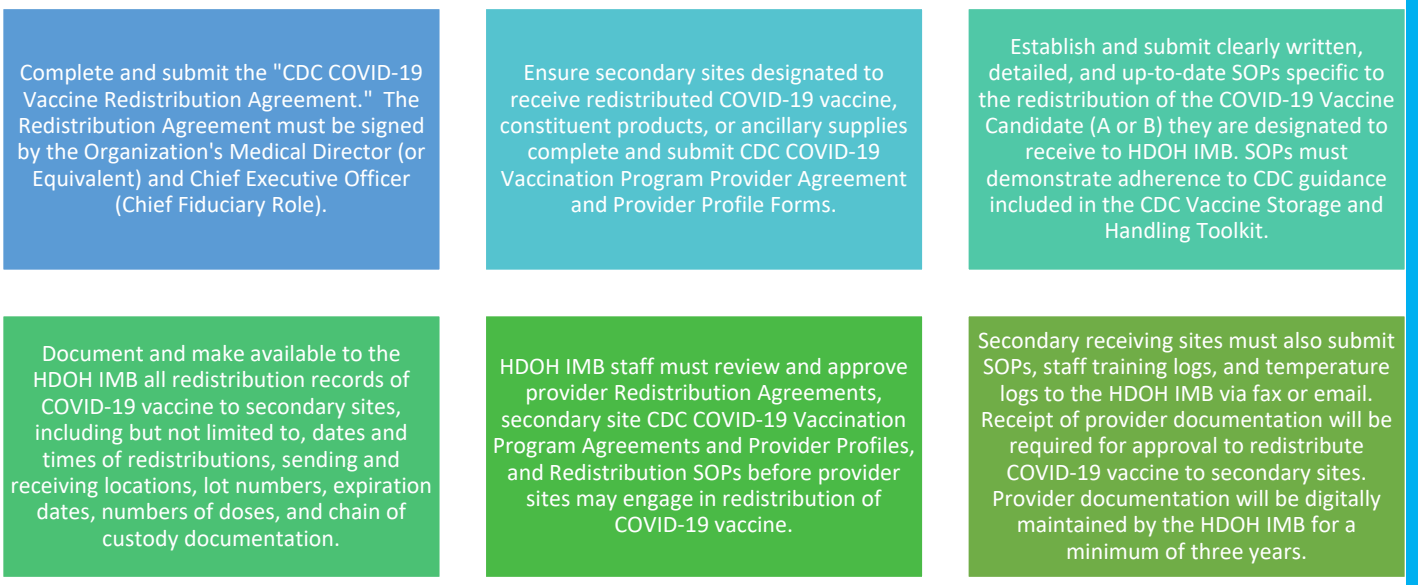


Figure D-45: COVID-19 Provider Requirements for Redistribution

Unplanned Repositioning Among Provider Locations

Any unplanned COVID-19 vaccine repositioning among provider locations must be coordinated and performed by the HDOH IMB or county-level DHOs (neighbor islands) or authorized providers who have met COVID-19 Redistribution Provider requirements.

HDOH IMB and county-level DHOs must complete and submit all documentation required to become approved COVID-19 vaccine providers and redistributors, including but not limited to:

- CDC COVID-19 Vaccine Provider Agreement Form
- CDC COVID-19 Vaccination Program Provider Profile Information
- CDC COVID-19 Vaccine Redistribution Agreement; and
- All required SOPs, staff training logs, and temperature logs.

HDOH IMB and DHOs must utilize DDL-monitored purpose-built, mobile, battery-powered refrigerators that have been prepositioned at all sites to reposition any COVID-19 vaccines. Documentation of dates and times of any COVID-19 vaccine repositioning, sending, and receiving locations, lot numbers, expiration dates, and numbers of doses, and chain of custody documentation must be submitted to the HDOH IMB.

Assessment Procedures for Monitoring Storage Capabilities

As a condition of enrollment in the COVID-19 Vaccine Program, providers must agree to store and handle COVID-19 vaccine under proper conditions, including maintaining cold chain conditions and chain of custody at all times in accordance with manufacturer guidance and CDC guidance, including but not limited to the CDC Vaccine Storage and Handling Toolkit.

To administer COVID-19 vaccines at their site, providers must complete the CDC COVID-19 Vaccination Program Provider Profile Information form and provide estimated storage capacity information and storage unit details. If a provider indicates "No Capacity" to store refrigerated or frozen vaccines, the provider will not be approved to receive COVID-19 vaccine orders. Providers that are permitted to enroll in the COVID-19 Vaccine Program must

supply copies of Vaccine Storage and Handling Standard Operating Procedures to HDOH IMB. In addition, providers will be required to submit temperature logs, at least once per month and with every COVID-19 vaccine order.

As mentioned previously, providers approved to conduct satellite, off-site, or temporary clinics and providers approved to redistribute COVID-19 vaccine also require additional oversight to monitor vaccine storage capabilities. **See "Satellite, temporary, or off-site settings" and "Planned redistribution to individual locations" for more detailed information.**

Emergency Vaccine Storage Plan

Emergencies like equipment failures, power outages, severe weather conditions, or natural disasters can happen without warning and may compromise vaccine storage conditions. All COVID-19 Vaccine providers, including those conducting satellite, temporary, or off-site clinics, or who may receive redistributed COVID-19 vaccine must establish Standard Operating Procedures for emergency vaccine storage, handling, and transport (i.e. - "Emergency Vaccine Storage Plans"). Emergency Vaccine Storage Plans must contain protocols for:

Figure D-46: Emergency Vaccine Storage Plan Requirements

See the CDC Vaccine Storage and Handling Toolkit, Section 6 for detailed guidance regarding vaccine transport and Section 7: Emergency Vaccine Storage and Handling.[29] Emergency Vaccine Storage Plans are a critical component of provider SOPs and must be reviewed and approved by HDOH IMB prior to authorization/approval to receive COVID-19 vaccines.

[29] https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit-2020.pdf

Tab 5: Vaccine Administration Documentation and Reporting[30]

CDC requires that vaccination providers enrolled in the COVID-19 Vaccination Program report certain data elements for each dose administered within 24 hours of administration. The state of Hawaii will assess the capability of COVID-19 vaccination providers to meet federal and state-specific reporting requirements before or upon enrollment. The required data elements are located on the ISD Awardees SharePoint site. COVID-19 vaccination providers may view the data requirements on CDC's IIS website. Counties should be prepared to provide additional support or technical assistance for smaller vaccination providers or rural clinic settings. HDOH will facilitate and monitor IIS reporting by enrolled vaccination providers. Each vaccination location should be ready (including trained staff, necessary equipment, and internet access) to report vaccine administration data to the IIS or other external system at the time of vaccination. If data will be entered off site, vaccination providers must ensure the required data are reported to the IIS or other designated system within 24 hours. Reporting data may be transmitted daily from HIR to the CDC via the IZ Gateway[31] "Connect" component. Additional information on the reporting process and specifications will be shared as soon as they have been finalized. **The state of Hawaii will not be responsible for reporting data from federal agencies or commercial partners who receive vaccine allocations directly from CDC.**

In addition to reporting vaccine administration, HDOH must put processes in place to match first and second doses including addressing the need to exchange data with or query county systems and/or the Immunization Data Lake[32] to obtain immunization history, if applicable.

See Tab 6: Requirements for Immunization Information Systems or Other External Systems for additional documentation/reporting information regarding Data Management and Redundant Systems in this Appendix.

Vaccine Documentation Requirements

As part of the enrollment process, IMB will enroll any COVID-19 vaccination providers who are not currently Hawaii Immunization Registry (HIR) users into the HIR system. HIR is a secure, state-wide database that stores and tracks patient immunization records and makes them available to participating healthcare workers. The IMB Registry Section will work with newly enrolled HIR providers to ensure staff receive appropriate training. Registry Section staff will work with HIR's vendor to capture all CDC required data elements in HIR. HIR is the state of Hawaii's primary Immunization Information System (IIS).

Table D-4 includes each data element that HIR will need to report to CDC. **Table D-5** includes each data element that will be optional for HIR to report to CDC. Optional data requirements will support additional national coverage analysis and vaccination monitoring efforts.[33] Data elements are also categorized as "Mass Vaccination" or "Standard." Standard data elements are likely already collected by HIR, whereas Mass Vaccination data elements are likely to require enhancements or a Mass Vaccination module for data collection

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[30] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf

[31] The Immunization Gateway (IZ Gateway) facilitates electronic messaging of vaccination records in a secure infrastructure allowing IIS systems across the nation to share vaccine administration data not only between jurisdictions, but also with provider organizations (e.g., Department of Defense, Federal Bureau of Prisons, IHS, Department of Veterans Affairs) that do not exchange data with the IIS today.

[32] The Immunization Data Lake is a cloud-hosted data repository to receive, store, and manage COVID-19 vaccination data for doses administered, vaccination coverage, ordering, inventory, and distribution. The Data Lake will provide a catalogue of different COVID-19 vaccine-related data sources that can be used to aid in monitoring COVID-19 vaccine ordering, distribution, coverage, and uptake. Data streams currently being onboarded to the Data Lake include provider enrollment data, VTrckS, and VaccineFinder.

[33] For more information on CDC Data Elements, **see Table D-6** below from CDC IIS Data Dictionary for COVID-19 Vaccine Monitoring

and reporting. Any identifiable data elements will be used to facilitate deduplication of data within the Immunization Data Lake, an analytic environment that will be used to consolidate, deduplicate, and reconcile vaccine administration information from multiple sources (e.g. county immunization programs, pharmacies, Department of Defense, Veterans Affairs, Bureau of Prisons, etc.). Identifiable elements will not be stored in the Data Lake environment.

Table D-4: CDC Required Data Elements

Required Data Element	Mass Vaccination or Standard
Data elements required for IIS (HIR) to report ***Identifiable Information**	***Mass Vaccination = may require mass vaccination module or enhancement*** ***Standard = IIS Core Data Element commonly collected during routine vaccination***
Administered at location: facility name/ID	Standard
Administered at location: type	Standard
Administration address (including county)	Standard
Administration date	Standard
CVX (Product)	Standard
Dose number	Standard
IIS Recipient ID*	Standard
IIS vaccination event ID	Standard
Lot Number: Unit of Use and/or Unit of Sale	Standard
MVX (Manufacturer)	Standard
Recipient address*	Standard
Recipient date of birth*	Standard
Recipient name*	Standard
Recipient sex	Standard
Sending organization	Standard
Vaccine administering provider suffix	Standard
Vaccine administering site (on the body)	Standard
Vaccine expiration date	Standard
Vaccine route of administration	Standard
Vaccination series complete	Mass Vaccination

Table D-5: CDC Optional Data Elements

Optional Data Element	Mass Vaccination or Standard
Data elements optional for IIS to report (e.g., state mass vaccination tool collects this information)	*Mass Vaccination = may require mass vaccination module or enhancement* *Standard = IIS Core Data Element commonly collected during routine vaccination*
Comorbidity status (Y/N)	**Mass Vaccination**
Recipient ethnicity	**Standard**
Recipient race	**Standard**
Recipient missed vaccination appointment (Y/N)	**Mass Vaccination**
Serology results (Presence of Positive Result, Y/N)	**Mass Vaccination**
Vaccination Refusal (Y/N)	**Standard**

COVID-19 vaccination providers must submit vaccine administration data to HIR within 24 hours. In the event of loss of connectivity, paper spreadsheets will be provided to document vaccine administration. Once connectivity is re-established, providers are expected to enter data into HIR or the software suite within 24 hours.

IMB is in the process of procuring a software suite that will automate online consent, mass vaccinations, and clinic management. When available, IMB's IT staff will ensure the software is able to capture all CDC required data elements. Data entered into the software suite will be uploaded to HIR.

Vaccination Record Cards

COVID-19 vaccination record cards for vaccine recipients will be provided by CDC in the ancillary supply kit (100 per kit).

Vaccination providers will be instructed on the importance of providing each vaccine recipient with the COVID-19 record card:

- COVID-19 vaccines will not be interchangeable
- Second dose must be the same product administered for the first dose
- Vaccine information must be completed accurately
    - Vaccine manufacturer
    - Lot number
    - Date of first dose administration
- Second dose due date

Vaccine providers should educate vaccine recipients on the importance of keeping the card:

- In case HIR is not available at the time of their second dose
- To ensure they receive the same product as the first dose administered
- Date for second dose appointment will be included on the card

Providers should encourage vaccine recipients to take a photo of their vaccination record in case the card is misplaced and to enter the second dose appointment on their electronic calendar.

Vaccine Reporting Requirements

As part of the enrollment process, IMB will enroll any COVID-19 vaccination providers who are not currently Hawaii Immunization Registry (HIR) users. HIR IMB staff will then initiate the data exchange onboarding process, including:

- Initiating connectivity testing
- Initiating format testing
- Conducting data quality testing of messages
- Moving provider to Production when test cases are successfully submitted
- In collaboration with provider, monitoring data quality on an ongoing basis

COVID-19 vaccination providers must submit vaccine administration data to HIR within 24 hours.

HIR IMB staff will:

- Monitor reporting from COVID-19 providers
- Contact Providers who have not submitted reports within each work week
    - Work with providers to resolve issues preventing submission of data every 24 hours
    - Providers who are unable or unwilling to submit COVID-19 administration data will be referred to the Vaccine Supply and Distribution Section (VSDS) Supervisor

    - VSDS Supervisor will review terms of enrollment with provider.
        - If unable or unwilling to comply with the 24-hour reporting process, provider will be disenrolled and COVID-19 vaccine will be retrieved by VSDS staff
- Monitor Inventory Reports in HIR weekly to ensure providers are reporting each dose administered
- Generate COVID-19 vaccination coverage reports
    - Reports will be provided to Immunization Branch Chief and DOCD Chief for evaluation of statewide coverage and assessment of the need to implement further measures to reach vulnerable populations

In the event of loss of connectivity, paper spreadsheets will be provided to document vaccine administration. Once connectivity is re-established, providers are expected to enter data into HIR within 24 hours. HIR Registry staff will transmit COVID-19 vaccination data daily to the CDC via the IZ Gateway "Connect" component.

The IMB is in the process of procuring a software suite that will automate online consent, mass vaccinations, and clinic management. Data entered into the software suite will be uploaded to HIR.

Monitoring of Provider-Level Data

The HDOH IMB is in the process of purchasing PrepMod which is an end-to-end system that automates all aspects of managing public health programming, including pandemics and other public health emergencies. Key points:

- PrepMod will provide online, paperless system to use at vaccination clinics to schedule, screen, ensure contactless documentation and report to the Hawaii Immunization Registry.
- PrepMod will automate registration, planning, implementation, evaluation, recording, and reporting for mass vaccination efforts.
- HDOH IMB will provide more details and training to users once the system is established in Hawaii.

Real-Time Documentation/Reporting from Satellite, Temporary or Offsite Clinic Settings[34]

This section helps clinic coordinators/supervisors overseeing vaccination clinics held at satellite, temporary, or offsite locations to follow CDC guidelines and best practices for vaccine shipment, transport, storage, handling, preparation, administration, and documentation. These CDC guidelines and best practices are essential for patient safety and vaccine effectiveness. This checklist should be used in any non-traditional vaccination clinic settings, such as workplaces, community centers, schools, makeshift clinics in remote areas, and medical facilities when vaccination occurs in the public areas or classrooms. Temporary clinics also include mass vaccination events, walk-through, curbside, and drive-through clinics, and vaccination clinics held during pandemic preparedness exercises. Counties document **(see Tab 6: Requirements for Immunization Information Systems or Other External Systems-Data Management, and Redundant Systems of this Appendix)** and report throughout vaccine operations. Best practices include:

[34] Checklist of Best Practices FOR Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations, available at: https://www.izsummitpartners.org/content/uploads/2019/02/off-site-vaccination-clinic-checklist.pdf, accessed October 1, 2020.

Vaccine Storage and Handling (at Facility/Clinic)	Vaccine Documentation	Post-Clinic Documentation
• If vaccines are being stored in a storage unit at the site, vaccine temperature data are being reviewed and documented a minimum of 2 times during each clinic workday (preferably at the beginning and middle of an 8-hour shift) to ensure they remain at correct temperatures (i.e., between 2–8° Celsius or 36–46° Fahrenheit for ALL refrigerated vaccines). • VFC providers should check with the state immunization program for specific requirements for vaccine temperature monitoring during mass vaccination clinics.	• Each vaccination is fully documented with name of person vaccinated using redundant systems; vaccination date; vaccine type, lot number, manufacturer; patient receipt of vaccine information statement (VISs or Emergency Use Authorization [EUA] form), including edition date and date VIS was provided; injection site; vaccination route; dosage; and name, title, and office/company address of person who administered the vaccine. • Immunization Information System (IIS) is used to document vaccinations administered. • Patients are receiving documentation for their personal records and to share with their medical providers • Vaccine recipents will also receive Vaccination Record Card with a date for second dose appointment.	• Vaccinations are recorded in the Immunization Information System (IIS) where available. • If not submitted to an IIS, vaccination information is sent to primary health care providers as directed by an established procedure based on regulations and guidance. • Any adverse events were reported to the Vaccine Adverse Event Reporting System (VAERS): vaers.hhs.gov/index. • All patient medical information was placed in a secured storage location for privacy protection. • Attach the on-duty staff sign-in sheet to this document (with shift times, clinic location, and date).

Figure D-47: Vaccine Documentation

Counties are required to adhere to Hawaii laws concerning documentation of vaccinations, use of immunization information systems (IISs), and types of health care providers who can administer vaccines. For questions, contact the HDOH DOC.

Generation/Use of Vaccination Coverage Reports

The Hawaii Immunization Registry Section will take lead in generating coverage reports from data submitted to HIR. Providers enrolled as vaccinators will need to also enroll in the HIR and all data submitted to the HIR will be reviewed and collected for the data elements required by CDC for reporting on COVID-19 vaccination efforts. Data collected from PrepMod at the vaccination clinics will be downloaded into HIR.

HDOH IMB will need to confirm the data elements needed by CDC, the State, and public to ensure the information is collectable and it is provided in a timely manner. CDC's request is for COVID-19 vaccine data to be submitted by 24 hours. If the data is able to be submitted in that time to CDC, the State would also be receiving the same information at that time. Determination on how the public receives this data will be determined at a later date on what would be best for the public to view the information that has been collected while observing all federal and state regulations regarding the sharing of data.

Vaccination Second-Dose Reminders

Current CDC guidance is that most COVID-19 vaccine products will require two doses, separated by an interval of 21 or 28 days. Since the different vaccine products will not be interchangeable, a vaccine recipient's second dose must be from the same manufacturer as their first dose. At the appointment for the first dose, vaccine providers should schedule vaccine recipients for their second dose, and note the second-dose appointment date and time on the Vaccination Record Card.

IMS is in the process of procuring a software suite that will automate online consent, mass vaccinations, and clinic management.

Vaccination providers should educate the recipient regarding:

Figure D-48: Vaccine Recipient Education

Vaccination providers will be encouraged to use their current reminder/recall systems for patient notifications for the second dose. The reminder/recall feature in HIR may also be used to generate letters to recipients of the first dose of COVID-19 vaccine. HIR IMB staff will generate reports monthly to determine patients that have only received one dose of COVID-19 vaccine. HDOH IMB will work with providers to notify patients in need of their second dose.

Procedures for Matching First and Second Doses

As different vaccine products will not be interchangeable, a vaccine recipient's second dose must be from the same manufacturer as their first dose. Each COVID-19 vaccination provider will receive product from **only one** manufacturer to avoid inadvertently administering a different vaccine for the second dose. Ideally, the vaccine recipient will receive the second dose from the same vaccination provider who administered the first dose. If the vaccine recipient goes to a different provider for the second dose, the following steps must take place to ensure the correct product is administered:

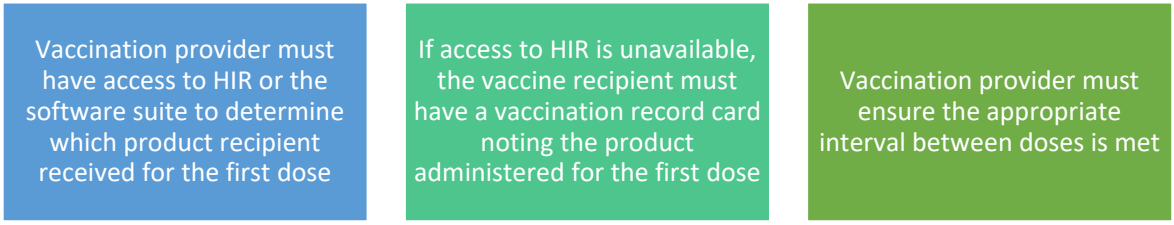

Figure D-49: Vaccine Matching Procedures

Adverse Event Reporting

COVID-19 Vaccination Providers will be instructed via a DOCD Medical Advisory of the requirement to report any clinically important adverse event following COVD-19 vaccination to VAERS.[35] VAERS, co-managed by the CDC and the U.S. Food and Drug Administration (FDA), collects and analyzes reports of adverse events following vaccination. VAERS is not designed to determine if a vaccine caused an adverse event but is useful for detecting unusual or unexpected patterns of adverse event reporting that might indicate a possible safety problem with a vaccine. Anyone can report an adverse reaction to VAERS[36]. The primary objectives of VAERS are to:

[35] https://vaers.hhs.gov/index.html

[36] **Note:** Knowingly filing a false VAERS report is a violation of Federal law (18 U.S. Code §1001) punishable by fine and imprisonment.

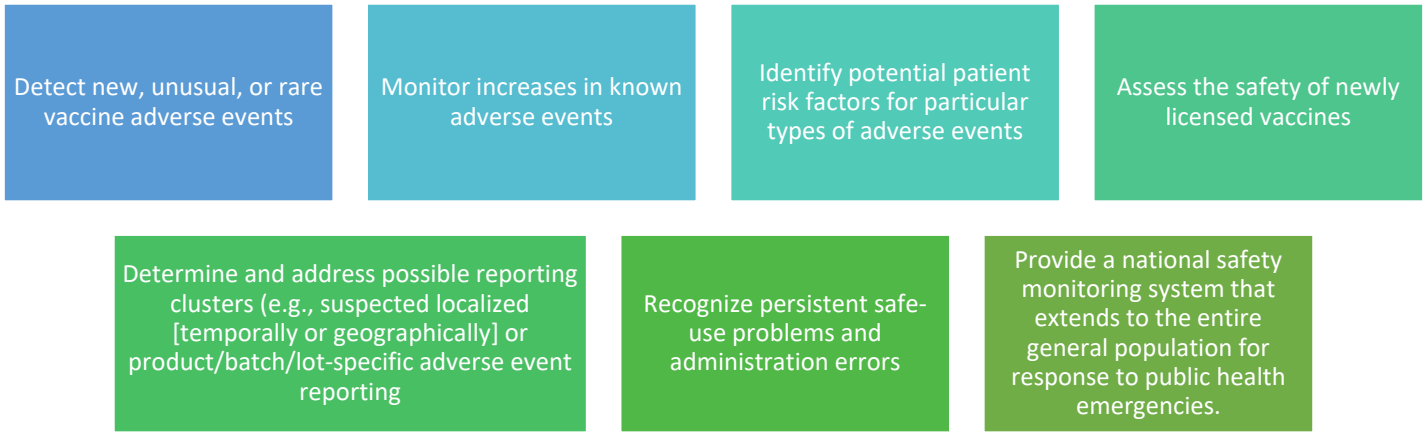

Figure D-50: VAERS Objectives

Prior to the implementation of the COVID-19 vaccination program, healthcare providers will be sent a Medical Advisory with instructions on reporting adverse events post-vaccination to VAERS. COVID-19 vaccination providers will be instructed on:

- Required reporting of adverse events following COVID-19 vaccination
- Reporting clinically important adverse events even if they are not sure the vaccination caused the event
- Reporting vaccine administration errors
- Procedures for submitting reports to VAERS:
  - Report online to VAERS (Preferred)
  - Report using a Writable PDF Form

Once the COVID-19 vaccination program begins, CDC will share information on VAERS reports for COVID-19 vaccines weekly with the HDOH IMB's Vaccine Safety Coordinator (VSC). CDC will post VAERS data weekly on CDC's secure Epidemic Information Exchange (Epi-X) in an Excel spreadsheet that will include unredacted patient identifying information. Epi-X is CDC's web-based communications solution for public health professionals, allowing access and sharing of health surveillance information quickly and securely. HDOH's VSC will have access to unredacted county-specific data and to redacted summary data consisting of cumulative report counts to date, by county. In addition to HDOH's VSC, the Acting State Epidemiologist has requested access to the unredacted COVID-19 vaccine VAERS data on Epi-X. NOTE: If VAERS receives a death report from Hawaii, CDC staff will send an email and call the VSC.

Since confidential patient data will be shared, the Acting State Epidemiologist has signed the Non-Disclosure Agreement for HDOH, confirming that the VAERS data will be kept confidential as required by law. If significant issues are identified in the VAERS reports shared by CDC, DOCD will issue a Medical Advisory to providers.

Tab 6: Requirements for Immunization Information Systems (IIS) or Other External Systems

The primary intent of HIR is to maintain records of immunizations to assist providers to appropriately immunize their patients and to identify populations at risk of under immunization and vaccine preventable diseases (VPDs). Authorized users of the system create, update, and maintain client records in HIR. Data collected in HIR is used to generate aggregate reports (e.g. assessment reports, vaccine usage and vaccine waste reports, etc.). In addition, patient specific reports are generated (e.g. immunization history, recommended vaccinations due, vaccinations overdue, etc.) by authorized users of HIR.

CDC is making available a vaccination clinic mobile application that may be used to register patients and record dose-level vaccination data that meets CDC reporting requirements. IIS and other external systems that support COVID-19 response efforts must have solid infrastructure, engaged partners, high-quality data, and efficient processes for managing vaccination.

HIR is currently populated with patient demographic and immunization data by immunization providers statewide via direct data entry and electronic data exchange. The State also enters patient-specific data received from the following HDOH programs[37]:

Stop Flu at School (SFAS) program	Vaccines for Children (VFC)	Newborn Hepatitis B Prevention vaccination program
A statewide school located influenza vaccination program for students in kindergarten through the eighth grade at participating public, charter, and private schools.	A federally funded program providing vaccines without cost to eligible children ages 0 through 18 years at 220+/- participating provider offices statewide.	Hepatitis B vaccines distributed by HDOH to all birthing hospitals (except Tripler Army Medical Center) statewide for administration to newborn infants.

Figure D-51: HDOH Vaccine Programs

In addition to data entered directly via the user interface, HIR accepts electronic data transfers and utilizes web services to enable real-time data exchanges.
https://www.cdc.gov/vaccines/programs/iis/func-stds.html

All Hawaii VFC providers submit vaccine inventory reports and order VFC vaccine through HIR. VFC providers submit vaccine administration data directly to HIR through the user interface or via electronic data exchange. Vaccine administration data from providers that do neither data exchange nor direct entry through the user interface are submitted on Vaccine Administration Visit Record (VAVR) forms and hand entered in HIR by contracted staff. As of May 31, 2020, 1,052,434 patients and 5,209,929 million immunizations have been processed into the HIR database.

[37] NOTE: HDOH used HIR for all reported H1N1 influenza vaccines administered by physicians, pharmacies, and at school-located clinics during the 2009 H1N1 influenza pandemic.

Use of IZ Gateway Connect and Share components[38]

The Immunization Gateway (IZ Gateway)(**see Figure D-52**)[39] is a portfolio of components that share a common IT infrastructure. These components support the exchange of immunization data between immunization information systems (IISs), provider organizations, and consumer applications. The IZ Gateway can streamline time- and resource-intensive data exchange onboarding. It also replaces multiple one-to-one connections with centralized routing. The HDOH IMB will be working with the Association of Public Health Laboratories (APHL) who is hosting the IZ Gateway on the needed agreements to be signed in order to connect to the IZ Gateway. **The Hawaii Deputy AG assigned to HDOH IMB will need to review any data sharing through IZ Gateway to ensure legality and protection of information.**

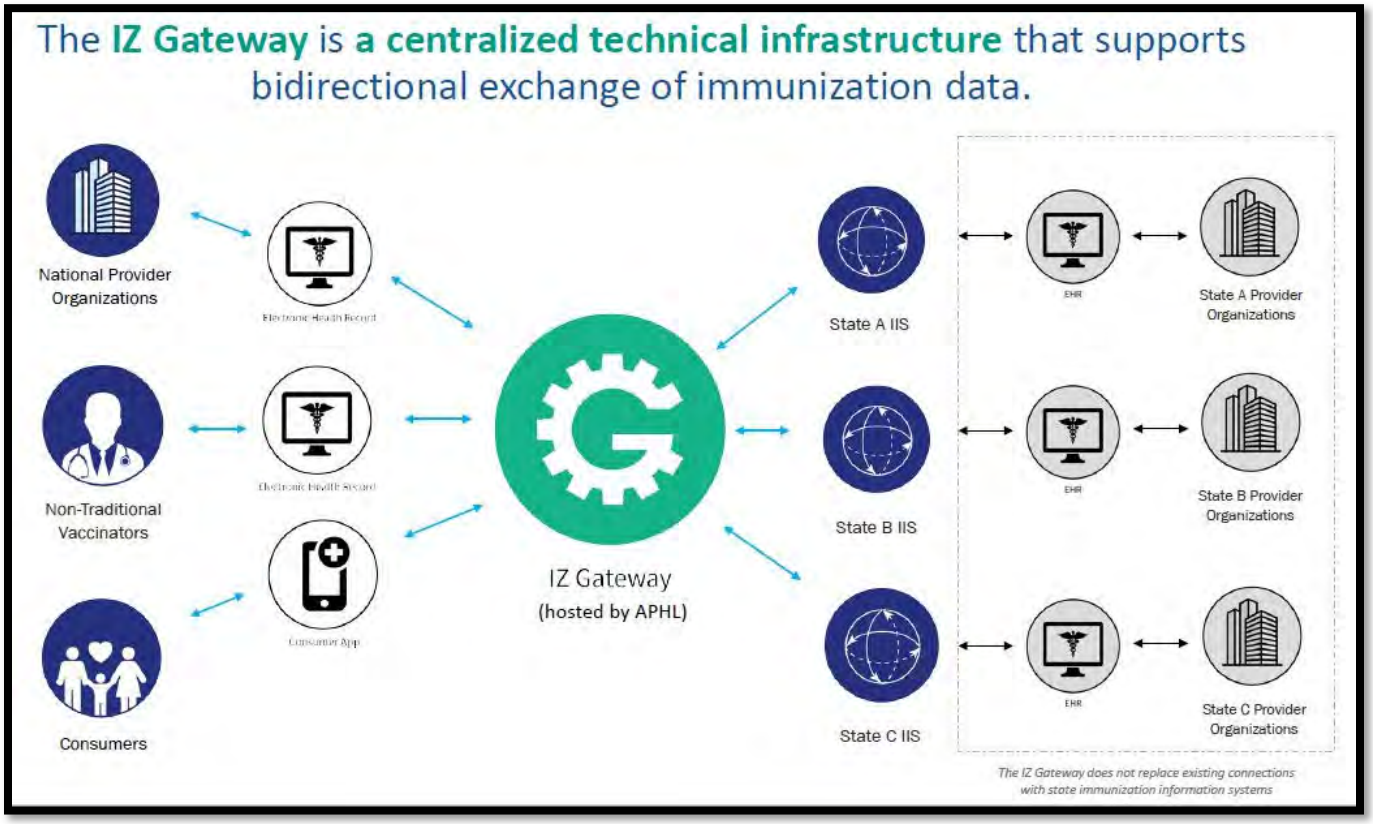

Figure D-52: IZ Gateway Overview

Vaccination Provider Preparation

As HDOH IMB enrolls providers in the COVID-19 Vaccination Program **(see Tab 2: Vaccination Provider Recruitment and Enrollment)**, it is critical that they onboard providers to the IIS. HDOH IMB plans to rapidly onboard vaccination providers expected to support Phase 1 activities and will use efficient processes to onboard vaccination providers expected to support expanded efforts in Phases 2 and 3. HDOH plans to support the conduct of nontraditional COVID-19 vaccination clinics, such as temporary, off-site, or mobile vaccination clinics to reach critical populations, particularly during early vaccination efforts. This may require HDOH IMB to identify, enroll, and train additional partners to report doses administered in the system designated to support those efforts.

[38] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf

[39] https://repository.immregistries.org/resource/the-immunization-gateway-portfolio/, accessed October 13, 2020.

Data Management

The HIR section will take the lead in reviewing and analyzing the data collected by the HIR. As data are entered into HIR, the Registry section staff are able to monitor and troubleshoot issues when vaccinating clinics may have issues with submitting data to HIR. Data will be extracted out of HIR and put into a report format to be provided to CDC, the State, and the public.

Redundant Procedures

HDOH IMB will establish redundant measures and procedures for recording vaccine administration data in instances of connectivity problems or failures in the IIS or other system. HIR will collect, report, and submit data directly to CDC's Immunization Data Lake and meet state reporting requirements (NOTE: Additional information on CDC data requirements is forthcoming.) Planning activities should include onboarding to IZ Gateway Connect and Share (if feasible) components; exchanging data with other jurisdictions through the IZ Gateway; generating coverage reports for use within Hawaii; and providing data to HDOH (who provides information to the CDC) that meet defined standards.

There are multiple ways to onboard to the IZ Gateway, including Connect and Share.

- **Connect** enables large national and non-traditional vaccination systems for satellite/temporary/off-site clinic settings to report and query immunization data with IISs, using the gateway's centralized data exchange, avoiding multiple individual, and point-to-point connections.
- **Share** allows exchange of immunization data between IIS jurisdictions by automating message triggers through the IIS for patients immunized outside of their jurisdiction, to route messages to the patient's state of residence through the IZ Gateway.

Figure D-53: IZ Gateway Onboarding

Procedures to Monitor Data Quality/Completeness

HDOH will have processes in place for monitoring data quality and completeness while managing and tracking COVID-19 vaccine ordering, distribution, and inventory. HDOH will review business processes and IIS functionality to identify and implement improvements where possible; develop plans to trigger orders, assist in monitoring activities, and manage COVID-19 vaccine inventory in the IIS using HDOH/CDC standards; and explore opportunities to adopt other solutions (i.e. barcoding technology) to improve data quality.

Procedures to Identify and Implement Business Process and IIS Functionality Improvements

The following resources address quality management and business improvement activities[40]:

CDC Vaccination Clinic Mobile Application: Vaccine Administration Management System (VAMS)

- VAMS: An overview of the functionality of the four VAMS modules: IIS Counties, employers/organizations, clinics, and vaccine recipients. (Located in SharePoint).

Provider Onboarding

- CDC Provider IIS Participation Community of Practice:[41] An overview of the CDC Provider IIS Participation Community of Practice and ideas for addressing important provider IIS participation issues, including onboarding, EHR assistance, data quality, and provider training and outreach presented as a webinar.
- American Immunization Registry Association (AIRA Data Validation Guide – for the IIS Onboarding Process (2017):[42] A guide with recommendations on the data validation process.

[40] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf

[41] https://vimeo.com/330887879

[42] Available at: https://repository.immregistries.org/resource/data-validation-guide-for-the-iis-onboarding-process/

- Onboarding Consensus-Based Recommendations (2018):[43] A guide for improving and standardizing onboarding intended for technical and programmatic staff that make up IIS onboarding teams and for program administrators responsible for allocation of onboarding resources.

Data Quality

- CDC Provider IIS Participation Community of Practice:[44] An overview of the CDC Provider IIS Participation Community of Practice and ideas for addressing important provider IIS participation issues, including onboarding, EHR assistance, data quality, and provider training and outreach presented as a webinar.
- IIS Data Quality Blueprint:[45] — A guide to help immunization program awardees address and advance data quality within IISs.
- Data Quality Assurance in Immunization Information Systems: Incoming Data (2008):[46] A summary of best practice guidelines and immediate actions an IIS can take to improve data quality.
- IIS Data Quality Practices to Monitor and Evaluate Data at Rest (2018):[47] Practical guidance on techniques, methodologies, and processes for IISs to use in assessing the quality of data at rest, including demographic and immunization record information that is currently in the live, production environment (e.g., database or other data store).
- Consolidating Demographic Records and Vaccination Event Records (2017):[48] Consensus-based best practice recommendations to support the process of consolidating demographic and vaccination event records.

Immunization Gateway (IZ Gateway)

- Immunization Gateway Information Sheet (Located in SharePoint).
- Immunization Gateway Overview (Located in SharePoint available to immunization programs).
- Immunization Gateway Q&As for IIS Awardees (Located in SharePoint).

Ordering and Inventory

- Immunization Information System Inventory Management Operations (2012):[49] Consensus-based best practice recommendations for IISs to support immunization program requirements for provider organizations' vaccine inventory management and associated IIS reports that support the vaccine inventory management needs of provider organizations and grantee immunization programs.
- Decrementing Inventory via Electronic Data Exchange (2016):[50] Consensus-based best practice recommendations to support the process of decrementing inventory via electronic data exchange.
- Guidance on Unit of Sale/Unit of Use Lot Numbers (2018):[51] Clarifications to the process and expectations for management of vaccine lot numbers.
- Vaccine Code Set Considerations (2020):[52] A general overview of vaccine code sets and brief description of how code sets support multiple and varied IIS functions, including electronic data exchange with EHRs and other health information systems and vaccine ordering and inventory management.

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[43] https://repository.immregistries.org/files/resources/5c377a4b2a490/aira_onboarding_recommendations_final.pdf

[44] https://vimeo.com/330887879

[45] https://www.cdc.gov/vaccines/programs/iis/downloads/Data-Quality-Blueprint-508.pdf

[46] https://www.cdc.gov/vaccines/programs/iis/downloads/Data-Quality-Blueprint-508.pdf

[47] https://repository.immregistries.org/files/resources/5c002cbde216d/aira_dq_guide_data_at_rest_-_final.pdf

[48] https://repository.immregistries.org/files/resources/59d677eb1b908/aira_mirow_consolidating_demographic_records_full_guide_-_final_new_logo.pdf

[49] https://repository.immregistries.org/resource/immunization-information-system-inventory-management-operations/

[50] https://repository.immregistries.org/resource/decrementing-inventory-via-electronic-data-exchange-1/

[51] https://repository.immregistries.org/files/resources/596f7218ad93e/aira_sisc_vaccine_lot_number_guidance_20180614.pdf

[52] Available at: https://repository.immregistries.org/files/resources/5ec6ba69859a6/vaccine_code_set_considerations_final-0.pdf

1 *Table D-6: CDC IIS Data Dictionary for COVID-19 Vaccine Monitoring: Required Data*

Data Elements	Mass Vaccination or Standard	Data Element Description	Naming Convention	Value Set	Data Format	Sample Responses
Administered at location	Standard	The facility name/identifier of the facility that administered the immunization. This information may not be available for a historical dose.	admin_name	open field	Character	Hope Clinic
Administered at location: type	Standard	Report the characteristic of the provider site that reported the immunization to the IIS (i.e. the sending organization)	admin_type	clinic, health dept, healthcare provider's office, pharmacy, community provider/ immunizer, point of dispensing	Character	Pharmacy
Administration address: city	Standard	The city component of the administered at location's address (exception for mobile clinics)	admin_address_city	open field	Character	Atlanta
Administration address: county	Standard	The county component of where the vaccine is being administered (i.e. the administered at location). Exception for mobile clinics.	admin_address_county	open field	Character	Fulton
Administration address: state	Standard	The state component of where the vaccine is being administered (i.e. the administered at location). Exception for mobile clinics.	admin_address_state	open field	Character	Georgia
Administration address: street	Standard	The street component of where the vaccine is being administered (i.e. the administered at location). Exception for mobile clinics.	admin_address_street	open field	Character	123 Long Road
Administration address: zip code	Standard	The zip code component of where the vaccine is being administered (i.e. the administered at location). Exception for mobile clinics.	admin_address_zip	open field	Character	12345
Administration date	Standard	The date the vaccination event occurred. Note: Based on local need, this may include immunoglobulin or other medical substances.	admin_date	open field	Date	11/1/2020
CVX (Product)	Standard	The vaccine type that may be administered, historical, or refused, and is messaged using the NDC or CVX code sets. Note: based on local need, this may include immunoglobulin or other medical substances.	CVX	To be updated when vaccine is available	Number	198
Dose Number	Standard	Report dosage/dose number being administered, if the vaccine requires more than one (e.g., dose #1, dose #2)	dose_num	First dose, second dose, third dose	Number	First dose
IIS Recipient ID	Standard	Report the same unique patient identifier reported in the Demographic Record. This can be	recip_id	open field	Number	#####

Data Elements	Mass Vaccination or Standard	Data Element Description	Naming Convention	Value Set	Data Format	Sample Responses
		the ID used by your IIS to uniquely identify the individual. Or it can be a randomly assigned unique identifier.				
IIS Vaccination Event ID	Standard	The vaccination event's unique identifier assigned by the submitting system. Note: this is referred to as the "Filler Order Number," in the HL7 Implementation Guide.	iis_vax_event_id	open field	Number	#####
Lot Number: Unit of Sale	Standard	The lot number of the vaccine administered: Unit of Sale (UoS). Note: Based on local need, this may include immunoglobulin or other medical substances	lot_num_uos	To be updated when vaccine is available	Number	#####
Lot Number: Unit of Use	Standard	The lot number of the vaccine administered: Unit of Use (UoU). Note: Based on local need, this may include immunoglobulin or other medical substances	lot_num_uou	To be updated when vaccine is available	Number	#####
MVX	Standard	The manufacturer of the vaccine administered	MVX	To be updated when vaccine is available	Character	PFR
Recipient address: county	Standard	The county component of the recipient's address	recip_address_county	open field	Character	Fulton
Recipient address: city	Standard	The city component of the recipient's address	recip_address_city	open field	Character	Atlanta
Recipient address: state	Standard	The street component of the recipient's address	recip_address_state	open field	Character	Georgia
Recipient address: street	Standard	The state component of the recipient's address	recip_address_street	open field	Character	Peachtree
Recipient address: zip code	Standard	The zip code of the recipient's address	recip_address_zip	open field	Character	12345
Recipient date of birth	Standard	Recipient's date of birth	recip_dob	open field	Date	4/20/1980
Recipient name	Standard	Recipient's first, middle, last name	recip_name	open field	Character	Jane Doe
Recipient sex	Standard	Report the sex of recipient	recip_sex	Male , female , other, unknown	Character	Female
Sending Organization	Standard	The identifier of the organization that connects to the IIS and submits the record. May be referenced as IIS-AO ID.	sending_org	open field	Character	Emory Hospital
Vaccine administering provider suffix	Standard	The professional designation of the person administering the vaccination. (e.g., MD, LPN, RN). May also be referenced as vaccination administering provider type.	vax_prov_suffix	R.N. M.D. N.P. P.A. L.P.N. Other	Character	N.P.

Data Elements	Mass Vaccination or Standard	Data Element Description	Naming Convention	Value Set	Data Format	Sample Responses
Vaccination Complete	Mass Vaccination	Report the completion status of the vaccination	vax_complete	Complete, Refused, Not Administered, Partially Administered, No recorded completion status	Character	Complete
Vaccine administering site	Standard	Record the site of vaccine administration associated with the vaccine reported in the CVX code variable.	vax_admin_site	Left thigh, left arm, left deltoid, left gluteous medius, left vastus lateralis, left lower forearm, right arm, right thigh, right vastus lateralis, right gluteous medious, right deltoid, right lower forearm, no recorded site	Character	Left arm
Vaccine expiration date	Standard	The expiration date of the vaccine administered. Note: Based on local need, this may include immunoglobulin or other medical substances.	vax_expiration	open field	Date	12/1/2020
Vaccine route of administration	Standard	The route of vaccine administration (e.g., oral, subcutaneous) - this should be captured in the IIS if the IIS is used as the primary vaccination event record (e.g., mass vaccination clinic)	vax_route	Intradermal, Intramuscular, Intranasal, Nasal, Intravenous, Oral, Other/Miscellaneous, Subcutaneous	Character	Intramuscular

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Appendix E: Vaccine Program Communication

This section describes the organization, process, and procedures by which HDOH will provide timely, accurate, and useful public information throughout the COVID-19 Vaccination Program. It focuses on communications with key stakeholders and incorporates guidance from the HDOH Emergency Public Information Plan.[1] HDOH will use a COVID-19 Communications Working Group to implement this plan in coordination with other stakeholders such as the COVID-19 Joint Information Center (JIC).

Vaccine Communications Objectives and Assumptions[2]

Starting before COVID-19 vaccines are available, clear, effective communication will be essential to implementing a successful COVID-19 Vaccination Program. Building vaccine confidence broadly and among groups anticipated to receive early vaccination, as well as dispelling vaccine misinformation, are both critical to ensure vaccine uptake.

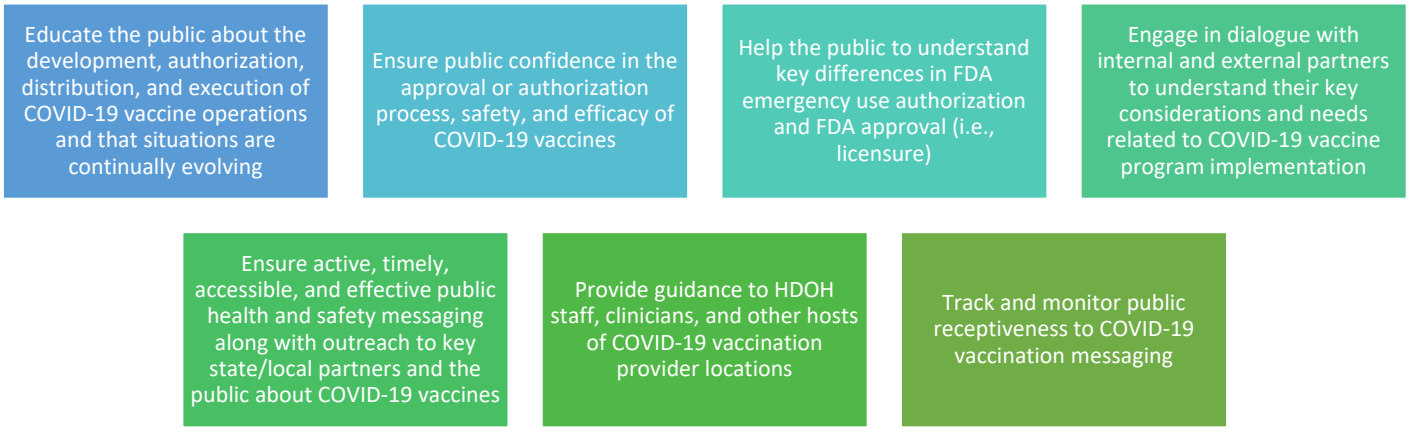


Figure E-1: COVID-19 Communications Objectives

Figure E-2 below contains initial planning assumptions for COVID-19 communications efforts.

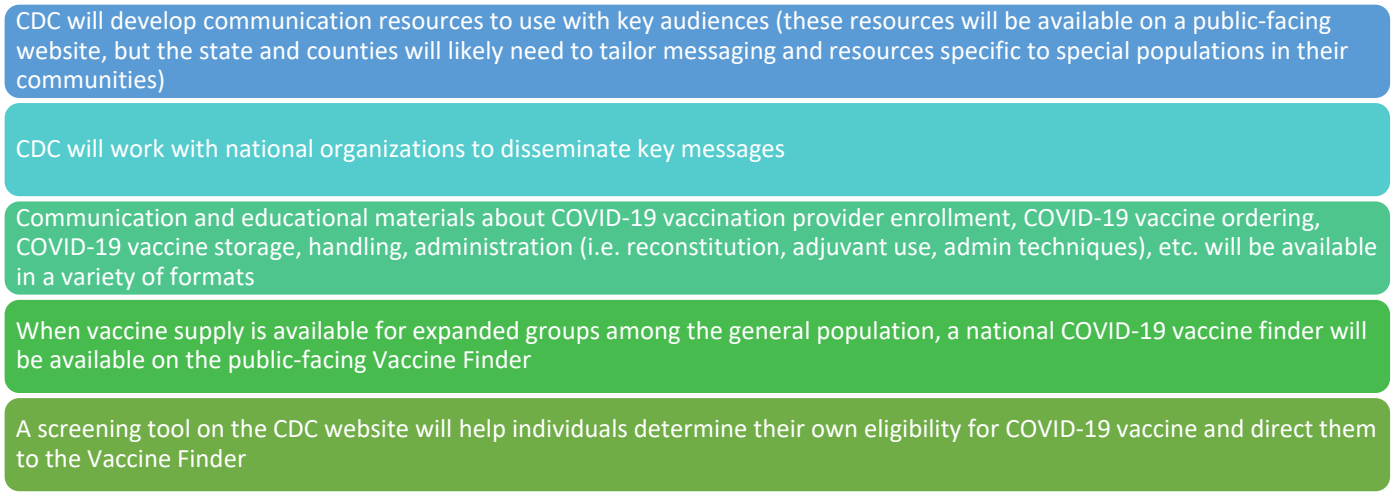


Figure E-2: COVID-19 Communications Assumptions

[1] 2010 State of Hawaii Department of Health Emergency Public Information Plan

[2] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

Key Audiences[3]

The COVID-19 Communications Working Group will tailor messages for each audience as appropriate to ensure communication is effective. Key audiences include the following:

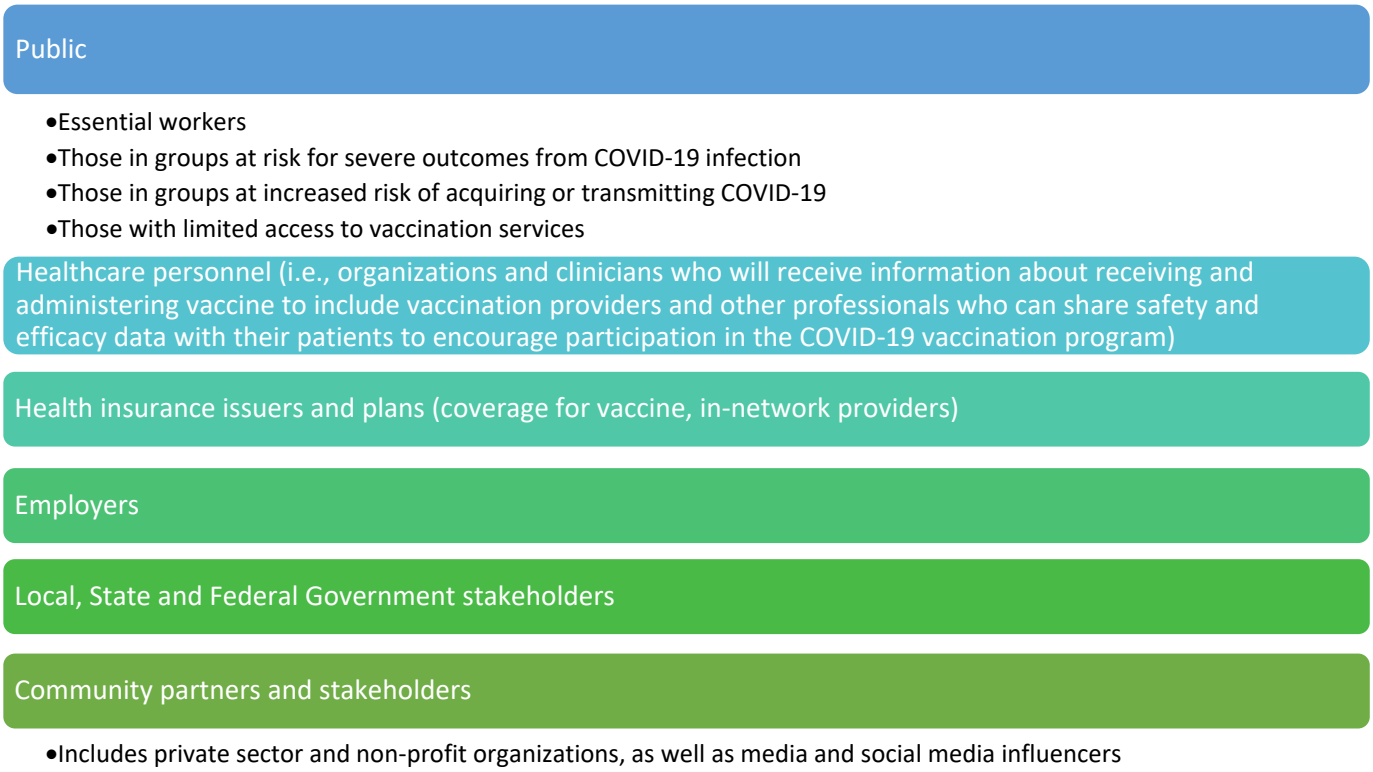


Figure E-3: COVID-19 Key Audiences

COVID-19 Vaccination Program Communications Planning Phases[4]

It is essential that the COVID-19 Communications Working Group not only develop a plan of action but also gain understanding, support and endorsement from county and state agencies for that plan. It should be noted Hawaii has already prepared crisis management plans that include public information plans. These have been refined over the years as the various counties and the state have dealt with major challenges to public health and safety such as hurricanes, SARS, H1N1 and dengue fever.[5] Messaging should be timely and applicable for each phase of the COVID-19 Vaccination Program. Note that the Communications Working Group will start messaging and outreach in "Phase 0", i.e. – before COVID-19 vaccine is available.

Figure E-4: COVID-19 Vaccination Program Communications Planning Phases

[3] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.
[4] Ibid.
[5] 2010 State of Hawaii Department of Health Emergency Public Information Plan

COVID-19 Vaccination Program Communications Activities by Phase

Table E-1: Phase 0 - Communications Activities

Phase 0 (Before Vaccine is available)
☐ Develop/validate Communications Objectives
☐ Produce an initial written communication plan
☐ Prepare informational materials and templates
☐ Foster alliances within or among agencies and the media to ensure that experts are speaking with one voice.
o Work closely with partner agencies, representatives of local communities with critical populations, and intermediaries to achieve consensus on actions, consistency in messages, and coordinated communication activities.
☐ Develop consensus communications recommendations, policies, and protocols
o Proactively anticipate questions and develop preliminary answers with available information
☐ Train communications staff
☐ Identify potential spokespersons
o Train spokespersons (ex. – elected officials, technical experts, COVID-19 vaccination program staff, etc.)
☐ Acquire necessary communications supplies and equipment
☐ Test messages and exercise communication plan
☐ Conduct outreach to the public, public health partners, and healthcare providers
o Communicate early about the safety of vaccines in general and have easily accessible, government information to address myths, questions, and concerns.
o Keep stakeholders well-informed about COVID-19 vaccine(s) development, recommendations, and public health's efforts.
o Engage and use a wide range of partners, collaborations, and communication and news media channels to achieve communication goals, understanding that channel preferences and credible sources vary among audiences and people at higher risk for severe illness and critical populations, and channels vary in their capacity to achieve different communication objectives.
o Communicate proactively whenever possible, anticipating issues and forecasting possible problems before they reach broad awareness.
o Use information and education campaigns to extend reach and increase visibility of vaccine recommendations and resources.
o Communicate transparently about COVID-19 vaccine risks and recommendations, immunization recommendations, public health recommendations, and prevention measures.
o Encourage increased participation in seasonal influenza campaign, and ensure the public is aware of the difference between the seasonal influenza campaign and the COVID-19 vaccination program.
☐ Ensure that communications meet the requirements of the Americans with Disabilities Act, the Rehabilitation Act, the Patient Protection and Affordable Care Act, the Plain Language Act, and other applicable disability rights laws for accessibility.
☐ Establish proactive media and social media monitoring efforts to include automated searches for key terms of interest within the state and in specific counties, as well as procedures for after-hours/week-end monitoring/response efforts.

Table E-2: Phase 1 - Communications Activities

Phase 1 (Potentially Limited Doses Available)
☐ Update Communications Objectives and incorporate into Incident Action Plan (IAP) as appropriate
☐ Update written communication plan
☐ Update informational materials and templates, and develop additional materials if needed
☐ Continue to foster alliances within or among agencies and the media to ensure that experts are speaking with one voice.
o Work closely with partner agencies, representatives of local communities with critical populations, and intermediaries to achieve consensus on actions, consistency in messages, and coordinated communication activities.
☐ Continue to coordinate and develop consensus communications recommendations, policies, and protocols
o Proactively anticipate questions and develop preliminary answers with available information
☐ Continue to train communications staff
☐ Identify additional spokespersons if needed and establish organization/spokesperson credibility
o Train spokespersons (ex. – elected officials, technical experts, COVID-19 vaccination program staff, etc.)
☐ Acquire additional communications supplies and equipment if needed
☐ Continue to test messages and exercise communication plan
☐ Continue and expand outreach to the public, public health partners, and healthcare providers
o Communicate latest information about the safety of vaccines in general and have easily accessible, government information to address myths, questions, and concerns about specific COVID-19 vaccines as they are released.
o Keep stakeholders well-informed about COVID-19 vaccine(s) development, recommendations, and public health's efforts to include sharing realistic expectations for when COVID-19 vaccines will be available throughout the state.
o Engage and use a wide range of partners, collaborations, and communication and news media channels to achieve communication goals, understanding that channel preferences and credible sources vary among audiences and people at higher risk for severe illness and critical populations, and channels vary in their capacity to achieve different communication objectives.
o Communicate proactively whenever possible, anticipating issues and forecasting possible problems before they reach broad awareness.
o Use information and education campaigns to extend reach and increase visibility of vaccine recommendations and resources
o Communicate transparently about COVID-19 vaccine risks and recommendations, immunization recommendations, public health recommendations, and prevention measures.
o Acknowledge concerns with empathy
o Provide consistent guidance on how/where to get information to include location of vaccination providers, allocation/prioritization decisions impacting critical populations, etc.
o Maintain periodic and regular media and public updates to include posting to websites and social media channels.
o Continue to encourage increased participation in seasonal influenza campaign
☐ Ensure that communications meet the requirements of the Americans with Disabilities Act, the Rehabilitation Act, the Patient Protection and Affordable Care Act, the Plain Language Act, and other applicable disability rights laws for accessibility.
☐ Continue proactive media and social media monitoring efforts to include automated searches for key terms of interest within the state and in specific counties, as well as implementing procedures for after-hours/week-end monitoring/response efforts.

Table E-3: Phase 2 - Communications Activities

Phase 2 (Large Number of Doses Available, Supply Likely to Meet Demand)
☐ Update Communications Objectives and incorporate into Incident Action Plan (IAP) as appropriate
☐ Update written communication plan as needed
☐ Update informational materials and templates, and develop additional materials as needed
☐ Continue to foster alliances within or among agencies and the media to ensure that experts are speaking with one voice.
o Work closely with partner agencies, representatives of local communities with critical populations, and intermediaries to achieve consensus on actions, consistency in messages, and coordinated communication activities.
☐ Continue to coordinate and develop consensus communications recommendations, policies, and protocols
o Proactively anticipate questions and develop preliminary answers with available information
☐ Continue to train communications staff
☐ Identify additional spokespersons if needed and establish organization/spokesperson credibility
o Train spokespersons (ex. – elected officials, technical experts, COVID-19 vaccination program staff, etc.)
☐ Acquire additional communications supplies and equipment if needed
☐ Continue to test messages and exercise communication plan
☐ Continue and expand outreach to the public, public health partners, and healthcare providers
o Communicate latest information about the safety of vaccines in general and have easily accessible, government information to address myths, questions, and concerns about specific COVID-19 vaccines as they are released.
o Keep stakeholders well-informed about COVID-19 vaccine(s) development, recommendations, and public health's efforts to include sharing realistic expectations for when a large amount of COVID-19 vaccines will be available throughout the state.
o Engage and use a wide range of partners, collaborations, and communication and news media channels to achieve communication goals, understanding that channel preferences and credible sources vary among audiences and people at higher risk for severe illness and critical populations, and channels vary in their capacity to achieve different communication objectives.
o Communicate proactively whenever possible, anticipating issues and forecasting possible problems before they reach broad awareness.
o Use information and education campaigns to extend reach and increase visibility of vaccine recommendations and resources.
o Communicate transparently about COVID-19 vaccine risks and recommendations, immunization recommendations, public health recommendations, and prevention measures.
o Acknowledge concerns with empathy
o Provide consistent guidance on how/where to get information to include location of vaccination providers, allocation/prioritization decisions impacting critical populations, etc.
o Maintain periodic and regular media and public updates to include posting to websites and social media channels.
☐ Ensure that communications meet the requirements of the Americans with Disabilities Act, the Rehabilitation Act, the Patient Protection and Affordable Care Act, the Plain Language Act, and other applicable disability rights laws for accessibility.
☐ Continue proactive media and social media monitoring efforts to include automated searches for key terms of interest within the state and in specific counties, as well as implementing procedures for after-hours/week-end monitoring/response efforts.

Table E-4: Phase 3 - Communications Activities

Phase 3 (Likely Sufficient Supply, Slowing Demand)
☐ Update Communications Objectives and incorporate into Incident Action Plan (IAP) as appropriate
☐ Update written communication plan as needed
☐ Update informational materials and templates, and develop additional materials as needed
☐ Continue to foster alliances within or among agencies and the media to ensure that experts are speaking with one voice.
o Work closely with partner agencies, representatives of local communities with critical populations, and intermediaries to achieve consensus on actions, consistency in messages, and coordinated communication activities.
☐ Continue to coordinate and develop consensus communications recommendations, policies, and protocols
o Proactively anticipate questions and develop preliminary answers with available information
☐ Continue to train communications staff
☐ Identify additional spokespersons if needed and establish organization/spokesperson credibility
o Train spokespersons (ex. – elected officials, technical experts, COVID-19 vaccination program staff, etc.)
☐ Acquire additional communications supplies and equipment if needed
☐ Continue to test messages and exercise communication plan
☐ Continue and expand outreach to the public, public health partners, and healthcare providers
o Communicate latest information about the safety of vaccines in general and have easily accessible, government information to address myths, questions, and concerns about specific COVID-19 vaccines as they are released.
o Keep stakeholders well-informed about COVID-19 vaccine(s) development, recommendations, and public health's efforts to include sharing realistic expectations for when there is sufficient supply and slowing demand for COVID-19 vaccines that will be available throughout the state.
o Engage and use a wide range of partners, collaborations, and communication and news media channels to achieve communication goals, understanding that channel preferences and credible sources vary among audiences and people at higher risk for severe illness and critical populations, and channels vary in their capacity to achieve different communication objectives.
o Communicate proactively whenever possible, anticipating issues and forecasting possible problems before they reach broad awareness.
o Use information and education campaigns to extend reach and increase visibility of vaccine recommendations and resources.
o Communicate transparently about COVID-19 vaccine risks and recommendations, immunization recommendations, public health recommendations, and prevention measures.
o Acknowledge concerns with empathy
o Provide consistent guidance on how/where to get information to include location of vaccination providers, allocation/prioritization decisions impacting critical populations, etc.
o Maintain periodic and regular media and public updates to include posting to websites and social media channels.
☐ Ensure that communications meet the requirements of the Americans with Disabilities Act, the Rehabilitation Act, the Patient Protection and Affordable Care Act, the Plain Language Act, and other applicable disability rights laws for accessibility.
☐ Continue proactive media and social media monitoring efforts to include automated searches for key terms of interest within the state and in specific counties, as well as implementing procedures for after-hours/week-end monitoring/response efforts.
☐ Identify triggers to begin demobilizing COVID-19 communications efforts and transition to normal ops.

Transition to Normal Operations[6]

As COVID-19 vaccination efforts transition into Phase 3, the public may be especially receptive to relevant disease prevention information. HDOH should continue periodic and regular media and public updates as needed. Key public health staff and public information personnel involved in outbreak management will meet for an after-action review of emergency communications activities, including media relations, dissemination of information to the public, rumor control and communications among COVID-19 vaccination program personnel. Additionally, HDOH will plan to use findings from public opinion surveys and other methods of gaining public input, comment, and perceptions to identify areas of concern and improvement. HDOH will address problematic areas and revise the communication plans and procedures as appropriate **(see Section 3: Concept of Operations for additional details on the corrective action program)**. COVID-19 Communications Objectives at this point include the following:

- Express gratitude for responders and community efforts
- Acknowledge actions of both individuals and groups
- Share information about appropriate corrective actions
- Continue to gather stakeholder feedback especially related to communications efforts

Role of the Joint Information Center (JIC)

The state of Hawaii established a COVID-19 JIC to maximize public information coordination efforts. The JIC is a central location where public information officers from participating agencies can come together to ensure the successful coordination, analysis, production, and dissemination of accurate and timely information for multiple agencies and jurisdictions. The JIC also serves as a "one stop shop" for the news media, providing a central location for them to interact with PIOs, gets news releases, obtain background data, be updated on developments, interview experts and designated spokespersons, and attend news conferences and briefings.[7] The COVID-19 Communications Working Group will support JIC efforts to provide a single source of accurate information for all audiences, thereby reducing rumors and helping the public take appropriate actions and make informed decisions. The intent is to get the right information to the right people at the right time so that the public is able to make the right decisions.[8]

Initial Guidance for Spokespersons

Spokespersons should strive to:[9]

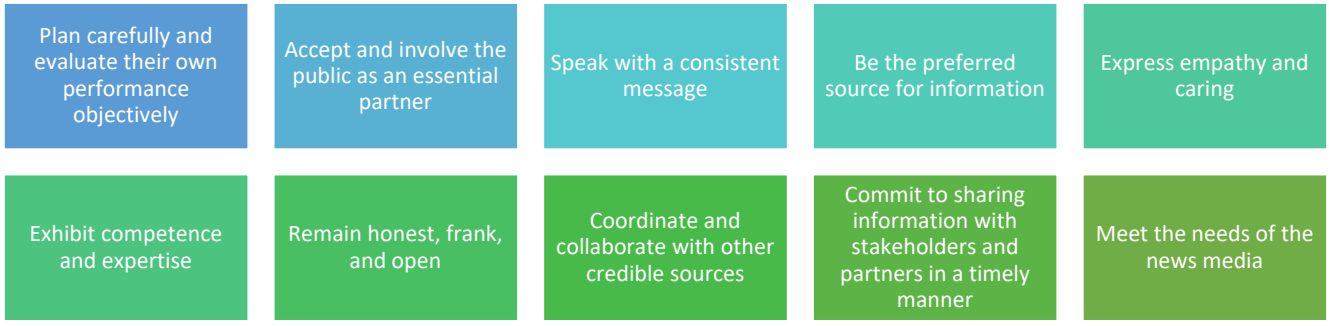


Figure E-5: COVID-19 Initial Guidance for Spokespersons

[6] Ibid.
[7] 2010 State of Hawaii Department of Health Emergency Public Information Plan
[8] HDOH SNS Base Plan Annex I: Public Information/Warning
[9] Ibid.

Messaging Considerations[10]

The COVID-19 Communications Working Group will tailor public health messages and products for each audience with consideration for health equity as appropriate. It is important to use plain language that is easily understood. The working group will present information in culturally responsive language and available in languages that represent communities within Hawaii. The working group will be careful to address all people inclusively, with respect, using non-stigmatizing, bias-free language. Insufficient consideration of culture in developing materials may unintentionally result in misinformation, errors, confusion, or loss of credibility. When developing/utilizing materials, the COVID-19 Communications Working Group will check for the following:

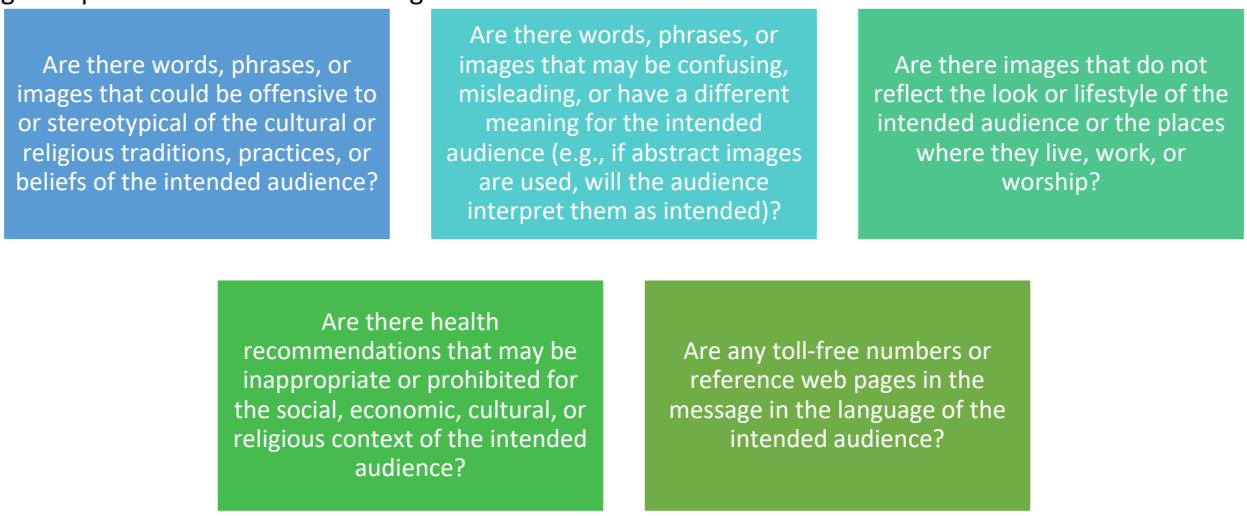


Figure E-6: Messaging Considerations

Additional Considerations:

- Epidemics do not increase vaccine acceptance in racial or ethnic minorities, meaning targeted communication from trusted messengers remains necessary – especially when a vaccine is new, data on safety or risk is limited, and negative informal messaging occurs

HDOH needs to be prepared to answer these questions, which are bound to change frequently.

- Who can get vaccinated?
- Where is the vaccine available?
- Which vaccines are available?
- How much vaccine has been distributed?
- What is the vaccine safety and effectiveness data saying?

Communications Channels

Because each county has its own particular characteristics, the COVID-19 Communications Working Group will need to work with each county to identify stakeholders, and what communications channels are effective and appropriate for providing needed information to them. This will include identifying the key contacts for accessing those channels, which include mass media, social media, as well as other channels. Additionally, each of the county emergency management agency should support efforts to identify credible spokespersons for disseminating information.[11]

[10] 2010 State of Hawaii Department of Health Emergency Public Information Plan
[11] Ibid.

The COVID-19 Communications Working Group will support existing emergency management channels as the primary means of reaching publics on each island. The working group will provide essential public health and safety information to each county EOC through the appropriate county DHO, and other established channels.[12]

To ensure timely dissemination of information to the media, the working group will use the following channels of communication where appropriate:[13]

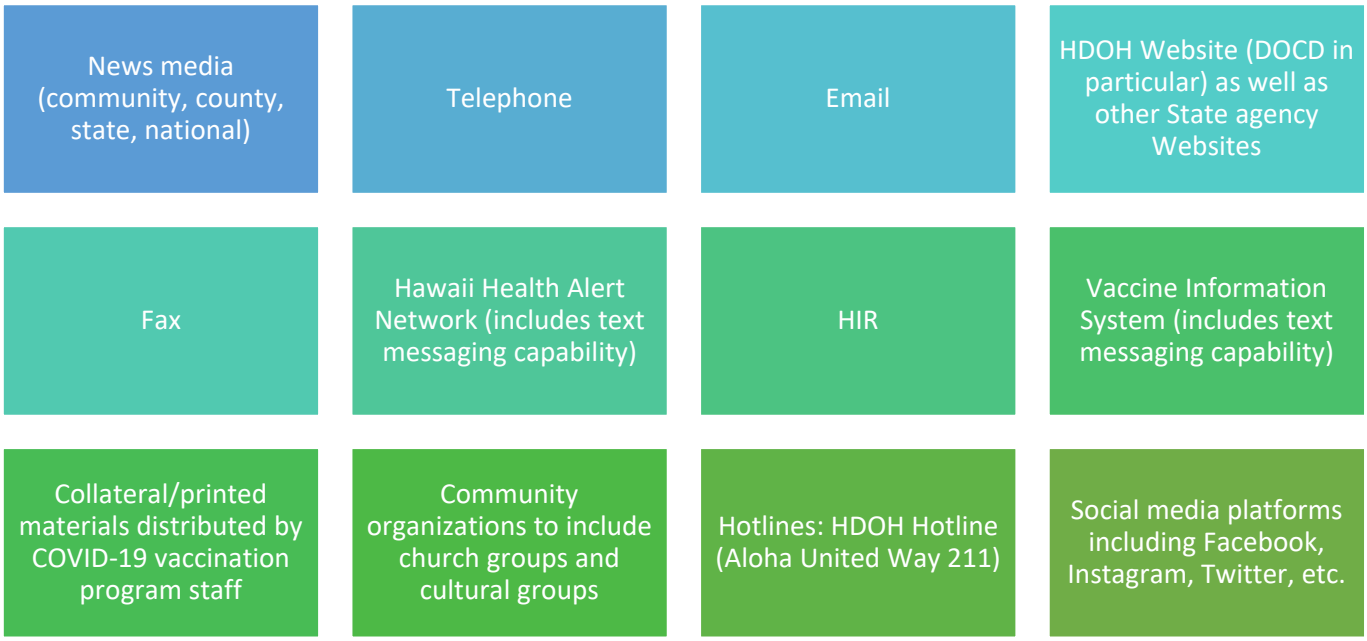


Figure E-7: Communications Channels

211 Procedures/Call Center Guidance[14]

Call Center operations are an integral part of HDOH's COVID-19 risk communications strategy. As a complimentary function to mass messaging, HDOH has a robust capacity to receive calls from the public and provide information one-on-one. Through a CDC-sponsored grant, HDOH has also developed a unique call screening tool to identify persons who might benefit from anti-viral medication to mitigate the effects of COVID-19.

HDOH has maintained a Memorandum of Understanding with Aloha United Way (AUW)[15] for statewide toll-free call center (2-1-1) services for several years. In 2009, HDOH enhanced its capacity for receiving calls from the public and at District Health Offices (DHOs) with the installation of supplemental phone lines and purchase of phones, netbook computers, headsets, and other support equipment. AUW's 2-1-1 line will be the primary resource but increased incoming call volume can be expected at DHOs as well. Call Takers will need to receive additional guidance specific to COVID-19 operations to respond to calls from vaccination providers on issues such as proper cold chain storage, vaccine preparation prior to vaccination, and documentation of vaccine administration into HIR.[16].

[12] Ibid.
[13] Ibid.
[14] 2009 H1N1 Vaccination Campaign Annex to the Hawaii State Pandemic Influenza Plan, September 11, 2009
[15] https://www.auw.org/
[16] 2010 State of Hawaii Department of Health Emergency Public Information Plan

Incoming calls can be expected to include questions about vaccine safety, priorities for vaccination, and the locations of vaccination clinics. Call Takers will be provided pre-scripted messages in response to frequently asked questions (FAQs). The FAQs will be updated as the situation warrants and transmitted to Call Centers in real time to ensure messaging is consistent, current, and easy to understand.

Partners and Trusted Sources[17]

Working to engage and empower partners is critical to reinforcing COVID-19 vaccination messages as noted previously. The COVID-19 Communications Working Group will integrate efforts with partners and trusted sources into other channels in addition to programmatic and community engagement efforts such as the SFAS program (HDOH maintains a COVID-19 vaccination program specific contact list for these stakeholders). These partners include:

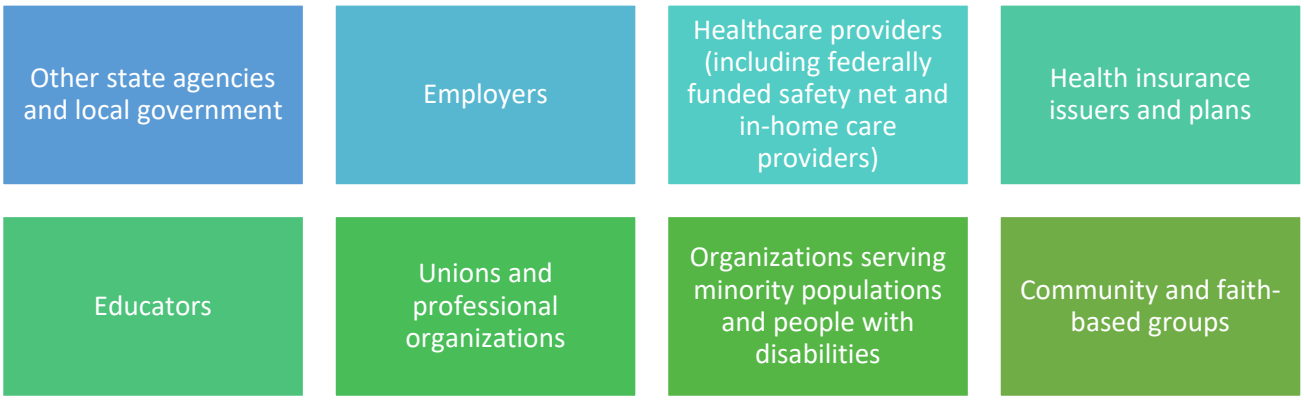


Figure E-8: Partners and Trusted Sources

Ways to Engage and Empower Partners and Trusted Sources:

- Work closely with partner agencies and intermediaries to
  - Build consensus on actions
  - Consistency in messages
  - Coordination of communication activities
- Keep public, public health partners, and healthcare providers informed
  - Communicate transparently about risks and recommendations
  - Communicate proactively, anticipating issues and forecasting possible problems before they reach broad awareness

Cultural Competency

Cultural Competency[18]:

- Health care staff and first responders should provide culturally competent messaging and care – and include minority groups in planning – to encourage equitable engagement and outcomes in a pandemic response
- HDOH has the following capabilities to support communications efforts related to cultural competency issues of concern:
  - Pre-planned communications materials in various languages

[17] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.
[18] 2010 State of Hawaii Department of Health Emergency Public Information Plan

- Information on additional interpreter resources to assist with translation and sign-language services
- Statewide toll-free public information hotline
- Health information posted on the HDOH website in multiple languages
- Communications' needs assessment information and research for each island regarding the special populations on their island

The COVID-19 Communications Working Group will give special attention to populations at high risk of COVID-19, and those with special communications needs, as well as populations in the following groups:[19]

Figure E-9: Groups with Specific Communications Needs/Concerns

In addition, the size and composition of the critical populations identified to allocate/prioritize for COVID-19 vaccine in **Appendix C: Critical Populations** vary by island and by area on the island. In developing informational materials to support the counties in their public information efforts, HDOH will tailor messages to meet the cultural, literacy, practical and language needs of these specific populations. The COVID-19 Communications Working Group will partner with public and private agencies to support the development and dissemination of appropriate messages.[20]

DIVERSITY IN HAWAII

- The ethnic diversity of the state's special populations is extensive.
- A statewide survey conducted in October 2003 and sponsored by the DOH showed that 29 percent of Hawaii residents speak a language other than English at home with 6 percent having no English speakers at home. Statewide, the primary languages spoken in the no-English-at-home category are Japanese, Tagalog, Ilocano, Chinese (Mandarin and Cantonese), Korean, Vietnamese, Samoan, and Hawaiian.
- These languages account for 88 percent of the category.
- Thus, approximately 99.3 percent of the population will be reached through English, Japanese, Tagalog, Ilocano, Chinese, Korean, Vietnamese, Samoan, and Hawaiian.
- The remaining 0.7 percent is spread among Hawaii's other spoken languages that primarily include Marshallese, Spanish, Tongan, Chuukese, Visayan, Laotian, Pohnpei an, Thai, Portuguese, Pangasinan, Palauan, Cambodian, Chamorro, Pampango and Fijian.[1]

[19] Ibid.
[20] Ibid.

Tailoring messages is of particular importance to crowd out misinformation as suggested by the Johns Hopkins Center for Health Security[21] **(see Figure E-10).**

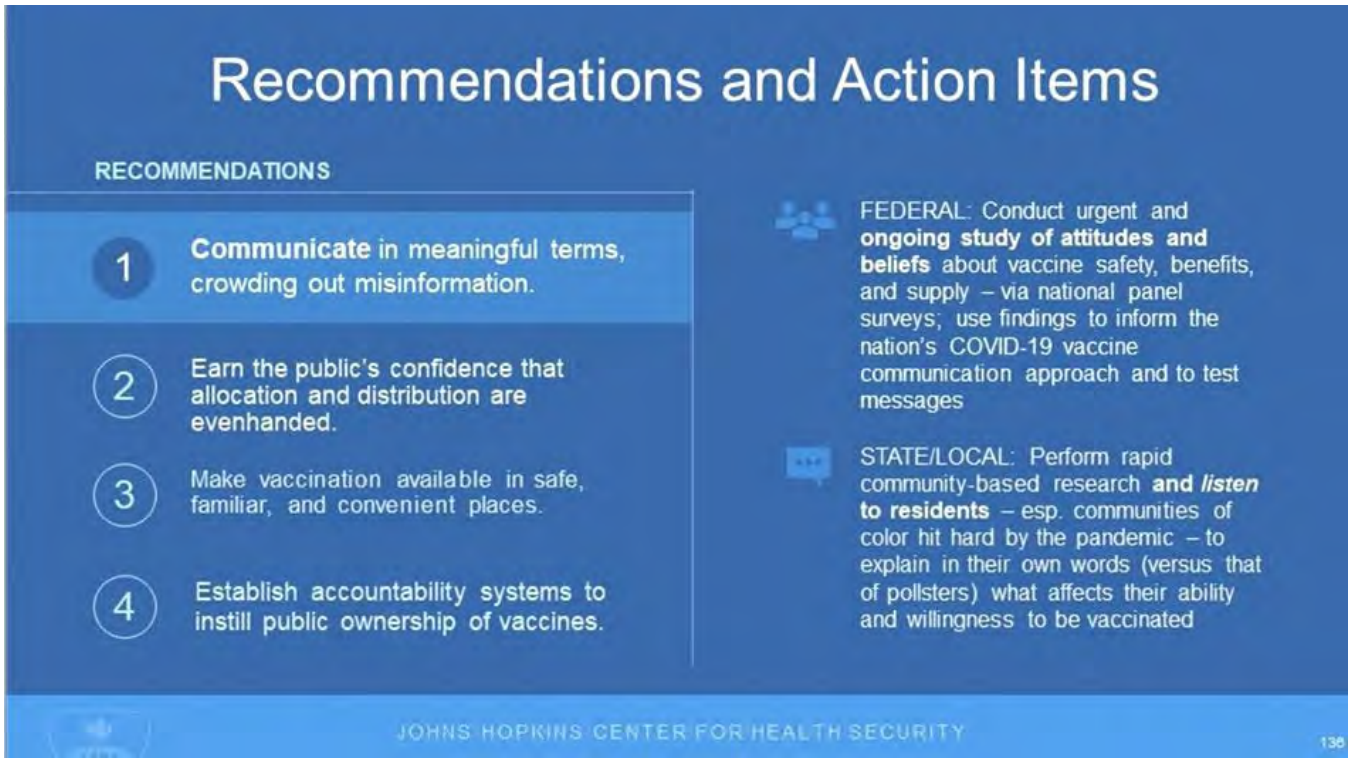


Figure E-10: Recommendations and Action Items for COVID-19 Vaccination Efforts

Crisis and Risk Communication[22]

The COVID-19 Communications Working Group will need to ensure that communication messaging before, during, and after COVID-19 vaccine is available to help communities understand the importance of vaccination as well as the benefits and risks as noted previously. Communicating what is currently known, regularly updating this information, and continuing dialogue with media and other partners throughout the vaccine distribution and administration process is essential to establish and maintain trust and credibility. Crisis and emergency risk communication (CERC) is the application of evidence-based principles to effectively communicate during emergencies. These principles are used by public health professionals and public information officers to provide information that helps people, stakeholders, and entire communities make the best possible decisions for themselves and their loved ones. CERC recognizes that during emergencies, we work under impossible time constraints and must accept the imperfect nature of our choices. CERC principles include[23]:

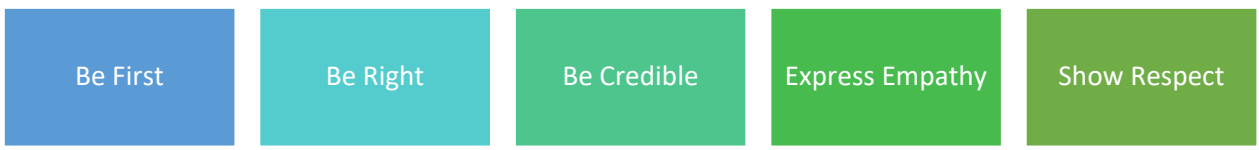
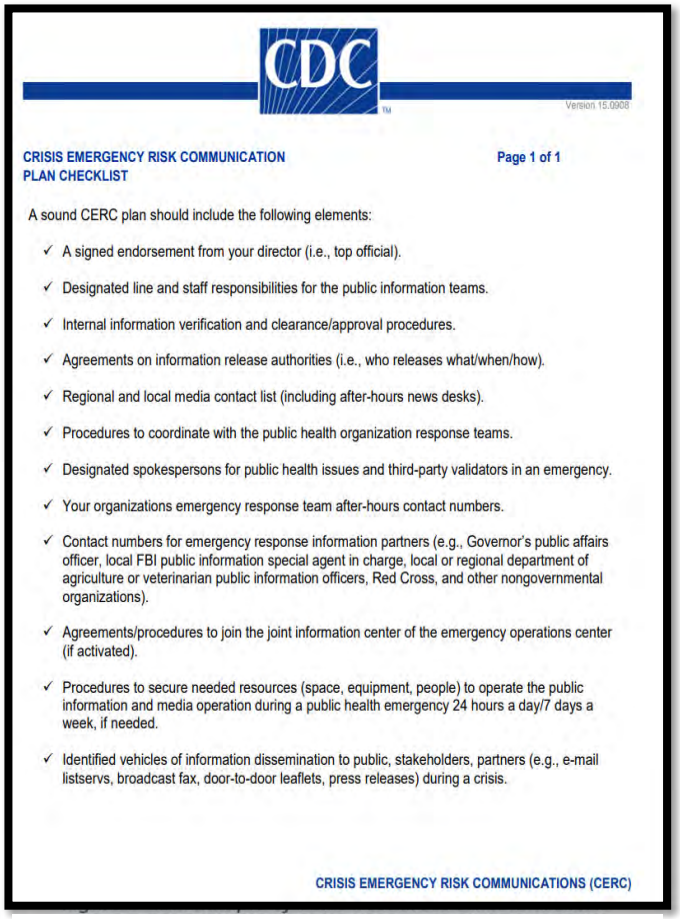


Figure E-11: CERC Principles

[21] https://www.centerforhealthsecurity.org/resources/COVID-19/, accessed on October 12, 2020.
[22] 2009 H1N1 Vaccination Campaign Annex to the Hawaii State Pandemic Influenza Plan, September 11, 2009
[23] **See https://emergency.cdc.gov/cerc/index.asp for additional information**

Related Guidance and Reference Materials[24]

The COVID-19 Communications Working Group should regularly review available CDC COVID-19 Communication Resources[25]. CDC developed COVID-19 One-Stop Shop Toolkits[26] for communication, including toolkits tailored for different populations as well as a social media toolkit. To reach essential workers for vaccination, the COVID-19 Communications Working Group may need to assist industry and businesses in communicating with employees about vaccination clinics. CDC's COVID-19 Communications Plan for Select Non-Healthcare Critical Infrastructure Employers [27]may be helpful for this purpose. CDC's CERC manual is available online, including online trainings, and examples of how CERC is applied during emergencies, at https://emergency.cdc.gov/cerc/manual/index.asp. The World Health Organization also developed a guide that provides strategies and tools to support effective communication planning and management in response to vaccine safety events.



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CRISIS EMERGENCY RISK COMMUNICATION PLAN CHECKLIST **Page 1 of 1**

A sound CERC plan should include the following elements:

- ✓ A signed endorsement from your director (i.e., top official).
- ✓ Designated line and staff responsibilities for the public information teams.
- ✓ Internal information verification and clearance/approval procedures.
- ✓ Agreements on information release authorities (i.e., who releases what/when/how).
- ✓ Regional and local media contact list (including after-hours news desks).
- ✓ Procedures to coordinate with the public health organization response teams.
- ✓ Designated spokespersons for public health issues and third-party validators in an emergency.
- ✓ Your organizations emergency response team after-hours contact numbers.
- ✓ Contact numbers for emergency response information partners (e.g., Governor's public affairs officer, local FBI public information special agent in charge, local or regional department of agriculture or veterinarian public information officers, Red Cross, and other nongovernmental organizations).
- ✓ Agreements/procedures to join the joint information center of the emergency operations center (if activated).
- ✓ Procedures to secure needed resources (space, equipment, people) to operate the public information and media operation during a public health emergency 24 hours a day/7 days a week, if needed.
- ✓ Identified vehicles of information dissemination to public, stakeholders, partners (e.g., e-mail listservs, broadcast fax, door-to-door leaflets, press releases) during a crisis.

CRISIS EMERGENCY RISK COMMUNICATIONS (CERC)

Figure E-12: Crisis Emergency Risk Communication Plan Checklist

[24] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

[25] https://www.cdc.gov/coronavirus/2019-ncov/communication/index.html

[26] https://www.cdc.gov/coronavirus/2019-ncov/communication/toolkits/index.html.

[27] https://www.cdc.gov/coronavirus/2019-ncov/community/communication-plan.html.

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Appendix F: Vaccination Program Training Requirements

This section outlines roles/responsibilities and describes initial, periodic, and Just-in-Time (JITT) training requirements for those involved in supporting vaccine operations in Hawaii.

Training for HDOH Vaccination Program Staff

Training of COVID-19 Vaccination Program staff and vaccine providers is vital to ensure the success of the COVID-19 Vaccination Program. As of the writing date of this plan, CDC is scheduled to provide educational resources, but HDOH IMB may begin developing or using other materials in conjunction with existing CDC materials and guidance. HDOH will determine the most efficient methods for training delivery and tracking of training completion. HDOH is not required to provide training for federal entities and commercial partners receiving direct vaccine allocations from CDC.[1] HDOH IMB will lead the coordination of all COVID-19 Vaccination Program-related training and education activities in coordination with OPHP. Responsibilities include those shown in **Figure F-1** below:

- Identifying and coordinating required or recommended training for staff and volunteers to include operational positions and geographical assignments as they relate to the COVID-19 vaccination mission throughout the state.
- Providing vaccine-specific training or guidance for community partners, including groups representing at-risk populations, to assist them in educating their own constituency groups.
- Coordinating with OPHP to ensure that there are a sufficient number of HDOH staff trained in the Homeland Security Exercise and Evaluation Program (HSEEP) to develop after-action reports (AAR) and improvement plans (IP) in support of exercises and COVID-19 response operations.
- Providing input to the state's Multi-Year Training and Exercise Plan (MYTEP) to ensure that relevant events incorporate vaccine activities and address issues identified in improvement plans.
- Coordinating with partners to facilitate risk-specific safety and health training related to the COVID-19 vaccination mission.
- Coordinating the development and delivery of just in time training, materials, and safety instructions.
- Tracking the completion of required training for key staff supporting the COVID-19 Vaccination Plan.

Figure F-1: HDOH IMB Training Program Responsibilities

[1] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imzmanagers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

Initial Training

All organizations supporting the COVID-19 vaccination mission should ensure that their staff with roles and responsibilities under this plan receive the following initial training shown in **Figure F-2** within 60 days of their assignment to their position:

Orientation training	Position specific training	IT/Equipment specific training
•Includes an overview of the Hawaii COVID-19 Vaccination Plan with a specific emphasis on their organization's tasks, the incident command system (ICS)(as required), as well as notification and activation procedures.	•Includes any of the training staff may need to take such as ICS 100, 200, reporting procedures, vaccine accountability and administration, vaccine reporting systems, etc. •Vaccination providers will need training on vaccine-related health risks, including the use of appropriate PPE, dispensing site security protocols, vaccine specific procdures, etc.	•Includes training on the use of the tools required to support job specific tasks. For example, depending on the position to which they are assigned staff may need training on the use of radios, inventory management systems, MS Teams, or vaccine specific software such as HIR, etc.

Figure F-2: Initial Training Requirements

COVID-19 Vaccination Program Staff

Program staff should receive training tailored to sections of this plan based on their responsibilities such as the following topics shown in **Figure F-3**:

Base Plan:

- Situation
- Mission
- Concept of Operations
- Administration, Resources and Funding
- Oversight, Coordinating Instructions, and Communications

Appendices

- Appendix A: Task Organization
- Appendix B: Situational Awareness
  - Critical Information Requirements (CIR)
  - Essential Elements of Information (EEI)
- Appendix C: Critical Populations
- Appendix D: Logistics
- Appendix E: Vaccine Program Communication

Figure F-3: Training Requirements for Program Staff

Vaccination Providers

Specific vaccine provider training requirements include the following topics shown in **Figure F-4 below** (NOTE: This is not all inclusive – IMB will provide additional guidance as it becomes available):

Appendix C: Critical Populations

- This will include Advisory Committee on Immunization Practices (ACIP) COVID-19 vaccine recommendations, when available

Appendix D: Logistics

- How to order and receive COVID-19 vaccine
- COVID-19 vaccine storage and handling (including transport requirements)
- How to administer vaccine, including reconstitution, use of adjuvants, appropriate needle size, anatomic sites for vaccine administration, avoiding shoulder injury with vaccine administration, etc.
- How to document and report vaccine administration via the jurisdiction's IIS or other external system
- How to manage vaccine inventory, including accessing and managing product expiration dates
- How to report vaccine inventory
- How to manage temperature excursions (response actions/notifications/reporting requirements, etc.)
- How to document and report vaccine wastage/spoilage
- Procedures for reporting moderate and severe adverse events as well as vaccine administration errors to VAERS
- Providing EUA fact sheets or VISs to vaccine recipients

Appendix E: Vaccine Program Communications

- How to submit facility information for COVID-19 vaccination clinics to CDC's VaccineFinder (particularly for pharmacies or other high-volume vaccination providers/settings), as well as IMB's VaccineFinder on-line tool (To be provided when available)

Figure F-4: Training Requirements for Vaccination Providers

Periodic Training

COVID-19 Vaccination Program staff, as well as Vaccination Providers, should conduct periodic refresher training that incorporates best practices and lessons learned as the COVID-19 Vaccination Program progresses.

Figure F-5: Periodic Training

Just-in-Time Training

Just-in-time training (JITT) will primarily focus on training for spontaneous volunteers, as well as any staff who may not have received previous training, and training to support specific efforts such as POD operations. JITT includes the following topics shown in **Figure F-6 below**:

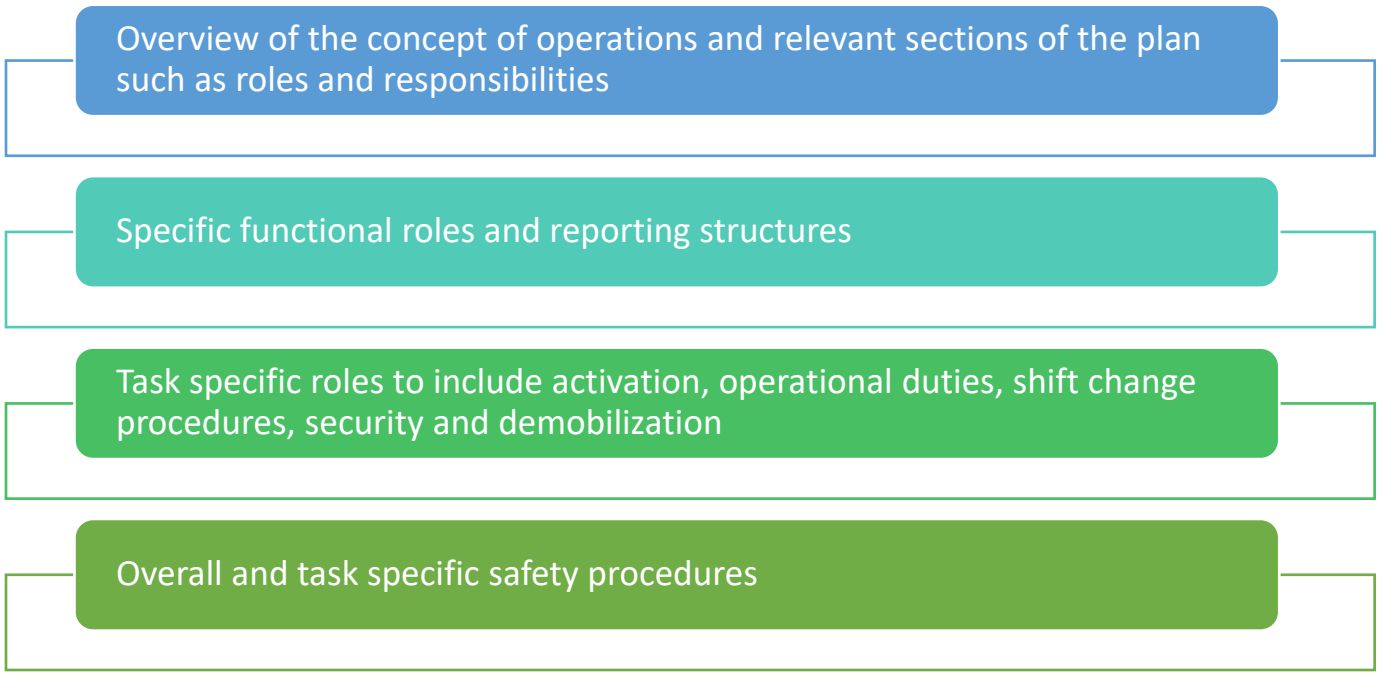

Figure F-6: Just-In-Time Training Requirements

Appendix G: Vaccine Characteristics

According to the Framework for Equitable Allocation of COVID-19 Vaccine[1], a COVID-19 vaccine could be effective in two ways:

1) By preventing people from getting infected or
2) By reducing the severity of disease if a person does become infected

Table G-1: Description of Vaccine Trial Phases

Phase	Name	Explanation
Phase 1	Safety Trials	The vaccine is given to a small number of people. Dosage, safety, and stimulation of the immune system are tested. This is the first trial in humans.
Phase 2	Expanded Trials	The vaccine is given to hundreds of people across different population groups to see how and if the vaccine behaves differently in them. These test further the safety and stimulation of the immune system.
Phase 3	Efficacy Trials	The vaccine is given to thousands of people to monitor how many become infected or develop the disease in comparison to a placebo control group. This helps establish whether or not the vaccine can protect against the virus, and additional safety monitoring is conducted as well. (A COVID-19 vaccine will have to protect at least 50 percent of those who received the vaccination in orderto be deemed effective by the U.S. Food and DrugAdministration.)

In May 2020, the U.S. Department of Health and Human Services (HHS) launched Operation Warp Speed (OWS)[2] as a public–private partnership with the objective of delivering 300 million doses of a safe and effective COVID-19 vaccine by January 2021. The vaccine candidates included span four platform technologies: replication-defective vector Messenger RNA (mRNA), , subunit protein adjuvanted, and live-attenuated vector.[3] See below for a description of six candidate vaccines in **Table G-2**.

Table G-2: Description of Leading Candidates for COVID-19 Vaccine in Partnership with Operation Warp Speed

Vaccine Producer	Type of Vaccine	Description of Methodology Used	Estimated Number of Doses Needed	Estimated Cold Chain Requirements	Doses Guaranteed to U.S.
AstraZeneca and the University of Oxford	Replication defective vector	• Use different vectors to deliver recombinant SARS-CoV-2 spike protein genes—derived from the surface of the virus— to human cells and induce an immune response • Johnson & Johnson's adenovirus vector-based COVID-19 vaccine candidate leverages the company's AdVac	Currently being tested for use with either one or two doses	Anticipated to remain stable at –20 degrees Celsius	300 million
Johnson & Johnson (Janssen)	Replication defective vector			Anticipated to remain stable at –20 degrees Celsius	100 million

[1] Framework for Equitable Allocation of COVID-19 Vaccine: available at: https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus. Accessed October 8, 2020.
[2] https://www.hhs.gov/coronavirus/explaining-operation-warp-speed/index.html. Accessed October 8, 2020.
[3] Framework for Equitable Allocation of COVID-19 Vaccine: available at: https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus. Accessed October 8, 2020.

Vaccine Producer	Type of Vaccine	Description of Methodology Used	Estimated Number of Doses Needed	Estimated Cold Chain Requirements	Doses Guaranteed to U.S.
		technology, which was also used for its Ebola vaccine that has been approved for use by the European Commission			
Moderna	Messenger RNA (mRNA)	• Uses a novel method for inducing the production of a robust immune response that does not require introducing SARS-CoV-2 itself. • This type of vaccine would be easier to produce in mass quantities than would other categories of COVID-19 vaccine, but an mRNA vaccine has never before been approved for commercial use to prevent infections.	Two doses (28 days between doses)	Ultra-cold storage (–80 degrees Celsius)	100 million
Pfizer and BioNTech	Messenger RNA (mRNA)		Two doses (21 days between doses)	Anticipated to remain stable at –20 degrees Celsius	100 million
Novavax	Protein adjuvanted	TBP	Two doses	TBP	100 million
GlaxoSmithKline and Sanofi	Protein adjuvanted	• Uses the same recombinant protein-based technology as one of Sanofi's seasonal influenza vaccines with GSK's established pandemic adjuvant technology.[4]	TBP	TBP	100 million

OWS as well as other efforts around the world are in the process of developing these COVID-19 vaccine candidates. This includes the conduct of clinical trials simultaneously with large-scale manufacturing. At the current time, it is not known which vaccines will be approved. COVID-19 vaccination program plans must be flexible and accommodate multiple scenarios. For the purpose of initial planning, HDOH and its stakeholders considered the following assumptions regarding potential COVID-19 vaccine requirements and early supply estimates in the event the FDA authorizes a vaccine under Emergency Use Authorization (EUA).

HDOH will revise this section of the plan with the latest available information as it becomes available and replace the planning scenarios with actual vaccine characteristics.

CDC developed the three planning scenarios described below for use by state and local jurisdictions to develop operation plans for early COVID-19 vaccination when vaccine supply may be constrained. The scenarios describe potential COVID-19 vaccine requirements, early supply estimates in the event that a vaccine is authorized under

[4] Sanofi and GSK initiate Phase 1/2 clinical trial of COVID-19 adjuvanted recombinant protein-based vaccine candidate**: available at:** https://www.sanofi.com/en/media-room/press-releases/2020/2020-09-03-07-00-00, accessed October 8, 2020.

EUA, and populations that may be recommended for vaccination during this early period. These scenarios are designed to support HDOH, federal, and partner planning, but they are still considered hypothetical. Planners should assume that by January 2021, significantly more COVID-19 vaccine may be available for distribution and plans will need to evolve to address additional vaccine availability.[5]

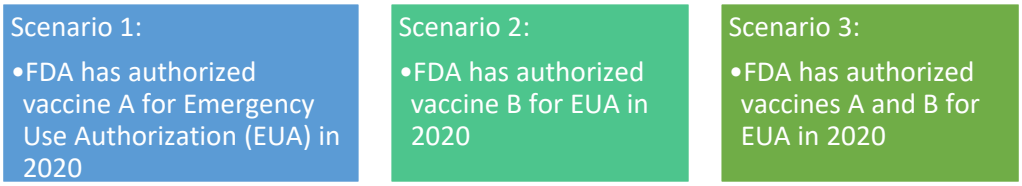

Figure G-1: Initial Vaccine Planning Scenarios

Vaccine Availability Assumptions

Table G-3: Availability Assumptions[6]

Doses	End of Oct 2020	End of Nov 2020	End of Dec 2020
Scenario 1 (A)	2 Million	10-20 Million	20-30 Million
Scenario 2 (B)	1 Million	10 Million	15 Million
Scenario 3 (A + B)	3 Million	20-30 Million	35-45 Million

CDC Provided Vaccine Planning Scenarios

Table G-4: Additional Considerations for Early Vaccination Planning

Scenario 1 (Vaccine A)	Scenario 2 (Vaccine B)	Scenario 3 (Vaccines A and B)
"Healthcare personnel" includes paid or unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to people with COVID-19 or infectious materials.	Same as Vaccine A	Same as Vaccine A
Jurisdictions should plan for real-time shipment of doses.	Same as Vaccine A	Same as Vaccine A
Administration sites (during Phase 1) will not be required to store vaccine products beyond the period of time Vaccine A can be stored in the ultra-cold shipment box.	Administration sites (during Phase 1) will not be required to store vaccine products beyond the period of time Vaccine B can be stored at 2–8 °C.	Administration sites (during Phase 1) will not be required to store vaccine products beyond the period of time Vaccine A can be stored in the ultra-cold shipment box or Vaccine B can be stored at 2–8 °C.
Given the challenging storage, handling, and administration requirements, early vaccination should focus on administration sites that can reach critical populations with as much throughput as possible	Same as Vaccine A	Same as Vaccine A
Stability testing is ongoing for Vaccine A; the storage and handling requirements presented here may shift. The requirements in these scenarios are likely the strictest set of requirements for which planning is needed.	Stability testing is ongoing for Vaccine B; the storage and handling requirements presented here may shift. The requirements in these	Same as Vaccine A

[5] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

[6] IBID.

Scenario 1 (Vaccine A)	Scenario 2 (Vaccine B)	Scenario 3 (Vaccines A and B)
	scenarios are likely the strictest set of requirements for which planning is needed.	
Jurisdictions should consider partnering with the private sector and with local hospital systems to provide vaccine in closest proximity to the critical populations as possible, given limitations with the product. For example: Vaccine A may be administered through mobile clinics if multiple mobile clinics are planned over a short period of time to ensure sufficiently high throughput	Jurisdictions should consider partnering with the private sector and with local hospital systems to provide vaccine in closest proximity to the prioritized populations as possible, given limitations with the product.	Same as Vaccine A

Vaccine related assumptions as of the writing of this plan:

- Limited vaccine doses may be available by early November 2020
- The initial vaccine will be approved as a licensed vaccine or authorized use under an Emergency Use Authorization (EUA)
- Cold chain storage and handling will vary by vaccine from refrigerated (2°C to 8°C) to frozen (-20°C) to ultra-cold (-60°C to -80°C) temperatures
- There may be a two-dose vaccine schedule
  a. Vaccine providers must ensure that they only provide the correct match of COVID-19 vaccine for both doses
  b. Vaccine providers must verify that vaccine recipients observe the appropriate separation (i.e. - > 21 or >28 days) between doses
  c. Vaccine providers must implement procedures to send reminders for the 2nd dose through multiple channels
- Some vaccine product may likely require reconstitution with a diluent or adjuvant at the point of administration
- Vaccines are not interchangeable
- Vaccine efficacy and adverse event profiles in different populations are unknown at this time

Figure G-2: Vaccine-Related Assumptions

Distribution, Storage, Handling, and Administration Assumptions

Table G-5: Distribution, Storage, Handling, and Administration Assumptions[7]

Type	Scenario 1 (Vaccine A)	Scenario 2 (Vaccine B)
Shipment	1) Vaccine (direct to site from manufacturer (on dry ice)); Multidose vials (5 doses/vial) 2) Diluent (direct to site from USG (at room temp)) 3) Ancillary supply kits (direct to site from USG (at room temp))	1) Vaccine (To central distributor (at -20° C); Multidose vials (10 doses/vial) 2) Ancillary supply kits (direct to site from USG (at room temp))
Orders	Large quantity orders to large administration sites only • Minimum order = ~ 1,000 doses • Maximum order = ~ 5,000 doses	Central distribution capacity • Required by Dec 2020 • Maintained at - 20° C
On-site Vaccine Storage	**Frozen (-70° C +/- 10° C)** • Must use/recharge w/in 10 days **Thawed (2-8°C)** • Must use within 5 days **Reconstituted (room temp)** • Must use within 6 hours	**Frozen (-20° C)** • Storage in shipping container (replenish dry ice if needed) **Refrigerated (2-8° C)** • Must use within 14 days **Room temp** • Must use within 6 hours
Administration	**2-dose series (21 days between doses)** • On-site mixing required (reconstitute with diluent just prior to administration) • Intramuscular (IM) injection	**2-dose series (28 days between doses)** • NO On-site mixing required • Intramuscular (IM) injection

[7] Ibid.

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Appendix H: Countermeasures Injury Compensation Program[1]

Hawaii does not have a state or county medical countermeasure injury compensation program for the CDC COVID-19 Vaccination Program. However, the U.S. Congress has enacted the Public Readiness and Emergency Preparedness Act (PREP Act), which authorizes the Countermeasures Injury Compensation Program (CICP) to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of covered countermeasures identified in and administered or used under a PREP Act declaration. The CICP also may provide benefits to certain survivors of individuals who die as a direct result of the administration or use of such covered countermeasures.

The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are:

1.) Any antiviral, any other drug, any biologic, any diagnostic, any other device, any respiratory protective device, or any vaccine, used:

- To treat, diagnose, cure, prevent, mitigate, or limit the harm from COVID-19, or the transmission of SARS-CoV-2 or a virus mutating therefrom, or
- To limit the harm that COVID-19, or the transmission of SARS-CoV-2 or a virus mutating therefrom, might otherwise cause; or

2.) Any device used in the administration of any such product, and all components and constituent materials of any such product.

Figure H-1: Covered Countermeasures

Covered Countermeasures must be ''qualified pandemic or epidemic products,'' or ''security countermeasures,'' or drugs, biological products, or devices authorized for investigational or emergency use, as those terms are defined in the PREP Act, the Federal Food, Drug, and Cosmetic Act (FD&C Act), and the Public Health Service Act, or a respiratory protective device approved by National Institute for Occupational Safety and Health (NIOSH) under 42 CFR part 84, or any successor regulations, that the Secretary of the Department of Health and Human Services determines to be a priority for use during a public health emergency declared under section 319 of the Public Health Service Act.

For more information about the CICP, visit the program's website at www.hrsa.gov/cicp, email cicp@hrsa.gov, or call 1-855-266-CICP (1-855-266-2427).

[1] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

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Appendix I: Liability Immunity for Covered Persons

There are a number of protections for those engaged in COVID-19 response and support in Hawaii's COVID-19 Vaccination Program.

Hawaii Protections

Hawaii protections include, but may not be limited to, the following non-exhaustive list. Readers should seek legal counsel for specific questions regarding liabilities, immunities, and questions of law.

Table I-1: Hawaii Revised Statute (HRS) Protections

Hawaii Protection	Description
HRS § 321-23.3. **Volunteer emergency medical disaster response personnel**	Volunteer emergency medical disaster response personnel, including physicians, psychologists, nurses, emergency medical technicians, social workers, mobile intensive care technicians, physicians assistants, and pharmacists licensed in the state or employed by a health care facility while engaged in the emergency response to a mass casualty event or disaster condition, including training, are deemed state employees and enjoy the powers, duties, rights, and privileges (including workers' compensation benefits).
HRS § 325-20. **Agreements; collaborative assistance in control of disease outbreaks.**	Except in cases of willful misconduct, volunteers engaged in disease prevention and control functions are not liable for the death of or injury to any person who is provided care pursuant to HRS § 325-20 relating to agreements and collaborative assistance in control of disease outbreaks.
HRS § 127A-9. **Immunities; rights**	Except in cases of willful misconduct, gross negligence, or recklessness, volunteers engaged in emergency management functions pursuant to HRS Chapter 127A are immune from liability for any death or injury of any person or damage to property. The provisions of HRS § 127A-9 apply to the state, county, owner or operator of a public utility or critical infrastructure facility (which would include hospitals, medical staff, etc.), or persons engaged in emergency management functions, including volunteers whose services are accepted by any authorized person.
HRS § 121-26. **Relief from civil or criminal liability**	Members of the Army or Air National Guard ordered into active service by any proper authority are not liable civilly or criminally, for any acts or acts done by them in pursuance of duty.
HRS § 90-4. **Volunteer benefits**	For purposes of HRS Chapter 662, volunteers are deemed employees of the state when acting for an agency in their capacity as a volunteer and, pursuant to HRS 386-171, entitled to workers' compensation medical benefits on a payor of last resort basis.
HRS § 662D-2. **Scope of immunity**	Under HRS Chapter 662D, a volunteer is a person who performs services without compensation, other than reimbursement for actual expenses incurred, for a nonprofit organization, a nonprofit corporation, a hospital, or government entity. Volunteers as defined under HRS Chapter 662D are immune from civil liability in any action on the basis of any act or omission resulting in damage or injury under the following conditions: • The Volunteer acted in good faith • The Volunteer acted within the scope of their official functions & duties as a Volunteer • The damage or injury was caused by the Volunteer's negligent conduct If the Volunteer was acting for any nonprofit organization, nonprofit corporation, or hospital, the protections apply if the entity has one of the following: • General liability insurance $200,000 per occurrence & $500,00 aggregate policy limits • Total assets of less than $50,000 Exceptions to Volunteer Immunity may be found under HRS § 662D-3.

The Governor of Hawaii has issued numerous emergency rules that include the Rules Relating to Immunities for Health Care Practices that provide numerous protections for health care response actions in response to the COVID-19 emergency and immunities for health care facilities, health care professionals, and health care volunteers.

As part of his authority under Chapter 127A, Hawaii Revised Statutes, the Governor of the State of Hawaii has issued numerous proclamations suspending specific statutes to facilitate and expedite the use of medically trained professionals to assist in the COVID-19 Emergency and which would also apply to the Hawaii COVID-19 Vaccination Program. The Governor's COVID-19 Emergency proclamations and emergency rules can be found at: https://governor.hawaii.gov/emergency-proclamations/ or https://dod.hawaii.gov/hiema/category/emergency-proclamations/2020-covid19/

Federal Protections

The Declaration Under the Public Readiness and Emergency Preparedness Act (PREP Act) for Medical Countermeasures[1] Against COVID-19 provides liability immunity to covered persons. The third amendment to the declaration defines "covered persons" as follows[2]:

> "V. Covered Persons 42 U.S.C. 247d–6d(i)(2), (3), (4), (6), (8)(A) and (B) Covered Persons who are afforded liability immunity under this Declaration are ''manufacturers,'' ''distributors,'' ''program planners,'' ''qualified persons,'' and their officials, agents, and employees, as those terms are defined in the PREP Act, and the United States. In addition, I [the Secretary] have determined that the following additional persons are qualified persons:
>
> (a) Any person authorized in accordance with the public health and medical emergency response of the Authority Having Jurisdiction to prescribe, administer, deliver, distribute or dispense the Covered Countermeasures, and their officials, agents, employees, contractors and volunteers, following a Declaration of an emergency;
>
> (b) any person authorized to prescribe, administer, or dispense the Covered Countermeasures or who is otherwise authorized to perform an activity under an Emergency Use Authorization in accordance with Section 564 of the FD&C Act;
>
> (c) any person authorized to prescribe, administer, or dispense Covered Countermeasures in accordance with Section 564A of the FD&C Act; and
>
> (d) a State-licensed pharmacist who orders and administers, and pharmacy interns who administer (if the pharmacy intern acts under the supervision of such pharmacist and the pharmacy intern is licensed or registered by his or her State board of pharmacy), vaccines that the Advisory Committee on Immunization Practices (ACIP) recommends to persons ages three through 18 according to ACIP's standard immunization schedule.

[1] https://www.federalregister.gov/documents/2020/03/17/2020-05484/declaration-under-the-public-readiness-and-emergency-preparedness-act-for-medical-countermeasures

[2] NOTE: The information provided is a direct quote from Covid-19 Vaccination Program Interim Playbook for Jurisdiction Operations – September 16, 2020; available at: https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf, accessed on October 8, 2020.

Such State-licensed pharmacists and the State-licensed or registered interns under their supervision are qualified persons only if the following requirements are met:

- The vaccine must be FDA authorized or FDA-approved.
- The vaccination must be ordered and administered according to ACIP's standard immunization schedule.
- The licensed pharmacist must complete a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education (ACPE). This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.
- The licensed or registered pharmacy intern must complete a practical training program that is approved by the ACPE. This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.
- The licensed pharmacist and Hawaii-State licensed or registered pharmacy intern must have a current certificate in basic cardiopulmonary resuscitation.
- The licensed pharmacist must complete a minimum of two hours of ACPE-approved, immunization-related continuing pharmacy education during each State licensing period.
- The licensed pharmacist must comply with recordkeeping and reporting requirements of the jurisdiction in which he or she administers vaccines, including informing the patient's primary-care provider when available, submitting the required immunization information to the State or local immunization information system (vaccine registry), complying with requirements with respect to reporting adverse events, and complying with requirements whereby the person administering a vaccine must review the vaccine registry or other vaccination records prior to administering a vaccine.
- The licensed pharmacist must inform his or her childhood-vaccination patients and the adult caregiver accompanying the child of the importance of a well-child visit with a pediatrician or other licensed primary care provider and refer patients as appropriate.

Figure I-1: Federal Protection Qualifications

Nothing in this Declaration shall be construed to affect the National Vaccine Injury Compensation Program, including an injured party's ability to obtain compensation under that program. Covered countermeasures that are subject to the National Vaccine Injury Compensation Program authorized under 42 U.S.C. 300aa–10 et seq. are covered under this Declaration for the purposes of liability immunity and injury compensation only to the extent that injury compensation is not provided under that Program. All other terms and conditions of the Declaration apply to such covered countermeasures."

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Appendix J: Acronyms

AAP	American Academy of Pediatrics – Hawaii Chapter
AAR	After Action Report
ACIP	Advisory Committee on Immunization Practices
ACPE	Accreditation Council for Pharmacy Education
AES	AES Corporation
AG	Hawaii Attorney General
AG-ID	Hawaii Attorney General Investigative Division
ALF	Assisted Living Facility
AMHD	Hawaii Department of Health Adult Mental Health Division
AMR	American Medical Response
APHL	Association of Public Health Laboratories
ARC	American Red Cross
ARCH	Adult Residential Care Home
ARES	Amateur Radio Emergency Services
ASPR	Department of Health and Human Services Assistant Secretary for Preparedness and Response
ATF	United States Bureau of Alcohol, Tobacco, and Firearms
ATSDR	Agency for Toxic Substances and Disease Registry
AUW	Aloha United Way
AWHONN	Association of Women's Health, Obstetric and Neonatal Nurses—Hawaii Chapter
BARDA	Biomedical Advanced Research and Development Authority
BUD	Beyond Use Date
CAMHD	Hawaii Department of Health Child and Adolescent Mental Health Division
CCFFH	Community Care Foster Family Home
CCMD	Combatant Command
CDC	United States Centers for Disease Control and Prevention
CERC	Crisis and Emergency Risk Communication
CHC	Community Health Center
CICP	Countermeasures Injury Compensation Program
CIP	Critical Infrastructure Protection
CIR	Critical Information Requirements
CISA	Department of Homeland Security Cybersecurity and Infrastructure Security Agency
COA	Course of Action
COP	Common Operating Picture
COVID-19	Coronavirus Disease 2019
CPT	Core Planning Team
CSV	Comma Separated Values
DAGS	Department of Accounting and General Services
DBEDT	Hawaii Department of Business, Economic Development, and Tourism
DCAB	Hawaii Department of Health Disability Communications and Access Board

DCCA	Hawaii Department of Commerce and Consumer Affairs
DCO	Defense Coordinating Officer
DDD	Hawaii Department of Health Developmental Disabilities Division
DDL	Digital Data Logger
DEA	United States Drug Enforcement Agency
DEM	City and County of Honolulu Department of Emergency Management
DHS	Department of Homeland Security
DHS	Hawaii Department of Human Services
DHHS	United States Department of Health and Human Services
DHO	District Health Office
DLIR	Hawaii Department of Labor and Industrial Relations
DLNR	Hawaii Department of Land and Natural Resources
DOC	Department Operations Center
DOCARE	Hawaii Department of Land and Natural Resources Division of Conservation and Resource Enforcement
DOCD	Hawaii Department of Health Disease Outbreak Control Division
DOD	United States Department of Defense
DOE	Hawaii Department of Education
DOHIC	Department of Health Information Center
DOJ	United States Department of Justice
DOT	Hawaii Department of Transportation
DOT-A	Hawaii Department of Transportation Airports Division
DOT-H	Hawaii Department of Transportation Harbors Division
DSCA	Defense Support to Civil Authorities
DUA	Data Use Agreement
EEI	Essential Elements of Information
EHR	Electronic Health Record
EMA	Emergency Management Agency
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
Epi-X	Centers for Disease Control and Prevention Epidemic Information Exchange
ER	Emergency Room
ESF	Emergency Support Function
ETEAM	eTeam, Inc.
ETS	Hawaii Office of Enterprise Technology Services
EUA	Emergency Use Authorization
ExIS	External Information System
FAA	Federal Aviation Administration
FAQ	Frequently Asked Question
FBI	United States Federal Bureau of Investigation

FDA	United States Food and Drug Administration
FD&C Act	Federal Food, Drug, and Cosmetic Act
FEMA	Federal Emergency Management Agency
FQHC	Federally Qualified Health Center
GRASP	Agency for Toxic Substances and Disease Registry Geospatial Research, Analysis & Services Program
HAH	Healthcare Association of Hawaii
HCCDA	Hawaii County Civil Defense Agency
HDOH	Hawaii Department of Health
HECO	Hawaiian Electric Company
HFD	Honolulu Fire Department
HHAN	Hawaii Health Alert Network
HHEM	Hawaii Healthcare Emergency Management
HHS	United States Department of Health and Human Services
HI-EMA	Hawaii Emergency Management Agency
HING	Hawaii National Guard
HIPAA	Health Insurance Portability and Accountability Act
HIR	Hawaii Immunization Registry
HMSA	Hawaii Medical Service Association
HNL	Honolulu Airport
HPCA	Hawaii Primary Care Association
HPD	Hawaii County Police Department
HPD	Honolulu Police Department
HPU	Hawaii Pacific University
HRS	Hawaii Revised Statute
HSEEP	Homeland Security Exercise and Evaluation Program
HSFC	Hawaii State Fusion Center
HSVOAD	Hawaii State Voluntary Organizations Active in Disasters
HTA	Hawaii Tourism Authority
IAP	Incident Action Plan
ICP	Information Collection Plan
ICS	Incident Command System
ICU	Intensive Care Unit
IIS	Immunization Information System
IMAT	Inventory Management Assessment Tool
IMB	Immunization Branch
IMS	Inventory Management System
INDOPACOM	United States Indo-Pacific Command
IP	Improvement Plan
IT	Information Technology
JIC	Joint Information Center

JIS	Joint Information System
JITT	Just-In-Time-Training
KDHO	Kauai District Health Office
KEMA	Kauai Emergency Management Agency
KLEAN	Kapolei Local Emergency Action Network
KPD	Kauai Police Department
LG	Lieutenant Governor
LNO	Liaison Officer
LTCF	Long-term Care Facility
MCM	Medical Countermeasures
MEMA	Maui Emergency Management Agency
MI	Managed Inventory
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MPD	Maui Police Department
MRC	Medical Reserve Corps
MS Teams	Microsoft Teams
MYTEP	Multi-Year Training and Exercise Plan
NACCHO	National Association of County and City Health Officials
NAICS	North American Industry Classification System
NAM	National Academy of Medicine
NAPNAP	National Association of Pediatric Nurse Practitioners—Hawaii Chapter
NASEM	National Academies of Sciences, Engineering, and Medicine
NDC	National Drug Code
NGO	Non-Governmental Organization
NI	Neighbor Island
NIMS	National Incident Management System
NIOSH	National Institute for Occupational Safety and Health
NIS	National Immunization Survey
NLT	No Later Than
NRF	National Response Framework
OB/GYN	Obstetrician/Gynecologist
OFA	Other Federal Agency
OHS	Hawaii Office of Homeland Security
OLA	Office of Language Access
OPCON	Operational Control
OPHP	Hawaii Department of Health Office of Public Health Preparedness
OSHA	Occupational Safety and Health Administration
OWS	Operation Warp Speed
PAO	Federal Emergency Management Agency Pacific Area Office
PHEO	Public Health Emergency Officer
PHIN	Public Health Information Network

PHNB	Hawaii Department of Health Public Health Nursing Branch
PHP	Public Health Preparedness
PIN	Provider Identification Number
PIO	Public Information Officer
POC	Point of Contact
POD	Point of Dispensing
POETE	Planning, Organization, Equipment, Training, and Exercise
PPE	Personal Protective Equipment
PREP Act	Public Readiness and Emergency Preparedness Act
PSD	Hawaii Department of Public Safety
QA/QC	Quality Assurance/Quality Control
QR	Quick Response
RACES	Radio Amateur Civil Emergency Services
RDS	Regional Distribution Site
RFA	Request for Assistance
RFI	Request for Information
RHC	Rural Health Clinic
RSS	Receipt, Staging, and Storage
SAMS	Security Access Management Services
SARS	Severe Acute Respiratory Syndrome
SEFS	State Emergency Support Function
SERT	State Emergency Response Team
SFAS	Stop Flu at School
SITREP	Situation Report
SLEC	State Law Enforcement Coalition
SLTT	State, Local, Tribal, and Territorial
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOG	Standard Operating Guideline
SOP	Standard Operating Procedure
STU	Secure Telephone Unit
SVI	Social Vulnerability Index
TAG	The Adjutant General
TAMC	Tripler Army Medical Center
TBD	To Be Determined
TRACIE	Technical Resources, Assistance Center, and Information Exchange
TTD/TTY	Telecommunications or Teletype Device for the Deaf
UCG	Unified Coordination Group
UCS	Unified Command System
UH	University of Hawaii

USCG	United States Coast Guard
USG	United States Government
USMS	United States Marshals Service
VAERS	Vaccine Adverse Event Reporting System
VAMS	Centers for Disease Control and Prevention Vaccine Administration Management System
VAVR	Vaccine Administration Visit Record
VC	Vaccination Clinic
VFC	Vaccines for Children
VIS	Vaccine Information Sheet
VPAWG	Vaccine Prioritization/Allocation Working Group
VPD	Vaccine Preventable Disease
VPH	Vaccinations Per Hour
VPIC	Vaccination Program Implementation Committee
VS	Vaccination Station
VSC	Hawaii Immunization Branch Vaccine Safety Coordinator
VTC	Video Teleconference
VSDS	Hawaii Immunization Branch Vaccine Supply and Distribution Section
VTrckS	Centers for Disease Control and Prevention Vaccine Tracking System

Appendix K: References

Table K-1: References

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Appendix L: Plan Maintenance

HDOH has the primary responsibility for coordinating the revision of the state of Hawaii's COVID-19 Vaccination Plan, reviewing, and updating materials, and coordinating the development of other necessary implementing plans and procedures such as COVID-19 vaccination program-related standard operating procedures.

HDOH responsibilities:

- Coordinate review activities with internal and external stakeholdes and complete updates.
  - Factors such as new guidance from the Federal Government, senior leadership, and/or lessons learned from actual events or exercises; changes to the COVID-19 disease; the release of specific COVID-19 vaccine(s), and the state of preparedness of relevant county, state, and federal response capabilities may create the need for review and revision of portions of this plan.
- Integrate this plan into other HDOH plans and programs.
- Integrate exercises efforts identified in this plan into the state of Hawaii's Multi-Year Training and Exercise Plan (MYTEP) as needed.
- Record relevant changes in the record of change log.
  - **NOTE:** Approved changes take effect upon distribution.

Organization responsibilities:

- Identify and submit recommended changes, revisions, and updates to HDOH IMB in writing to facilitate formal changes to the COVID-19 Vaccination Plan.
- Provide feedback on changes recommended by other organizations as appropriate.
- Make relevant changes in their supporting plans and procedures.

Figure L-1: Maintenance Responsibilities

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