

COVID-19 Vaccination Plan

MISSISSIPPI

Mississippi State Department of Health
10.16.2020 | VERSION 1

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Purpose and Overview

Mississippi State Department of Health (MSDH) Coronavirus 2019 (COVID-19) Vaccination Plan describes the methods and systems that will be used to order, store, distribute, track, and administer COVID-19 vaccine during the pandemic. It is the goal to provide vaccine to all residents of MS who wish to be vaccinated.

This plan is built with limited information and on assumptions that may or may not be correct. The plan is a living document that will be updated as MSDH receives more information with details of the vaccine and vaccination effort.

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Section 1: COVID-19 Vaccination Preparedness Planning

A. COVID-19 Planning Activities, Lessons Learned and Improvements from H1N1, Seasonal Influenza, and gaps

Vaccination Preparedness Planning activities are routinely conducted in a coordinated effort by the MSDH Office of Emergency Preparedness (OEPR) and the Office of Immunization. There are specific assigned staff to assure that the Influenza Preparedness Plan strategies are updated based on the most recent planning guidance to address specific high-risk populations of a pandemic. Extensive plans have been developed based on scenarios and guidance provided by CDC. These preparedness plans have been the foundation for the implementation of the COVID-19 vaccine planning in MS.

Areas identified with strengths and weaknesses within the H1N1 After Action Report, previous table-top exercises and mass vaccination campaigns for influenza and Hepatitis A outbreak response activities are being reviewed. Additionally, the most recent, real event activities for COVID-19 testing throughout the state has and will continue to provide operational guidance for areas to further develop program plans. Review of these actual events allows for implementation of the social distancing requirements that haven't been critical factors in the past, when developing mass vaccination campaigns.

Internal planning meetings as well as multiple meetings with subject matter experts are held bi-weekly to obtain specific information related to the vaccination strategies. MSDH understands that a key to a coordinated and effective pandemic response effort is communication internally and externally.

B. Planned workshops and exercises

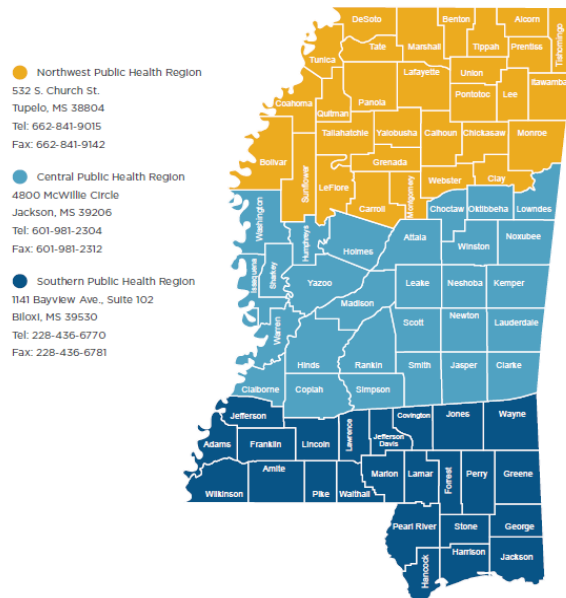
MSDH is planning real time events with the implementation of the Supplemental Influenza Vaccine program. This supplemental award has allowed the Immunization Program to expand staffing resources, increased efforts to partner with Federally Qualified Health Centers, Community and Rural Health Centers, Homeless Shelters and Free Clinics, and to increase influenza vaccination opportunities among uninsured and underinsured populations. Drive through influenza vaccine clinics are being planned along with drive through Covid-19 rapid testing sites. The additional staff can have real time experience and provide information for lessons learned before the implementation of Covid-19 vaccine administration clinics. As information is learned from the operation of these sites, feedback from staff will continually allow for updates and adjustments for the further development of this COVID-19 Vaccination Plan.

Section 2: COVID-19 Organizational Structure and Partner Involvement

A. Organizational Structure

MSDH is a centralized public health agency with health department clinics in 81 of the 82 counties. The state is divided into three public health regions each having a Regional Health Officer, a Regional Administrator, a Chief Nurse, and other regional program staff who direct activities in all of the local health departments in the counties within the Regions.

PUBLIC HEALTH REGIONS



B. Internal COVID-19 Planning/Back up

The centralized structure of MSDH allows for a coordinated effort statewide to address the COVID-19 pandemic. Statewide representation on the internal planning team ensures that all facets of the public health network are represented and contribute to the effort. This team is comprised of staff from the State Health Officer, the Office of Communicable Diseases, the Office of Epidemiology, the State Epidemiologist, the Office of Emergency Preparedness, the Office of Immunization, the State Pharmacy Director, the Office of Preventive Health, the Office of Field Services, the Office of Communications and the Office of Health Data, Operations and Research. Additionally, Regional level health department staff are included on the team to include the Regional Health Officers and Regional Administrators. This team has worked internally and with external partners for multiple portions of this effort. Reaching out at both the state and local levels to leverage the networks that can assist with the effort. (Internal partners refer to Appendix A)

MSDH has developed an Incident Command Vaccination Structure for Vaccine

Planning and Response to provide the additional levels of support and responsibilities. The Incident Command structure (Appendix B) for the COVID response encompasses the Vaccination Response Structure (Appendix C) which includes Providers (Recruitment, Enrollment, Provider and Resource Training), Call Center, MIIX (Remind/Recall, IZ Gateway Feeds, Deduplication), Logistics (Supplies and OPODs) and Vaccine Ordering (Order, Tracking, Distribution, and Inventory).

The vaccination response structure will consist of recruitment, enrollment and provider resources and training. this area will reach out to providers for recruitment, follow up and answer any questions the providers might have about the effort. In addition, as providers enroll, they will assist with the completion of all documentation and granting Mississippi Immunization Information eXchange (MIIX) access for ordering, and documenting administration of vaccine. Provider training will also be provided by this team. Staff will provide training and resources and be available to providers to assist with processes in MIIX and one-on-one assistance, as needed.

Provider Relations

Provider Relations will consist of staff hired for the Supplemental Flu effort that have transitioned to the COVID-19 Vaccination effort. Nurses will be utilized initially for recruitment of providers and to provide training and resources for those providers. Special Projects Officer IV's (SPOIV), will be utilized for enrollment of providers in addition to training and resources to supplement the nurse's role throughout the effort.

Call Center

The call center will roll into the current COVID-19 call center operations at MSDH. OIMM will provide materials related to the vaccination effort with decision trees for the call center staff. Those staff will transfer calls to the Vaccination Unit if they are unable to answer questions or resolve issues.

MIIX

The MIIX unit will be responsible for Remind/Recall, IZ Gateway Feeds, and deduplications. The current IIS Director will lead this team and will utilize SPOIV's to handle remind/recall and deduplication for the effort.

Logistics

The Logistics unit will be responsible for the deployment of Open Point of Distribution (OPOD) and the supplies that are needed to carry out the OPOD efforts. This staff will consist of OEPR staff to coordinate the effort. In addition, to contract nursing staff to assist in the drive through clinics.

Vaccine Ordering

The Vaccine ordering unit will be led by current vaccination staff and be assisted

by a team made of seasoned immunization staff. They will be responsible for processing provider orders, reviewing and tracking inventory and distribution. This team will work together to ensure that vaccine is allocated and reaching the populations that are eligible utilizing the phased approach.

The vaccination team will have daily stand-up meeting to ensure collaboration and cohesion throughout the effort. Concerns will be addressed and documented for after action plans.

C. Internal and External Partners

The need for extensive collaboration in this vaccination effort with stakeholders and partners throughout MS is critical to addressing the Covid-19 Vaccination Planning efforts. Many of these partners are already part of stakeholder groups who are being communicated with for COVID testing and surveillance throughout the State. Efforts to include these partners and additional stakeholders is ongoing.

The OEPR maintains updated lists for Closed Points of Distribution (CPOD) and is well known for the robust number of agreements established statewide for organization who agree to participate in vaccination efforts during a pandemic. These lists are updated annually and as needed to assure participation in pandemic response. Additionally, table-top exercises are conducted annually to test the pandemic plan and to provide training opportunities and to effectively prepare for rapid response during a pandemic.

The MSDH planning staff have been reaching out to groups who will be specifically involved in vaccination efforts in Phase I such as hospitals, and long-term care facilities. The current incident command structure for the Covid-19 Pandemic has allowed us to gather informational resources collected from hospitals and nursing homes for the appropriate contact persons for vaccine coordination and the number of healthcare workers exposed to COVID-19 patients in the facility.

D. Identify and list members internal /external committee

See Appendix A for MSDH Partners

E. Coordination between state, local and territorial authorities

MSDH's structure lends itself to be situated for statewide response that encompasses local response. MSDH has 86 health department clinics in 81 of the 82 counties. The state is divided into three public health regions each having a Regional Health Officer, a Regional Administrator, a Chief Nurse, and other regional program staff who direct activities in all of the local health departments in the counties within the Regions. These regional level health department staff are included on the team. They know the local HDs and the counties they serve. They can assist with the leveraging of resources available in each of these counties.

F. Tribal Communities

MSDH has contacted the Mississippi Band of Choctaw Indians (MBCI) Medical Director to address vaccine planning for the tribe. MBCI has a choice of ordering vaccine through the MSDH or to order and receive vaccine through the Federal Government. MBCI are holding planning meetings internally during the second week of October to make this decision and the contact has agreed to keep MSDH informed about the decision. Information will be obtained regarding population numbers and health clinic contacts if the decision is to order vaccine through MSDH.

G. Key Partners for Critical Populations

Plans are to expand to a formal external partnership by initiating Zoom meetings with the MS State Medical Association, The MS Hospital Association, The MS Health Care Association, MS Independent Nursing Home Association and the MS Board of Pharmacy and membership within the 3rd week of October, 2020. These calls will include key information about COVID-19 vaccine development based on guidance provided by the CDC and Operation Warp Speed (OWS), Phased approach information, vaccine program enrollment and vaccine administration guidance. These calls will also assist in identifying Frequently Asked Questions (FAQs) to help other providers as we progress through the phases. Through the partnerships developed MS can efficiently and equitably reach all Mississippians that want to be vaccinated. For a full list of MSDH Partners/Stakeholders refer to Appendix A.

MSDH has additionally contacted the Mississippi Department of Corrections (MDOC). MDOC has had key staff and healthcare provider changes within the past month. The new Medical Director is having conversations with their Healthcare provider, VitalCore about being the vaccination provider for MDOC. They will make this decision and contact MSDH.

MSDH through the supplemental flu effort has made contacts with multiple free clinics, homeless organizations, and Federally Qualified Health Centers, Rural and Community Health Centers to assist in administering vaccinations to hard to reach and critical populations.

Section 3: Phased Approach to COVID-19 Vaccination

There will be a Phased approach to the distribution and vaccination effort of the residents of Mississippi. Methods of Dispensing vaccine is captured below.

Phase 1: Potentially limited supply of COVID-19 vaccine doses available

In the initial phase, or Phase 1, of the COVID-19 Vaccination Program, initial doses of vaccine will likely be distributed in a limited manner, with the goal of maximizing vaccine acceptance and public health protection while minimizing waste and inefficiency.

The key considerations in planning for this phase are:

- COVID-19 vaccine supply may be limited.
- COVID-19 vaccine administration efforts must concentrate on the initial populations of focus to achieve vaccination coverage in those groups.
- Inventory, distribution, and any repositioning of vaccine will be closely monitored through reporting to ensure end-to-end visibility of vaccine doses.

MSDH will define strategies in this plan to address these constraints, including:

- Concentrating early COVID-19 vaccine administration efforts on the initial critical populations due to limited vaccine during Phase 1. MSDH will focus on
 - Phase 1-A: Paid and unpaid people serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials and are unable to work from home. These numbers have been gathered and are represented in the Phase I chart below.
 - Phase 1-B: People who play a key role in keeping essential functions of society running and cannot socially distance in the workplace (e.g., healthcare personnel not included in Phase I-A, emergency and law enforcement personnel not included in Phase 1-A, food packaging and distribution workers, teachers/school staff, childcare providers), and people at increased risk for severe COVID-19 illness, including people 65 years of age or older (e.g. LTCF residents, people with underlying medical conditions that are risk factors for severe COVID-19 illness, people 65 years of age or older.) These numbers have been gathered and are represented in the Phase I chart below.

Total numbers have been obtained for all identified groups. In addition, if these groups have a subgroup staff, paid or unpaid, that encounter patients that are COVID-19 positive those numbers have also been collected.

If sufficient doses are not allocated to cover the requested population groups or sub-groups MSDH will review data and reduce the allocation equitably for each qualified population group/provider.

During Phase I, MSDH will focus on closed point-of-dispensing (CPOD) settings that allow for the maximum number of people to be vaccinated while maintaining social distancing and other infection control procedures (e.g., large hospitals and [satellite, temporary, or off-site settings](#)). While prioritizing enrollment activities for CPODs in Phase 1, MSDH will simultaneously plan OPOD drive-through sites for future phases to vaccinate those who live in remote, rural areas and may have difficulty accessing vaccination services. In addition to enrolling commercial and private sector partners/providers and public health sites.

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

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:

1. Provide equitable access to COVID-19 vaccination for all critical populations to achieve high COVID-19 vaccination coverage for these populations in MS.
2. Ensure high uptake in specific populations, particularly in groups that are [higher risk for severe outcomes from COVID-19](#).

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 vaccine administration network for surge capacity will be necessary.
- Low COVID-19 vaccine demand is also a possibility. MSDH will monitor supply and adjust strategies to minimize vaccine wastage.

MSDH will adapt to the increase in COVID-19 vaccine supply levels by:

- Expanding vaccination efforts beyond initial population groups in Phase 1 with emphasis on equitable access for all populations.
- Administering vaccine through:
 - Commercial and private sector partners (pharmacies, doctors' offices, clinics)
 - Public health sites (mobile clinics, Federally Qualified Health Centers [FQHCs], RHCs, public health departments, temporary/off-site clinics)

Phase 3: Likely Sufficient Supply

COVID-19 vaccine will be widely available and integrated into routine vaccination programs statewide including 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
- Broad vaccine administration network for increased access

MSDH will continue to:

- Focus on equitable vaccination access to vaccination services through use of innovative vaccination approaches and strike teams
- Monitor COVID-19 vaccine uptake and coverage in critical populations and enhance strategies to reach populations with low vaccination uptake or coverage
- Partner with commercial and private entities to ensure COVID-19 vaccine and vaccination services are widely available
- Monitor supply and repositioning refrigerated vaccine products to minimize vaccine wastage

MS Vaccine Administration Methods of Dispensing

MSDH County Health Departments

Vaccination administration in MSDH clinics will occur during (this may vary depending on vaccination phase):

- Normal HD clinic hours,
- After hours HD clinics,
- In an Open POD as described below.

Closed Point of Dispensing (CPOD)

CPOD's will be used to vaccinate health care providers within those facilities that have signed the State Strategic National Stockpile/Pandemic Influenza Program Provider Enrollment Agreement (Appendix D).

Contained in the [State Strategic National Stockpile Plan](#) (SNS), MSDH has identified CPOD sites in all three PHR. CPODs are hospitals, nursing homes, health care providers, community health centers, Colleges/Universities-student health centers or large businesses that are able to administer vaccine/medications to their staff, staff's family members, students, students' family members, and their patients.

The Closed POD concept was designed to be able to administer medications to the entire population of the State in 48 hours, based on the worst-case scenario for a biological event. The Closed POD concept can be used to administer vaccine or respond to other Public Health emergencies. By providing medications/vaccine to the CPODs, the staff in these facilities will be able to provide medical care to the population they serve and at the same time assure that the staff receives medications/vaccine.

CPOD vaccination sites for COVID-19 Vaccine must adhere to the MSDH guidance for vaccination of priority vaccination groups. The recommendations for CPOD is

based on [CDC Vaccination Guidance During a Pandemic](#). Facilities should review recommendations and develop a plan suitable for their facility. A complete data base of Closed PODs in the state is maintained by the MSDH SNS Program and data is entered into the SNS Inventory Management System.

CPOD sites will act as one of the existing frameworks during Phase 1 and 2 COVID-19 vaccination effort. Enrolled CPOD will vaccinate their employees as they are notified, they are eligible for vaccination based on the Tier system.

CPODs will be required to enroll in the COVID-19 vaccination program by signing CDC COVID-19 Vaccination Program Provider Agreement, CDC COVID-19 Vaccine Redistribution Agreement and MIIX user agreement before they will be eligible to receive or redistribute vaccine (as described in Section 5)..

Open Point of Dispensing (OPOD)

Open Point of Dispensing (OPOD) will be an additional distribution method during Phase 1 and 2 for the COVID-19 vaccine response for priority or target populations such as, critical workforce, who don't have access to CPODs through their employer.

MSDH plans to conduct drive-through vaccination sites to assist with social distancing. The OPOD method will be set up to mimic MS drive through testing sites that are currently being held statewide at county health departments. The remote site set up manual describes the drive through process. MSDH has tested the OPOD model in COVID-19 Testing drive-through with a throughput of 500 persons per day using two administration points for COVID-19 testing.

Staffing at the OPODs will be a combination of Public Health employees, and Mississippi State National Guard (MSNG), both medical and non-medical. Best practices for vaccination held at temporary locations (Appendix E) will be followed.

Retail Pharmacies

Chain and independent pharmacies and pharmacists are likely to be used in all Phases of the COVID-19 Vaccination effort. Pharmacists across Mississippi have historically and successfully participated in seasonal influenza vaccination campaigns. As trusted members of communities statewide, pharmacist will be essential members of the MSDH COVID-19 Vaccination Provider Program. Pharmacist have a unique connection with the communities they serve. They are trusted and helpful members in those communities, which can be particularly useful in vaccine confidence in Mississippi. Pharmacists will participate in ensuring that the residents of MS have access to the COVID -19 vaccine. Pharmacists will enroll as COVID-19 Vaccination Program providers (described in Section 5) and will request vaccine through the MSDH OIMM.

Health Care Providers

Health care providers that haven't been captured in other categories are anticipated to be used in Phase 3 of the COVID-19 Vaccination effort, distribution to the general public through standard vaccination procedures. Healthcare providers will be encouraged to enroll in the MSDH COVID-19 Vaccination Provider Program (described in Section 5). Health Care providers may include primary care physicians, family practice, nurse practitioners, OBGYN physicians, pediatricians and any health care provider that is eligible and willing to administer vaccine to patient populations based on the priority populations.

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Section 4: Critical Populations

CDC’s Advisory Committee on Immunization Practices (ACIP), the National Institutes of Health, and the National Academies of Sciences, Engineering, and Medicine (NASEM) are working to determine populations of focus for COVID-19 vaccination and ensure equity in access to COVID-19 vaccination availability across the United States. CDC has established an ACIP work group to review evidence on COVID-19 epidemiology and burden as well as COVID-19 vaccine safety, vaccine efficacy, evidence quality, and implementation issues to inform recommendations for COVID-19 vaccination policy. A key policy goal is to determine critical populations for COVID-19 vaccination, including those groups identified to receive the first available doses of COVID-19 vaccine when supply is expected to be limited.

After a short period of potentially limited vaccine supply, supply will likely increase quickly, allowing vaccination efforts to be expanded to include additional critical populations as well as the general public.

Mississippi will develop plans to ensure equitable access to vaccination for each of the critical populations identified below or as set forth by the entities mentioned above.

Critical Populations identified for Mississippi include in no particular order:

Population	Numbers
Healthcare personnel	156,500
LTCF residents	19,850
People with underlying medical conditions	1,174,019
People 65 +	488,088
People from racial and ethnic minority groups	1,666,665
People in tribal communities	11,000
People who are incarcerated	17,297
People experiencing homelessness	1,184
People attending colleges/universities	77,894
People who work in Educational settings	Public schools 175,000 IHL 28,545
People living in Congregate Settings	
People living in Rural Communities	1,582,360
People with disabilities	351,185
People who are under- or uninsured	458,326

Locating Critical Populations

To improve vaccination among critical population groups, MSDH has and will work to ensure that these groups have access to vaccination services. MSDH will work internally using mapping tools provided by [NORC](#), [CMS](#) and Operation Warp Speed (OWS) Tiberius to create visual maps of these populations, including places of employment for the critical infrastructure workforce category, to assist in COVID-19 vaccination clinic planning.

MSDH will use established procedures to communicate key messages and coordinate vaccination logistics for these groups by partnering with organizations; community workforce and professional organizations to develop effective communication channels to rapidly disseminate information ensuring these population groups have access to the COVID-19 vaccine. MSDH will rely on its communication team and plan to get information and messages out to these populations.

MSDH partners (Appendix A) provides a more detailed/comprehensive list) include but are not limited to:

- Community Health Centers, FQHCs, RHCs
- Division of Medicaid
- Critical access hospitals
- Pharmacies
- First responder organizations
- Critical workforce organizations
- Non-traditional providers
- Homeless organizations
- Religious organizations
- Providers of In home care
- Institutions of Higher Learning
- Schools
- Daycares

In addition, MSDH is partnering with other efforts across the state to identify creative ways to reach hard to reach, high risk populations. MSDH is working collaboratively with the High Obesity Project through Mississippi State University Extension Services, Gulf Coast Healthy Families Mother and Babies Initiative, many Non-Profit Organization across the state and Free Clinics.

Currently, MSDH is working to coordinate drive-through food banks with OPOD vaccination drive-through sites in coordination with Medicaid non-emergency transportation. This endeavor involving collaboration of multiple agencies and projects could help reach populations that are hard to reach and at high-risk for COVID-19.

MSDH will continue to collaborate and network to reach populations in creative ways.

Populations by Phase

Phase 1a

Priority Group	Type	Estimated Doses	Sub-Group	Where vaccinated	How Notified	Estimated Doses
Healthcare Workers	Hospitals/ Clinics	156,500	Front Line Hospital workers	CPOD	Employer	42,525
	Public Health	3,000	Front Line Public Health	OPOD	Employer	250
Pharmacist	Licensed Pharmacist	3,333		Pharmacy	Licensing Board	3,333
First Responders	EMS	4507		CPOD	Employer	4,500
	Law enforcement	12,777		OPOD/ Pharmacy	Employer	12,000
	Fire services Career	3,691		OPOD/ Pharmacy	Employer	4,000
	Fire services Volunteer	13,100		OPOD/ Pharmacy	Fire Services	13,000
MSNG	Air and Army Guard	10,369		OPOD/ Pharmacy	MSNG	10,369

Phase 1b

Priority Group	Type	Estimated Doses	Sub-Group	Where vaccinated	How Notified	Estimated Doses
LTC	NH	25,250	Staff and Residents	CPOD	NH	25,250
	ICF/IID	4,901	Staff and Residents	CPOD	ICF/IID	4,901
	Assisted Living	5,822 residents	Staff and Residents	Pharmacy	Assisted Living	5,822
	Personal Care Homes	1,779 Residents	Staff and Residents	Pharmacy	Personal Care Home	1,779
	PRTF	1,931				1,931
Health Facilities	Home Care staff	3,873	Staff	Pharmacy	Employer	3,873
	Inpatient Hospice staff and residents	1,185	Staff and Residents	CPOD	Inpatient Hospice	
	Dialysis	11,818	Staff and Patients	CPOD	Clinic	11,818

Phase 2

Priority Group	Type	Estimated Doses	Sub-Group	Where vaccinated	How Notified	Estimated Doses
Critical Workforce	Education	36,554		OPOD		36,554
	Public Health	3000		CPOD		2,750
	Licensed Dentist	2,970		OPOD/ Pharmacy		2,970
	Licensed Dental Hygienist	2,087		OPOD/ Pharmacy		2,087
	Licensed Funeral Home Director/ Services and Trainees	1,388		OPOD/ Pharmacy		1,388
	Crematory Operator	113		OPOD/ Pharmacy		113
	Postal workers	4,390		OPOD		4,390
	Transportation	122,600		OPOD		122,600
	Grocery Store Employees	54,530		OPOD		54,530
	Animal Slaughtering, Butchers, meat packers	19,510		OPOD		19,510
People with Co-Morbid Conditions 18 years and up	Population	1,926,956	Obesity	OPOD		898,369
		189,176	Heart Disease	OPOD		189,176
		209,255	CPOD	OPOD		209,255
		331,392	Diabetes	OPOD		331,392
		80,542	Chronic Kidney Disease	OPOD		80,542
		218,223	Asthma	OPOD		218,223
Homeless		1,184		Shelters/ Food Pantry/ Strike team	Through Homeless Networks	1,184

Prison and Jails	Inmates and Staff	30,359		CPOD		30,359
Adults 65 + Not captured in a previous phase		488,088		OPOD, Physician's office, Clinics, pharmacy	TV, New, Radio, Social Media	488,088

Phase 3

Priority Group	Type	Estimated Doses	Sub-Group	Where vaccinated	How Notified	Estimated Doses
General Public				Physician's office, Clinics, pharmacy	TV, News, Radio, Social Media	227,295

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Section 5: COVID-19 Provider Recruitment and Enrollment

A. Provider Recruitment and Enrollment

MSHD realizes the importance of provider recruitment to ensure vaccine availability throughout the state for each phase of the COVID-19 vaccination effort. MSDH is and will utilize partnerships and stakeholders discussed previously to recruit providers throughout the vaccination effort. In areas where there are no providers and/or hard to reach populations, MSDH will leverage the partnerships for collaborative efforts for vaccination.

MSDH COVID-19 Vaccine Provider Enrollment Process:

- Ensure provider agreement profile form (Appendix G), and redistribution agreement (Appendix H), if applicable, are thoroughly and accurately completed by each enrolled provider, retained on e-file for a minimum of 3 years, and made available to CDC upon request
- Verify COVID-19 vaccination providers (prescribers only, e.g., MD, DO, RPh, NP, PA) have active, valid MS licensure/credentials to possess and administer vaccine (Appendix F).
- Onboard COVID-19 vaccination providers to the jurisdiction's IIS.
- Enter ship-to site information for each enrolled COVID-19 vaccination provider location in the Vaccine Tracking System (VTrcks) via direct upload or extensible XML information set (ExIS).
- Ensure that all COVID-19 vaccination providers have been trained appropriately and have the appropriate equipment at their location to manage any serious adverse events. For all vaccination providers and nontraditional provider settings, MSDH will provide training resources (Appendix I) that includes vaccination clinic planning guidance to ensure optimum staffing, layout, supplies, and infection control procedures are in place. Providers will be asked to attest they have completed all training provided by MSDH to be an eligible COVID-19 Vaccination Provider.

B. Provider types for first available doses

Initially MSDH will focus on recruitment of providers based on the assumptions of the tiered allocations provided by CDC while simultaneously recruiting and enrolling additional providers. As vaccine supply increases MSDH will expand recruitment of providers to ensure equitable access of COVID-19 vaccine.

The additional focus will be to provide vaccine to be administered at the local level to priority groups as issued by Advisory Committee on Immunization Practices (ACIP), guidance from Department of Health and Human Services (HHS), and local factors. Any sub priority decisions will be potentially determined in collaboration

with the State Epidemiologist and the State Health Officer using the best epidemiologic evidence and guidance from Centers for Disease Control and Prevention (CDC). MSDH Office of Emergency Preparedness and Response (OEPR) and Office of Immunization (OIMM) have the responsibility to plan and implement Points of Distribution (POD) in the 3 Public Health Regions (PHR) for administration of COVID-19 vaccine to priority groups. Regional planning of OPOD activities have been exercised in all 3 PHR through traveling POD testing. All 82 counties of the state can access vaccination in 1 week with 16 rotating PODs a day.

During the initial phase of recruitment MSDH will have focused Zoom meetings by provider groups and discuss MSDH Vaccination Plan, the enrollment process, requirements, and next steps. These meetings will be informative both for the providers and MSDH as we move forward. MS is focusing on Hospital, Long Term Care and Pharmacies for the initial recruitment and enrollment phase. Provider Frequently asked Questions (FAQs) will be developed from these meetings

C. Enrollment reporting to CDC

Enrollment data will be collected and compiled and reported electronically to CDC twice weekly on Monday and Thursday by 8:00pm CST using the CDC-provided Comma Separated Values (CSV) file via a SAMS-authenticated mechanism. Each location will be mapped to an organization. The data will be submitted through the Immunization Data Lake (IZDL) Partner Portal. MSDH has been identified to work with the IZDL Technical Assistance for early connection to implement the SCV file for data submission.

D. Process for verification of providers

The MSDH Program staff will be responsible as part of the enrollment process to review the Medical Licensure and Nursing Licensee to assure all providers are credentialed with active, and valid licenses to possess and administer vaccine. Verification will be conducted by searching State Licensing Boards, OIG Exclusion list and NPI verification through web sites (Appendix F).

E. Training

MSDH will provide training resources to COVID-19 vaccination providers to ensure the success of the COVID-19 Vaccination Program. MSDH will take advantage of the educational resources available through CDC (Additional materials may be used once the CDC materials are known.)

MSDH will provide resources to providers through email as well as make it available on the MSDH website. Providers will be provided a checklist containing a signature page, to be signed, attesting they have completed the training provided by MSDH at the time of enrollment.

The Training and Resources team will be available should providers need one-on-one assistance with any of the materials.

COVID-19 vaccination providers must understand the following:

- ACIP COVID-19 vaccine recommendations, when available
- How to order and receive COVID-19 vaccine
- COVID-19 vaccine storage and handling (including transport requirements), when available
- 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 MIIX
- How to manage vaccine inventory, including accessing and managing product expiration dates
- How to report vaccine inventory
- How to manage temperature excursions
- 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
- How to submit facility information for COVID-19 vaccination clinics to CDC's [VaccineFinder](#) (particularly for pharmacies or other high-volume vaccination providers/settings)

For MSDH training resources for Mississippi vaccination providers see Appendix I.

F. Redistribution

CDC COVID-19 Vaccine Redistribution Agreement (Appendix H) should be completed if 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 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.

Redistribution request will be made through the vaccine ordering team. The Vaccine Ordering Team member will review the request and the feasibility and either approve or deny. If the request is approved, the provider can process a transfer within MIIX and move the vaccine. Providers are responsible for all aspects of the redistribution including cold chain.

G. Ensure Equitable Access

Total numbers have been obtained for all identified groups. In addition, if these groups have any subgroup (i.e., staff, paid or unpaid, that encounter patients that are COVID-19 positive) those numbers have also been collected.

If sufficient doses are not allocated to cover the requested population groups or sub-groups MSDH will review data and reduce the allocation equitably for each qualified population group/provider.

H. Pharmacy Recruitment and Enrollment

MSDH is and will continue to reach out to pharmacies to enroll in the MSDH effort in Phase I to assist in reaching MS populations that cannot be vaccinated in CPODs. MS has reached out to pharmacies and pharmacists through the State Licensing Board and through National Association of Chain Drug Stores. MS has many rural communities that can be served by local private pharmacies and chain pharmacies that might be the only provider in the area. Both chain and independent pharmacies have offered their support during this effort.

DRAFT

Section 6: COVID-19 Vaccine Administration Capacity

A. Estimate vaccine administration capacity based on hypothetical planning scenarios.

MSDH will use the through put data identified at OPODs, CPODs and the ultra-cold distribution template. These numbers will be compared to populations identified in each Phase to determine what providers can meet the vaccination capacity for population groups through the Phase implementation.

In addition, MSDH will use Tiberius to inform this effort to ensure maximum administration distribution and/or low vaccination coverage rates to ensure maximum administration distribution is available to all populations identified in each phase.

MSDH recognizes that vaccine allocations available to the state will be fluid and will re-evaluate the allocation process based on the number of available doses at any given point in time.

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

MSDH through assumptions, planning scenarios and planning tools identified above have identified specific groups to which we will focus initial recruitment. Hospital, Long Term Care Facilities and Pharmacies will be recruited for Phase 1.

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

A. Vaccine allocation

Once vaccine is available (anticipated Fall 2020) and allocated to MS, MSDH OIMM will draw down vaccine allocation and authorize distribution at the local level to priority groups as issued by ACIP, guidance from HHS, and local factors. Any sub priority decisions will be potentially determined in collaboration with the State Epidemiologist and the State Health Officer using the best epidemiologic evidence and guidance from CDC in accordance with ACIP priority recommendations, MS COVID Vaccination Plan, State Epidemiologist and the State Health Officer input or their designees. MSDH will monitor baseline data against coverage and distribution data throughout the effort through OWS Tiberius to identify any gaps in coverage and distribution.

MSDH will develop allocation methods for critical populations of focus in early and limited supply scenarios discussed above. This scenario allocation is based on:

- ACIP recommendations
- Estimated number of doses allocated to the jurisdiction and timing of availability
- Populations served by vaccination providers and geographic location to ensure distribution throughout the jurisdiction
- Vaccination provider site vaccine storage and handling capacity
- Minimizing the potential for wastage of vaccine, constituent products, and ancillary supplies
- Other local factors

Vaccine will be administered at the local level to priority groups as issued by Advisory Committee on Immunization Practices (ACIP), guidance from Department of Health and Human Services (HHS), and local factors. Any sub priority decisions will be potentially determined in collaboration with the State Epidemiologist and the State Health Officer using the best epidemiologic evidence and guidance from Centers for Disease Control and Prevention (CDC). MSDH Office of Emergency Preparedness and Response (OEPR) and Office of Immunization (OIMM) have the responsibility to plan and implement Points of Distribution (POD) in the 3 Public Health Regions (PHR) for administration of COVID-19 vaccine to priority groups. Regional planning of OPOD activities have been exercised in all 3 PHR through traveling POD testing. All 82 counties of the state can access vaccination in 1 week with 16 rotating PODs a day.

MSDH recognizes that vaccine allocations available to the state will be fluid and will re-evaluate the allocation process based on the number of available doses at any given point in time.

B. Cold Chain Capability of Providers

Initially, during Phase I, the minimum order size and increment for vaccine distribution will be 1000 doses per order. This and the providers redistribution status will be taken into consideration with allocation and ordering during Phase I, to ensure no wastage.

Any Ultra-Cold vaccine will be shipped from the manufacturer, direct to the provider and will not go through a distributor (i.e., McKesson). Cold Chain Capacity of providers is being researched by reaching out to providers through the Ultra- Cold Chain Distribution Survey.

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

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. 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.

Facilities ordering outside of MS'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.

C. Vaccine Ordering Procedures

OIMM has experience with receiving vaccine orders from providers through the robust Statewide Immunization Registry, Mississippi Immunization Information eXchange (MIIX). All providers who are enrolled will have access to the MIIX system and be trained to process vaccine orders in MIIX and to review inventory and to enter doses administered into the system. MSDH staff have experience in reviewing vaccine orders for approval and submission to CDC through the Vtrcks system.

When a COVID-19 vaccine becomes available vaccine orders will be processed from COVID-19 approved providers through MIIX, the established Statewide Immunization Registry of the MSDH OIMM. MSDH utilizes MIIX on a daily basis to operate the Vaccine for Children (VFC) program. MIIX currently handles vaccine

ordering, vaccine tracking, distribution, and inventory. MIIX has the ability to capture all the CDC required documentation.

The COVID-19 vaccine will be managed (ordered, stored, distributed, and accounted) by MSDH OIMM COVID Vaccination Structure. This effort will be affected by the manufacturers' ability to produce and distribute vaccine. Therefore, Mass vaccination planning must be flexible and modified based on the status of vaccine technology, amount and speed at which the vaccine is produced and delivered, the characteristics of pandemic illness, critical infrastructure determinations along with groups at high-risk for severe disease. These factors will likely evolve as new information is available.

The MSDH vaccine ordering unit will review past orders, inventory transactions and lot number summaries to ensure providers order additional doses of the same presentation for people returning for their second dose, as vaccines are NOT interchangeable.

MSDH Vaccine ordering unit will track allocation, vaccine orders, and the administration data through MIIX. Providers who are not administering doses and/or reporting doses administered, will be contacted for technical assistance. Providers who are not meeting the requirements after technical assistance and continue to make no improvements, ordering privileges will be terminated.

D. Unplanned repositioning of vaccine

Redistribution request will be made through the vaccine ordering team. The Vaccine Ordering Team member will review the request and the feasibility and either approve or deny. If the request is approved, the provider can process a transfer within MIIX and move the vaccine. Providers are responsible for all aspects of the redistribution including cold chain.

Whenever possible, vaccine should be shipped 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 MSDH OIMM, 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 (Appendix H) for the sending facility/organization and have a fully completed and signed CDC COVID-19 Vaccination Provider Profile (Appendix G) form for each receiving location.

MSDH OIMM will be extremely judicious in allowing redistribution and limit any redistribution to refrigerated vaccines only.

E. Monitoring Wastage and Inventory

COVID-19 vaccination providers will be required to report inventory of COVID-19 vaccines, and MSDH OIMM will ensure this inventory information is submitted with each order through MIIX. MS's IIS system, MIIX, will capture inventory as ordered, delivered and decrement as providers enter vaccinations administered into the system.

It is anticipated COVID-19 vaccines will initially be authorized under an 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.
- **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.

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

Section 8: COVID-19 Vaccine Storage and Handling

A. Vaccine Storage and Handling

COVID-19 vaccine products are temperature-sensitive and must be stored and handled correctly to ensure efficacy and maximize shelf life. Proper storage and handling practices are critical to minimize vaccine loss and limit risk of administering COVID-19 vaccine with reduced effectiveness. MSDH OIMM will provide each COVID-19 vaccination provider site the appropriate vaccine storage and handling procedures so they can implement and follow as best practice.

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 to -25°C) to ultra-cold (-60°C to -80°C in the freezer or within the dry ice shipping container in which product was received). Ongoing stability testing may impact these requirements. Note: These temperatures are based on information available as of 9/04/2020. Updated information will be provided as it becomes available.

For a reliable cold chain, three elements must be in place:

- Well-trained staff
- Reliable storage and temperature monitoring equipment
- Accurate vaccine inventory management

The cold chain begins at the COVID-19 vaccine manufacturing plant, includes delivery to and storage at the COVID-19 vaccination provider site, and ends with administration of COVID-19 vaccine to a person.

- MS vaccination providers are responsible for maintaining vaccine quality from the time a shipment arrives at a vaccination provider site until the dose is administered. To minimize opportunities for breaks in the cold chain, most COVID-19 vaccine will be delivered from CDC's centralized distributor directly to the location where the vaccine will be stored and administered, although some vaccine may be delivered to secondary depots for redistribution. Certain COVID-19 vaccine products, such as those with ultra-cold temperature requirements, will be shipped directly from the manufacturer to the vaccination provider site. If redistributing vaccine, jurisdictions must adhere to all cold chain requirements and should limit transport of frozen or ultra-cold vaccine products.

MS Vaccination Providers are required to review CDC's revised [Guidance for Planning Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations](#) as well as [Vaccination Guidance During a Pandemic](#). These resources provide information on additional considerations that are necessary during the COVID-19 pandemic, including social distancing, PPE use, and enhanced sanitation efforts. This information can also be found in the Provider Training Resources

(Appendix I)

An addendum to the [Vaccine Storage and Handling Toolkit](#) that specifically addresses COVID-19 vaccines is currently being developed by CDC in addition to other training materials.

- Satellite, temporary, or off-site clinics in collaboration with community or mobile vaccinators may be necessary in providing equitable access for COVID-19 vaccination. However, these situations require additional oversight and enhanced storage and handling practices, including:
 - The quantity of COVID-19 vaccine transported to a satellite, temporary, or off-site COVID-19 vaccination clinic should be based on the anticipated number of COVID-19 vaccine recipients and the ability of the vaccination provider to store, handle, and transport the vaccine appropriately. This is essential to minimizing the potential for vaccine wastage and spoilage.
 - COVID-19 vaccines may be transported—not shipped—to a satellite, temporary, or off-site COVID-19 vaccination clinic setting using vaccine transportation procedures outlined in the upcoming COVID-19 addendum to CDC’s Vaccine Storage and Handling Toolkit. The procedures will include transporting vaccines to and from the provider site at appropriate temperatures, using appropriate equipment, as well as monitoring and documenting temperatures.
 - Upon arrival at the COVID-19 vaccination clinic site, vaccines must be stored correctly to maintain appropriate temperature throughout the clinic day.
 - Temperature data must be reviewed and documented according to guidance in the upcoming COVID-19 addendum to CDC’s Vaccine Storage and Handling Toolkit.
 - At the end of the clinic day, temperature data must be assessed prior to returning vaccine to fixed storage units to prevent administration of vaccines that may have been compromised.
 - As with all vaccines, if COVID-19 vaccines are exposed to temperature excursions at any time, the temperature excursion should be documented and reported according to the jurisdiction immunization program’s procedures. The vaccines that were exposed to out-of-range temperatures must be labeled “do not use” and stored at the required temperature until further information on usability can be gathered or further instruction on disposition or recovery is received.

B. Redistribution

Redistribution request will be made through the vaccine ordering team. The Vaccine Ordering Team member will review the request and the feasibility and

either approve or deny. If the request is approved, the provider can process a transfer within MIIX and move the vaccine. Providers are responsible for all aspects of the redistribution including cold chain.

Whenever possible, vaccine should be shipped 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 MSDH OIMM, 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 (Appendix H) for the sending facility/organization and have a fully completed and signed CDC COVID-19 Vaccination Provider Profile (Appendix G) form for each receiving location. MSDH OIMM will be extremely judicious in allowing redistribution and limit any redistribution to refrigerated vaccines only.

Section 9: COVID-19 Vaccine Administration Documentation

A. COVID-19 Vaccine Administration Documentation and Reporting

It is required by the CDC that MS enrolled vaccination providers in the COVID-19 Vaccination Program report certain data elements in MIIX for each dose administered within 24 hours of administration. Required elements can be found in the CDC IIS Data Requirements for COVID-19 Vaccine Monitoring (Appendix J). MSDH OIMM will require COVID-19 vaccination providers to meet this requirement upon enrollment. COVID-19 vaccination data requirements can be found on [CDC's IIS website](#) and MSDH website. MSDH OIMM will be available to provide additional support or technical assistance for smaller vaccination providers or rural clinic settings.

If internet access is not available, providers are required to complete the Vaccine Administration Record (VAR) form (Appendix K) during the vaccination event and record it in MIIX within 24 hours. All data elements must be captured to be entered into MIIX before the 24-hour requirement.

B. Immunization (IZ) Gateway

MSDH will facilitate and monitor IIS reporting by MS 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 at the time of vaccination. If data will be entered off site, vaccination providers must ensure the required data elements are reported to MIIX within 24 hours. The VAR (Appendix K) can be used to track information by paper but will be required to be entered into MIIX within 24 hours. Reporting data may be transmitted daily from MIIX to the CDC.

MSDH is not be responsible for reporting data from federal agencies or commercial partners who receive vaccine allocations directly from CDC.

MIIX can query other jurisdiction's systems and/or the Immunization Data Lake to obtain immunization history, if applicable. This process will be put in place once CDC supplies further guidance.

C. Vaccine Provider Readiness

MSDH will provide providers with Training Resources (Appendix I) to prepare, in addition to the requirements outlined in CDC Covid19 Vaccination Program Provider Agreement (Appendix G). MSDH staff are available for one on one Provider Training or Technical Assistance.

D. Real-time data reporting

Real time reporting is available through MIIX. MSDH will provide data to CDC as outlined through the IZ Gateway. As more information is available this section will

be updated.

E. Provider-level data monitoring to assure 24-hour reporting

Data monitored can be achieved through MIIX. Providers who are not administering doses and/or reporting doses administered, will be contacted for technical assistance. Providers who are not meeting the requirements after technical assistance and continue to make no improvements, order privileges will be terminated.

F. COVID-19 Vaccine Coverage level reports

MSDH will use Tiberius, the U.S. Department of Health & Human Services (HHS) Operation Warp Speed Protect (OWS) ecosystem of data sharing platforms that connects data sources for analysis and modeling. It pulls data from federal agencies, all states and territories, health care facilities, academia, and the private sector. This ecosystem of data sharing platforms informs policy makers and vaccine distribution personnel so they can make decisions with as much information and visibility as possible.

Tiberius will assist MSDH in analyzing coverage level across the state. This information will inform next steps and further provider recruitment and enrollment, throughout the effort.

Section 10: COVID-19 Vaccination Second-Dose Reminders

A. COVID-19 Second Dose Reminders

For most COVID-19 vaccine products, two doses of vaccine, separated by 21 or 28 days, will be needed. Because different COVID-19 vaccine products will not be interchangeable, a vaccine recipient's second dose must be from the same manufacturer as their first dose. Second-dose reminders for vaccine recipients are critical to ensure compliance with vaccine dosing intervals and achieve optimal vaccine effectiveness.

COVID-19 vaccination providers should make every attempt to schedule a patient's second-dose appointment when they get their first dose.

COVID-19 vaccination record cards are provided as part of vaccine ancillary kits. Vaccination providers are required to complete these cards with accurate vaccine information (i.e., vaccine manufacturer, lot number, date of first dose administration, and second dose due date), and give them to each vaccine recipient who receives vaccine to ensure a basic vaccination record is provided.

Vaccination providers should encourage vaccine recipients to keep the card in case the IIS or other system is not available when they return for their second dose. The card provides room for a written reminder for a second-dose appointment. If vaccine recipients have a smartphone, they may consider documenting their vaccine administration with a photo of their vaccination record and entering the date the next vaccine dose is due on their electronic calendar.

MSDH's IIS, MIIX, has remind/recall capability for COVID vaccination providers organizations in instances that providers do not have the capability in their system. Although, many pharmacies and healthcare providers have their own systems for patient notifications and reminders within their electronic health record (EHR).

In addition, MSDH an existing MS ITS contract through AVAYA for text reminders to remind of 2nd dose. This redundancy provides options as we move forward.

MyIRmobile.com is a public facing immunization site that will be promoted and encouraged as a method for people to access their or their children's immunization record. This system also provides forecasting and will indicate when additional doses are due.

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

A. Vaccine Administration in temporary or high-volume settings

MS COVID-19 vaccination providers are required to enter the CDC IIS Required Data Elements into MIIX, MS's IIS system. If MS COVID-19 vaccination providers are interfaced for bidirectional data exchange from between their EHR/EMR and MIIX, the required elements can be obtained through that interface.

In the event of network outages or in high-volume vaccination settings, COVID-19 providers are required to complete the Vaccine Administration Record (VAR) form during the vaccination event and record it in MIIX within 24 hours.

B. List the Variables required in the IIS/MIIX

Our IIS can capture the following variables: administration location (facility name/ID, type), administration address, administration date, CVX (product), dose number, IIS recipient ID, IIS vaccination event ID, lot number (unite of use, unit of sale), MVX (manufacturer), recipient address, recipient date of birth, recipient name, recipient sex, sending organization, vaccine administering provider suffix, vaccine administrating site, vaccine expiration date, vaccine route of administration.

MS's IIS system, MIIX, meets the infrastructure requirements to support vaccination tracking, and the system is up to date with the latest version of the platform.

COVID-19 required vaccine information will be collected through MIIX and sent to CDC via the IZ Gateway, using current HL7 standards. If this method is not available, we will compile a CSV file of the required data elements and send it to CDC via established method(s) of transfer (SFTP site).

C. Capacity for data exchange, storage, and reporting

MIIX can capture all patient vaccination data. This gives MSDH the ability to track and monitor when patients who receive vaccines, the number of doses received, and where they received it. MIIX also has the capability to run coverage reports and manage vaccine inventory. We plan to implement our online pandemic registration in mid-October.

D. Ability to rapidly enroll and onboard providers

MSDH plans to implement our online pandemic enrollment during the second or third week of October, which would include the CDC COVID-19 Vaccination Program Provider Agreement.

If online pandemic enrollment is unavailable, providers will complete the CDC COVID-19 Vaccination Program Provider Agreement, located in the document center of our MIIX homepage or a MSDH landing page. Once the form has been completed, providers will email the agreement to the Immunization program. Our team will process completed agreements, then update MIIX to indicate the organization and facilities as COVID-19 providers. Finally, we will notify the facility

that they are COVID-19 providers via email. Providers who are new to MIIX will be required to complete our enrollment documents found on the MSDH Immunization webpage.

E. IZ Gateway

MIIX currently queries Louisiana's IIS (LINKS) through the IZ Gateway Connect component to obtain a consolidated vaccination record. MSDH has been participating in the project since its inception and all legal documents have been fulfilled between APHL (BAA, DUA), AIRA (MOU for other states) and MSDH (BAA, DUA). MIIX is connected to both the IZ gateway and the IZ connect.

F. Data Use Agreements and MOU

MS has signed the Data Use Agreement (DUA) with Association of Public Health Laboratories (APHL) to participate in both IZ Gateway Connect and IZ Gateway Share. In addition, MS has executed the MOU to share data with other jurisdictions through the IZ Gateway IZ Connect.

G. Back-up solutions for offline use

COVID-19 vaccine providers will be required to enter vaccine administration data into MIIX within 24 hours of administration. If internet access is not available, providers are required to complete the Vaccine Administration Record (VAR) form during the vaccination event and record it in MIIX within 24 hours.

H. Monitoring of Data Quality

Our staff will continue to ensure high data quality standards and complete and accurate data input through various data quality reports and system monitoring. MSDH will continue to monitor data submissions by running daily immunization reports for each site. If reporting is not accurate, it will be addressed with the organization or facility's point of contact for correction and technical assistance will be offered. The process of accountability for COVID-19 will be the same as the process of accountability for VFC. Ultimately, providers who do not comply can be terminated from being COVID-19 providers.

Section 12: COVID-19 Vaccination Program Communication

A. COVID-19 Vaccination Program Communication Plan

MSDH Office of Communications is responsible for the comprehensive communication plan to disperse information to the public. 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 critical to ensure vaccine uptake.

The MSDH Office of Communications is planning to conduct focus groups to inform concerns, misconceptions and other issues regarding COVID-19 vaccination. MSDH will use the focus group findings to conduct an effective campaign.

The spokesperson for the MSDH is the State Health Officer (SHO) or designee. The MSDH Director of Communications will be the Lead PIO unless otherwise directed. In the absence of the Director of Communications, the Division Director of Emergency Preparedness Communications would serve as Lead PIO. Emergency Public Information Officers (E-PIO) an important link in the public health emergency chain and serve as local liaison; to pass on information provided by communications to the public.

The Office of Communication will use TV, radio, print, social media, and virtual meetings to communicate information regarding the COVID-19 Vaccination plans. Specific information about disease transmission prevention, and about vaccine priority groups for COVID-19 vaccine will be disseminated prior to vaccine availability. As vaccine becomes available, local and statewide media will disseminate information about access to the appropriate groups.

Covid-19 Vaccination Communication Objectives

MSDH will work towards these objectives:

- Educate the public about the development, authorization, distribution, and execution of COVID-19 vaccines and that situations are continually evolving.
- Ensure public confidence in the approval or authorization process, safety, and efficacy of COVID-19 vaccines.
- Help the public to understand key differences in FDA emergency use authorization and FDA approval (i.e., licensure).
- Engage in dialogue with internal and external partners to understand their key considerations and needs related to COVID-19 vaccine program implementation.
- Ensure active, timely, accessible, and effective public health and safety messaging along with outreach to key state/local partners and the public

about COVID-19 vaccines.

- Provide guidance to local health departments, clinicians, and other hosts of COVID-19 vaccination provider locations.
- Track and monitor public receptiveness to COVID-19 vaccination messaging.

Key Audiences

Messaging will be tailored for each audience to ensure communication is effective.

- Employers/labor unions
- Government and community partners and stakeholders
- Public/consumers
- Essential workers
- Those in groups at risk for severe outcomes from COVID-19 infection
- Those in groups at increased risk of acquiring or transmitting COVID-19
- Those with limited access to vaccination services

Broad Communication Planning Phases

Messaging will be timely and applicable for the current phase of the COVID-19 Vaccination Program.

- Before vaccine is available
- Vaccine is available in limited supply for certain populations of early focus (Phase 1)
- Vaccine is increasing and available for other critical populations and the general public (Phase 2)
- Vaccine is widely available (Phase 3)

Communication Activities

- Communicate early about the safety of vaccines in general and have easily accessible, government information to address myths, questions, and concerns.
- Keep the public, public health partners, and healthcare providers well-informed about COVID-19 vaccine(s) development, recommendations, and public health's efforts.
- 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.

- Communicate proactively whenever possible, anticipating issues and forecasting possible problems before they reach broad awareness.
- 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.
- Use information and education campaigns to extend reach and increase visibility of vaccine recommendations and resources.
- 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.
- Communicate transparently about COVID-19 vaccine risks and recommendations, immunization recommendations, public health recommendations, and prevention measures.

Messaging Considerations

MSDH messages and products will be tailored for each audience and developed with consideration for health equity. Plain language that is easily understood will be used. Information will be presented in culturally responsive language and available in languages that represent the communities in MS. MSDH will be careful to address all people inclusively, with respect, using non-stigmatizing, bias-free language. When developing/utilizing materials, MSDH will check for the following:

- Are there words, phrases, or images that could be offensive to or stereotypical of the cultural or religious traditions, practices, or beliefs of the intended audience?
- Are there words, phrases, or images that may be confusing, misleading, or have a different meaning for the intended audience?
- Are there images that do not reflect the look or lifestyle of the intended audience or the places where they live, work, or worship?
- Are there health recommendations that may be inappropriate or prohibited for the social, economic, cultural, or religious context of the intended audience?
- Are any toll-free numbers or reference web pages in the message in the language of the intended audience?

These considerations and any others that emerge during message development and deployment will be reviewed when material is translated.

Communications Channels

Even perfectly developed messages and materials will provide no benefit if they are not received by the intended audience. MSDH will explore how specific groups are most likely to access information with the communication methods available to them. Feedback mechanisms such as a web page or e-mail account to allow the audience to express concerns, ask questions, and request assistance are extremely important, and creating such mechanisms should be a priority for jurisdictions.

Traditional media channels

- Print
- Radio
- TV

Digital media

- Internet
- Social media
- Text messaging
- COVID and You (Facebook Live)
- Press conferences (In Person and Facebook Live)
- Zoom Meetings with various stakeholders

Partners and Trusted Sources

Working to engage and empower partners is critical to reinforcing COVID-19 vaccination messages. Efforts with partners and trusted sources will be integrated into other channels in addition to programmatic and community engagement efforts. These partners include:

- State and local government
- Stakeholders
- At Risk Populations
- Employers/labor unions
- Educators and students
- Professional organizations
- Organizations serving minority populations and people with disabilities
- Community and faith-based organizations

B. Risk Communication

MSDH has a Communication Plan that includes a comprehensive Risk Communication Plan that has been used for COVID-19. The communications

plan includes different methods to issue critical information to the public about the pandemic outbreak and control measures using joint information process (JIC), at both the State, and local levels.

These principles are included in MSDH Risk Communications:

- Be First
- Be Right
- Be Credible
- Express Empathy
- Show Respect

Messaging is at a 5th grade level, simple, easy to read words and ideas, formatted in 3 sentences that are easy to remember and repeat. MSDH will have 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. Communicating what is currently known, regularly updating this information, and continuing dialogue with media and other partners throughout the vaccine distribution and administration process are essential to establish and maintain trust and credibility.

Section 13: Regulatory Considerations for COVID-19 Vaccination

A. Emergency Use Authorization (EUA)

In the instance, that the initial COVID-19 vaccines doses are authorized for use under an EUA issued by FDA the following information will be implemented.

The EUA authority allows FDA to authorize either (a) the use of an unapproved medical product (e.g., drug, vaccine, or diagnostic device) or (b) the unapproved use of an approved medical product during an emergency based on certain criteria. The EUA will outline how the COVID-19 vaccine should be used and any conditions that must be met to use the vaccine. FDA will coordinate with CDC to confirm these “conditions of authorization.” Vaccine conditions of authorization are expected to include distribution requirements, reporting requirements, and safety and monitoring requirements. The EUA will be authorized for a specific time period to meet response needs (i.e., for the duration of the COVID-19 pandemic). Additional information on EUAs, including guidance and frequently asked questions, is located on the FDA website.

B. EUA Fact Sheets

Product-specific EUA fact sheet for COVID-19 vaccination providers will be made available that will include information on the specific vaccine product and instructions for its use. An EUA fact sheet for vaccine recipients will also be developed, and both will likely be made available on the FDA website and through the CDC website. Jurisdictions should ensure providers know where to find both the provider and recipient fact sheets, have read and understand them, and are clear on the requirement to provide the recipient fact sheet to each client/patient prior to administering vaccine.

Vaccine Information Statements

VISs are required only if a vaccine is added to the Vaccine Injury Table. Optional VISs may be produced, but only after a vaccine has been licensed (e.g., such as with zoster vaccines). Plans for developing a VIS for COVID-19 vaccine are not known at this time but will be communicated as additional information becomes available.

Section 14: COVID-19 Vaccine Safety Monitoring

A. Vaccine Adverse Event Reporting System

MS COVID-19 vaccination providers are required to report adverse events following COVID-19 vaccination and should report clinically important adverse events even if they are not sure if the vaccination caused the event. Vaccine manufacturers are required to report to VAERS all adverse events that come to their attention. MSDH will stress the requirement and importance to ensure that the MS COVID-19 vaccination providers understand the procedures for reporting adverse events to VAERS. Information will be provided during enrollment. Additionally, they will be provided information about the Vaccine Safety Datalink (VSD) CDC's Clinical Immunization Safety Assessment Project .

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Section 15: COVID-19 Vaccination Program Monitoring

A. Methods and Procedures for Monitoring Progress

- Provider enrollment
- Access to COVID-19 vaccination services by population in all phases of implementation
- IIS or other designated system performance
- Data reporting to CDC
- Provider-level data reporting
- Vaccine ordering and distribution
 - 1-and 2-dose COVID-19 vaccination coverage

B. Monitoring Resources

Administrative team will hold regular meeting to discuss and monitor:

- Budget – The budget is constantly monitored and reviewed to ensure MSDH is maintaining and operating within budget constraints.
- Staffing – Staffing will be monitored daily to ensure that the demands of the campaign are met. This monitoring will be pro-active and forward looking to ensure the campaign can keep up with the demand.
- Supplies/Resources – Supplies and resources will be taken into account to ensure the effort can maintain its momentum and pace.

C. Monitoring Communication

Office of Communications Employees two companies that assist with monitoring media: newspaper, television, radio, and social media. Office of communication monitors performance of websites. This combination provides communication with metrics and performance reports for all facets of the campaign. Communications can adapt and make necessary changes.

D. Monitoring of local-level situational awareness

MSDH will use Regional Public Health officials, local Mississippi Emergency Healthcare Coalition (MEHC) contacts, county emergency management contacts, regional immunization nursing staff and local officials to monitor local-level situational awareness. As members of the collaborative team they can provide valuable inform throughout the campaign. This will be used to inform the campaign and make need adjustments.

E. Vaccination Program Metrics

Vaccination program metrics will be captured and posted when vaccination begins. MSDH understands the importance of transparency and will post statistics on the MSDH website as available. MSDH is currently recruiting an epidemiologist to take the lead on data. This will include but not limited to data from obtained from MIIX, provider enrollments, doses distributed and administered and coverage by phases. These metrics will be captured in charts and graphs and reported.

Appendix

- A. Internal Partners**
- B. Incident Command Organizational Chart**
- C. Vaccination Response Structure**
- D. SNS Pandemic Program Enrollment Agreement Form 255E**
- E. Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations**
- F. Provider Verification**
- G. CDC Covid-19 Vaccination Program Provider Agreement**
- H. CDC Covid-19 Vaccine Redistribution Agreement**
- I. Training Resources**
- J. CDC IIS Data Requirements for COVID-19 Vaccine Administration**
- K. Vaccine Administration Record (VAR)**

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