

COVID-19 Vaccination Plan

OREGON

Oregon Health Authority | Oregon Immunization Program
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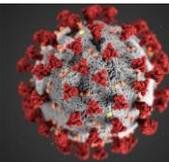
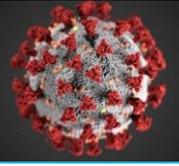
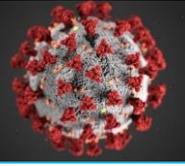


Table of Contents

Record of Changes	3
Introduction: Oregon’s COVID-19 Vaccine Plan	4
Health Equity Definition	4
Disproportionate Effects of COVID-19	5
Roots of Inequity: Social Determinants of Health and Determinants of Equity	5
Communities of Color are Disproportionately Affected by COVID-19	5
Historical Disparities	7
A Path Forward	8
Governor’s Health Equity Framework	8
Co-Creation Process	9
Section 1: COVID-9 Vaccination Preparedness Planning.....	11
Section 2: COVID-19 Organizational Structure and Partner Involvement	15
Coronavirus Response and Recovery Unit (CRRU)	16
Health Security, Preparedness and Response Program (HSPR)	16
Program Communications and Coordination with the Joint Information Center (JIC)/Health Information Center (HIC)	16
Community Engagement and Equity Team.....	17
Home Rule	32
State and Local Public Health Coordination	32
COVID-19 Response Coordination	33
Oregon CARES Influenza Project	34
Opportunities.....	34
Known Gaps and Opportunities.....	35
Tribal preparedness infrastructure	36
CARES Flu and COVID-19 Preparation funding	36
Tribal Immunization Preparedness MOUs	37
Updates to Tribes and tribal communities	37
Key Partnerships	38



Partnerships and Engagement Strategies	38
Known Gaps and Opportunities.....	40
Section 3: Phased Approach to COVID-19 Vaccination.....	42
Pharmacy Partnership for Long-term Care (LTC) Program:	45
Section 4: Critical Populations.....	53
Section 5: COVID-19 Provider Recruitment and Enrollment.....	64
Section 6: COVID-19 Vaccine Administration Capacity.....	70
Section 7: COVID-19 Vaccine Allocation, Ordering, Distribution and Inventory Management.....	72
Section 8: COVID-19 Vaccine Storage and Handling	76
Section 9: COVID-19 Vaccine Administration Documentation and Reporting	78
Section 10: COVID-19 Vaccination Second-Dose Reminders	81
Section 11: COVID-19 Requirements for IISs or Other External Systems	83
Section 12: COVID-19 Vaccination Program Communication	87
Section 13: Regulatory Considerations for COVID-19 Vaccination	103
Section 14: COVID-19 Vaccine Safety Monitoring	105
Section 15: COVID-19 Vaccination Program Monitoring	107
Appendix.....	105



Introduction: Oregon's COVID-19 Vaccine Plan

Oregon's plan to allocate and distribute COVID-19 vaccine is grounded in a commitment to health equity, which requires an examination of how power and resources are distributed. With this foundation, the vaccine plan presented here represents a starting point for the iterative, responsive work of co-creating this strategy in partnership with communities most impacted by longstanding health inequities and disproportionately impacted by COVID-19. This introduction presents the framework for Oregon's approach to co-creation and community collaboration.

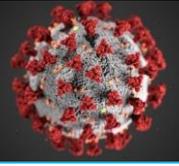
The COVID-19 pandemic has drawn focus to the inequities many communities face. We have been presented an opportunity to put our values into action. This plan is intended to be a living document that represents just one step of many for Oregon as we work toward the goal of eliminating health inequities in our state by 2030.

Health Equity Definition

The Oregon Health Authority (OHA) has an established definition of health equity which guides the work of the agency. Oregon's health equity definition is:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.



Disproportionate Effects of COVID-19

Roots of Inequity: Social Determinants of Health and Determinants of Equity

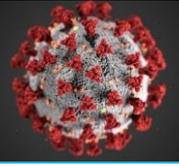
People's health depends on much more than just their biology and behaviors. The conditions in which people are born, grow, live, work and age have a profound effect on how healthy they can be. These conditions are known as the social determinants of health.

They are not typically within individual control. Rather, they are a product of policies and practices that create an unfair distribution of resources and opportunities. People and communities with limited access to these resources and opportunities, and who have faced barriers that have persisted for decades, if not centuries, are placed at a disadvantage. They experience worse health outcomes and premature death. Epigenetics and other origins of chronic disease also factor into the health outcomes. One legacy of racism and longstanding oppression is that people of color, tribal communities and people living with intellectual, developmental and other disabilities, due to historical and current injustices, structural racism, the colonization of relationships and processes experience overall worse health outcomes.

Everyone is experiencing the effects of COVID-19, but not all are experiencing this pandemic the same way. Physical distancing with adequate space and resources is different than physical distancing in a densely populated neighborhood, in a food desert, or for individuals who are still required to put themselves at risk in order to support their families. Individuals with disabilities often rely on in direct support workers to meet their basic needs and are unable to physically distance, which puts them and their staff at risk. Racism, discrimination and the stigmatization of communities as either the source of the issue or as expendable, factor into how people can access both services and safety.

Communities of Color are Disproportionately Affected by COVID-19

The inequitable burden of disease and other negative health conditions on communities of color and indigenous and American Indian/Alaska Native communities are not new. COVID-19 has simply highlighted this inequity at a time



when more people are paying attention to illness, health and racial justice in the U.S.

Data on COVID-19 cases in Oregon show how this illness has affected tribal communities and communities of color disproportionately.

The following tables from OHA’s COVID-19 Weekly Report¹ published on October 14, 2020, demonstrate this inequitable burden of disease:

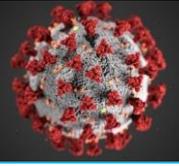
Oregon COVID-19 Cases by Race

Race	Cases	% of total cases	Cases per 100,000
White	16,037	42.8%	448.4
Black	1,261	3.4%	1562.0
Asian	1,068	2.9%	589.7
American Indian/Alaska Native	920	2.5%	1887.6
Pacific Islander	627	1.7%	3774.4
Other	12,308	32.9%	n/a
>1 race	728	1.9%	362.2
Not available	4,518	12.1%	n/a
Total	37,467	100.0%	884.4

COVID-19 Cases by Ethnicity

Ethnicity	Case count	% of total cases	Cases per 100,000
Hispanic	14,060	37.5%	2585.6
Non-Hispanic	18,865	50.4%	510.9
Not available	4,542	12.1%	n/a
Total	37,467	100.0%	884.4

¹ Oregon Health Authority. *COVID-19 Weekly Report*. (2020, October 7). <https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/DISEASESAZ/Emerging%20Respiratory%20Infections/COVID-19-Weekly-Report-2020-10-07-FINAL.pdf>



Though data in Oregon is clear that people of color have been disproportionately affected by COVID-19, the data to accurately describe these inequities is often not available. Oregon Health Authority is committed to ensuring that Oregon's COVID-19 data can describe inequities in disproportionately affected communities and inform our actions. To achieve this, on October 1, 2020 healthcare providers began gathering expanded data on race, ethnicity, language, and disability (REALD) pursuant to House Bill 4212. This data is critical to informing OHA's plans to address health inequities in Oregon. Oregon has an urgent responsibility to identify how inequities in the social determinants of health have driven this disproportionate disease incidence. We must work with communities to ensure that interventions to protect health are culturally appropriate and delivered in the language and channels that enable communities to act.

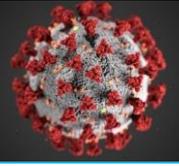
Historical Disparities

Communities of color and tribal communities in Oregon have long faced barriers to access to preventive medical services, including immunizations. Though there are significant differences between age groups and individual vaccines, some groups including Latino, Latina, Latinx, African American and Black communities, Hawaiian and Pacific Islanders, and tribal communities trail behind whites. In addition to unmet, health-related social need, these communities also face barriers in the medical system to receiving culturally responsive and linguistically appropriate care. Some of the most concerning disparities occur in seasonal influenza vaccination where Hispanic/Latino people have vaccination rates 17 percentage points lower and African Americans 6 percentage points lower than whites. As we approach a respiratory season where influenza and COVID-19 patients will require the same limited pool of healthcare resources, these disparities represent critical needs that must be addressed in COVID-19 vaccine planning.

Individuals with Intellectual, Developmental and Other Disabilities

A study² published in May 2020 in the Disability and Health Journal looked at COVID-19 outcomes for people living with intellectual and developmental

² Turk MA, Landes SD, Formica MK, Goss KD, "Intellectual and Developmental Disability and COVID-19 Case-Fatality Trends: TriNetX Analysis, *Disability and Health Journal*, published online May 24, 2020. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7245650/>



disabilities (IDD). Using data from the TriNetX COVID-19 Research Network /platform, a network of EHR data from 42 health care organizations, the authors identified that the overall case-fatality for people with IDD (5.1%) was similar to people without IDD (5.4%), however the case-fatality rate varied significantly by age group. Younger adults (18-74 years) living with IDD had a significantly higher case-fatality rate (4.5%) than young adults without IDD (2.7%). For children ≤ 17 years of age, the difference was even more stark; the COVID-19 case-fatality rate for a child with an IDD was 1.6% versus $<0.01\%$ for children without an IDD.

According to the CDC, people living with intellectual, developmental, and physical disabilities are not inherently at higher risk of COVID-19, however they are three times as likely to have a high-risk underlying condition than adults without disabilities. In addition, they are more likely to rely on direct support providers for their care.

People living in congregant settings are at higher risk of contracting COVID-19 as social distancing can be difficult in shared housing. Even people living with their families may risk exposure given that their in-home caregivers often serve multiple individuals. A recent CDC study identified household transmission occurred 53% of the time. Among household contacts that became ill, 3 out of 4 of them acquired the infection within 5 days of symptom onset in the index patient.

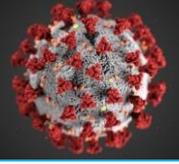
A Path Forward

Governor's Health Equity Framework

Governor Kate Brown shared a framework³ for applying equity across the state's response to the pandemic. This framework highlights three equity values that guide our work:

1. **Prioritizing Equity:** Prioritizing equity and addressing racial disparities as we work toward recovery from COVID-19.
2. **Addressing Health and Economic Impacts:** Address underlying systemic causes of health and wealth inequalities especially for those most impacted.
3. **Ensuring an Inclusive and Welcoming Oregon:** Commitment for Oregon to be an inclusive and welcoming state for all.

³ Office of Governor Kate Brown. *State of Oregon Equity Framework in COVID-19 Response and Recovery*. (2020, June). https://www.oregon.gov/gov/policy/Documents/EquityFrameworkCovid19_2020.pdf



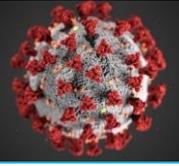
Building on this framework, OHA and the Oregon Department of Human Services (ODHS) have recommended three additional values to further operationalize our commitment to leading with equity in every aspect of this pandemic response:

4. **Prioritizing Community:** Commitment to prioritizing community engagement and recognizing the role communities should play, especially with communities disproportionately impacted by COVID-19 and historical and contemporary racism, discrimination, and oppression, in our response and recovery efforts.
5. **Addressing Power, Privilege, and Race:** Address the roles power, privilege, and race play in our individual and collective responses to, and experiences of, the COVID-19 pandemic, as well as addressing structural racism and other forms of systemic oppression.
6. **Sharing Power:** Strive to identify, examine, and challenge where power lies in our system and to continually work to share power both internally as well as externally with our communities.

Co-Creation Process

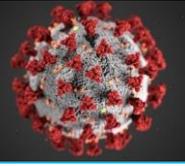
OHA considers the planning for COVID-19 vaccine to be an opportunity to reimagine how the agency engages communities in co-creating the work of public health. This vaccine plan, as mentioned above, is a starting point for this journey. The agency is building a COVID-19 Vaccine Advisory Committee that is representative of those disproportionately affected by the pandemic, to integrate communities in establishing priorities, processes and desired outcomes.

In assembling this committee, OHA will build on the model developed for the agency's Cover All Kids Advisory Committee, in which individuals who represent the voice of communities were involved early. Their priorities were given equal consideration with representatives from other key groups such as healthcare providers. Co-creation is part of a participatory approach to public health, bolstered by continuous community engagement, that allows for the development of accountability and trust between communities and governmental public health. In the current landscape, having these trusting relationships will help increase uptake of the public health interventions needed to slow the spread of disease, such as immunization. It is a long-term strategy that includes rebuilding foundational



structures for immunization across Oregon to better meet community needs. As this co-creation process moves forward Oregon's COVID-19 vaccination plan will change to better meet the needs of people in Oregon and begin to address longstanding health inequities.

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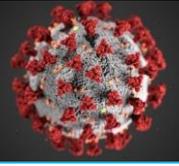
Section 1: COVID-9 Vaccination Preparedness Planning

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

Following the H1N1 pandemic, the Oregon Health Authority Public Health Division performed a thorough after-action report (AAR) of the statewide response including vaccine rollout. As part of early COVID-19 vaccine planning, Public Health Division Immunization Program and Health Security, Preparedness and Response staff reviewed the H1N1 AAR to identify gaps that had not been addressed as part of routine program work since that event. During the after-action review of the 2009 H1N1 vaccination campaign, the following gaps were identified:

Due to varying resources, strategies and allocation methods at the county level, there was inconsistent implementation of the campaign and subsequent availability of vaccine throughout Oregon. This included significant differences in vaccination availability between urban and rural counties. This arose due to a lack of clarity of the role of counties and the role of the state, and differences in county level resources. The H1N1 AAR recommended the state immunization program revise program procedures to ensure prioritization, ordering, distribution, and oversight were included and clear resulting in a set of immunization preparedness Standard Operating Procedures (SOPs), used to guide pandemic vaccination preparedness planning efforts.

To address these issues, Oregon is building clear communication pathways to facilitate cooperative planning with counties, engage county partners to establish clear roles and responsibilities for counties and the state, and clarify allocation processes to ensure consistent COVID-19 vaccine usage throughout the state. Since H1N1, provider vaccine ordering has been moved into the OR ALERT IIS, the state immunization registry, which will simplify the allocation methodology and allow OHA to allocate vaccine doses directly to vaccinating providers.



In addition to county and state coordination, there were specific populations identified in the H1N1 after action reports as having inadequate access to vaccination services, including:

- Individuals experiencing homelessness
- Homebound individuals and individuals unable to go to a medical home or pharmacy for vaccination, such as people living with intellectual, developmental, and other disabilities, adults in some congregate living settings and adult foster care

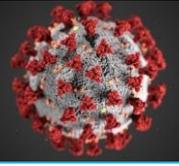
Though not explicitly identified in H1N1 after action reports, Oregon has identified additional gaps that are likely to emerge during COVID-19 vaccination implementation due to existing health inequities throughout Oregon:

- Long term and community-based care facility (LTCF) residents, who have experienced disparities in mortality due to COVID-19
- LTCF employees who have had historical disparities in vaccination when compared to other healthcare providers

Additionally, populations disproportionately impacted by COVID-19 and with historic disparities in vaccination rates, including seasonal influenza, will need specific interventions to ensure access to COVID-19 vaccine in culturally appropriate settings.

These populations include, but are not limited to:

- Black and African American communities
- Latino, Latina and Latinx populations
- Migrant and seasonal farm workers and other agricultural and food processing workers



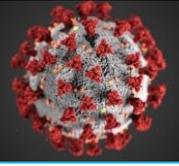
Significant gaps persist in the collection of data and reporting on the impact to people living with intellectual, developmental and other disabilities and others facing systemic barriers to access to care.

To address these critical access issues that may impact COVID-19 vaccine distribution, Oregon is developing a supplementary system for vaccine administration that will use statewide Emergency Medical Services (EMS) partners to provide vaccination in coordination with community-based organizations, local public health authorities, Tribes, homeless shelters, agricultural partners, agencies serving priority populations and other key strategic partners to address the needs of communities without adequate access through the traditional medical system. These partnerships are under development and will be deployed during this year's flu season and will continue throughout the COVID-19 vaccine implementation.

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

Oregon is using the distribution of seasonal influenza vaccine to pilot the components of this plan, including extensive closed points of dispensing (POD) events with the at risk populations outlined above as well as transitioning to open POD events with community-based organizations serving communities disproportionately impacted by COVID-19. This will allow the planning team to identify gaps in vaccination plans, key partnerships, and opportunities for improvement in advance of COVID-19 vaccine distribution. By early 2021, the Public Health Division plans to host 100-200 closed POD and community vaccination events, and administer 10-20,000 doses of seasonal influenza vaccine through the following mechanisms:

Contracts are currently under development with statewide EMS agencies, with 1 pilot already in place, to improve vaccine administration access for communities without access to a healthcare provider. Due to the nature of both statewide and



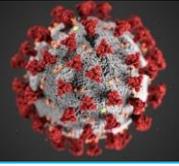
local EMS structure, this represents a scalable system for vaccine administration with broad availability in all geographic regions of the state.

EMS agencies will provide vaccination services in partnership with a network of LPHAs, Tribes and 170 Community Based Organizations (CBOs) currently contracted with the Oregon Health Authority to provide services related to the COVID-19 response. These services include education and outreach, contact tracing and case investigation, and the provision of wraparound services for individuals under isolation and quarantine. Using EMS vaccinators, Oregon plans to add flu season vaccination events to scheduled COVID-19 testing events.

Contracts are under development with the Oregon Department of Human Services, and its contracted nurses, to vaccinate home-bound populations and individuals in congregate care settings, like adult foster care, group homes and community-based care settings.

As this work progresses OHA will survey EMS agencies, community-based organizations, and community members to identify potential unmet needs and areas for improvement. In acknowledging the historical mistrust within some communities toward governmental public health authorities, OHA intends to work with community-based organizations to better understand the priorities of these groups. This will allow OHA to be responsive to concerns arising from community partners and will be incorporated into the continuous quality improvement process. Direct community feedback during flu season will be sought through the existing listening sessions facilitated by the COVID-19 Response and Recovery Unit.

In addition to the development and exercise of resources to administer immunizations, using flu season activities as a way to prepare for the COVID-19 vaccine implementation provides an opportunity to expand capacity to disseminate public health information to critical populations, build trust and partnership with communities, and lessen the burden on the health system by providing flu vaccine to communities most at risk for COVID-19.



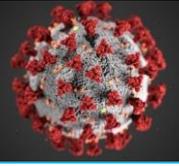
Section 2: COVID-19 Organizational Structure and Partner Involvement

A. Describe your organizational structure.

The Oregon Health Authority (OHA) regulates or administers many of the state's health care programs, such as those administered through the Public Health Division (PHD), as well as Oregon's Medicaid program, the Oregon Health Plan (OHP). The Oregon Immunization Program (OIP), part of the OHA Public Health Division's Center for Public Health Practice (CPHP), works to reduce the incidence of vaccine-preventable disease in Oregon. OIP works closely with local public health authorities and other CPHP Sections, including the Acute and Communicable Disease Prevention (ACDP) Section, which addresses infectious disease outbreak and response statewide, and the Health Security Preparedness and Response Program, which coordinates the all hazards emergency response for state public health.

The Oregon Immunization Program is responsible for facilitating the delivery of immunizations to Oregonians of all ages, increasing provider and community awareness around the importance of vaccines and improving immunization coverage by using an equity-based approach in working responsively and collaboratively to:

- Assure vaccine access to federal and state programs for all ages.
- Operate the OR ALERT Immunization Information System (IIS) to provide consolidated immunization records and high-quality immunization data for individuals and providers.
- Administer and monitor immunization requirements for schools and children's facilities.
- Deliver technical assistance, quality improvement strategies and other provider resources.
- Perform statewide surveillance, analysis, response and reporting of vaccine preventable disease.



Coronavirus Response and Recovery Unit (CRRU)

The COVID-19 Response and Recovery Unit (CRRU) is a temporary division combining the expertise of two state agencies – the health knowledge of the Oregon Health Authority (OHA) and the social service delivery of the Oregon Department of Human Services (ODHS) – to address and mitigate the impacts of the pandemic on Oregonians. Built on the foundational values of equity, coordination and shared resources, the CRRU shifted from the “incident command” structure that responded to the immediate crisis to a more sustainable model for 18-24 months, in September 2020.

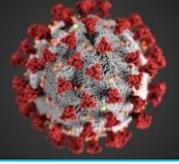
Health Security, Preparedness and Response Program (HSPR)

The Health Security, Preparedness and Response program (HSPR) is working in conjunction with the Vaccine Planning Unit by providing subject matter expertise in the areas of medical countermeasures, preparedness exercises, response, medical surge, and risk communications. For the purposes of COVID-19 vaccine implementation, HSPR is supporting the planning for points of dispensing (POD) and providing technical assistance, as appropriate. This team will work with contractors to coordinate all state-funded and state-directed vaccine PODs with community-based organizations (CBOs), Tribes and LPHAs. These PODs are intended to reach underserved populations and populations most affected by the COVID-19 pandemic in the fall of 2020 to provide influenza vaccine, with a goal of building additional infrastructure in preparation for the delivery of a COVID-19 vaccine.

Program Communications and Coordination with the Joint Information Center (JIC)/Health Information Center (HIC)

Oregon Immunization Program COVID-19 Communication

The Oregon Immunization Program, the Health Security Preparedness and Response program, and Acute and Communicable Disease Prevention programs comprise much of the Vaccine Planning Unit Functional Organization chart. The Communications Coordinator will develop and coordinate internal communications projects and support the development of vaccine program materials, ensuring those materials are culturally responsive and translated



appropriately in multiple languages. Specific roles within the communication structure are defined below.

The Risk Communication Analyst will serve as a liaison to the Agency Operations Center Joint Information Center (AOC-JIC), act as the risk communications subject matter expert, liaise with local public health authorities, CBOs and equity partners and will serve in a leadership capacity in the development of the communications strategy. Oregon Immunization Program educators will support the education of vaccine providers.

Agency Joint Information Center (AOC-JIC)

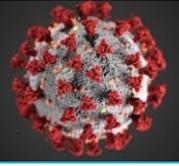
Throughout the response the AOC-JIC has been referred to as the Health Information Center (HIC). Key positions include the Communications Director, Lead Public Information Officer (PIO), Deputy PIO for Media Relations, Deputy PIO for Content Strategy, Deputy PIO for Equity Review, and Deputy PIO for Partnerships. This organizational structure will remain intact throughout the vaccine implementation period.

The role of the HIC will be to support the production of health and vaccine education materials, the distribution of those materials, and campaign project management. The HIC will take a leadership role in communicating and supporting the OHA leadership and Governor's policy decisions related to COVID-19 vaccine.

Community Engagement and Equity Team

The Oregon Health Authority recognizes the impact that longstanding health inequities, which are rooted in systemic racism and oppression, are having on the transmission and prevalence of COVID-19 in Oregon. We also recognize that partnering with community-based organizations is key to preventing and mitigating COVID-19 in communities that are most impacted.

A team assembled within the Public Health Division has provided grant funding to over 170 community-based and faith-based organizations. These grant funds are

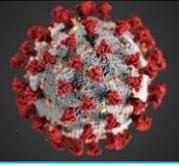


directed to communities that include but are not limited to: people of color, people living with intellectual, developmental and other disabilities, people who are houseless, individuals with substance use disorder, immigrant and refugee communities, faith communities, undocumented communities and farm workers, people experiencing mental health issues, older adults and LGBTQIA+ communities. A team of public health professionals works with each organization to build relationships across diverse community settings in Oregon. This team provides technical assistance to organizations as they perform contact tracing, wrap around support for people in isolation and quarantine, and outreach and engagement.

A core component of this work relates to relationship building between OHA, LPHAs and CBOs to prevent the spread of COVID-19. Communication venues include individual relationship building conversations with OHA staff, regional webinar conversations with other CBOs and LPHAs, topic specific technical assistance conversations and collaboration based on topic area or community served. CBO feedback is amplified to leaders within OHA and the state government to help guide prioritization and decision making. This team coordinates closely with the CRRU.

B. Describe how your jurisdiction will plan for, develop, and assemble an internal COVID-19 Vaccination Program planning and coordination team that includes persons with a wide array of expertise as well as backup representatives to ensure coverage.

The OIP Vaccine Planning Unit has been formed to coordinate the planning and implementation of COVID-19 vaccine distribution in Oregon. Key functions of vaccine planning and implementation were identified, and a diverse group of subject matter experts recruited to lead the work. Members of the OHA COVID-19 Vaccine Planning Unit come from across the state, representing the Oregon Immunization Program, the Health Security, Preparedness and Response program, other OHA units, sections and teams, as well as other state agencies, as described in part A above.



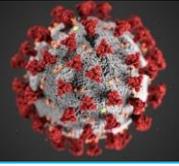
C. Describe how your jurisdiction will plan for, develop, and assemble a broader committee of key internal leaders and external partners to assist with implementing the program, reaching critical populations, and developing crisis and risk communication messaging.

The process for assembling the committee will be informed by the desired outcome – trust and partnership. Building on the foundation of existing work and investments while also acknowledging that this process represents a major opportunity to embark on a coordinated approach to continuous community engagement that can continue beyond the scope of the pandemic response. COVID-19 vaccine planning provides the urgency and impetus to ensure this development is a priority.

Several OHA programs and divisions have extensive experience engaging with communities and building partnerships: the Office of Equity and Inclusion, Community Partner Outreach Program, and sections within the Public Health Division are among them, as described in more detail in Section 4. The COVID-19 Vaccine Advisory Committee formation will draw upon the practices, expertise and relationships these units have developed.

As noted in the Introduction, meaningful community engagement involves co-creation and sharing of power. OHA will enter this work with communities from a position of expertise but without a predetermined outcome. The committee will be asked to engage in the planning and development process, not simply asked to approve materials they have not been closely involved in creating.

The COVID-19 Vaccine Advisory Committee will include participants from communities historically overlooked in creating health policy and communities disproportionately affected by COVID-19 in addition to representatives from health care organizations, provider associations and other key partners. Key internal leaders will be engaged throughout and will provide essential guidance for all committee activities, including developing messaging around these efforts.

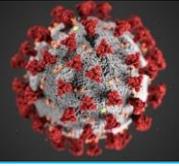


OHA is engaging with communities throughout the pandemic, but there continues to be room for improvement. These efforts are discussed further in Section 4. They are mentioned here to emphasize the existing partnerships and platforms that will inform the committee development:

- Regional Health Equity Coalitions (OHA Equity and Inclusion Division)
- Health Equity grants program (OHA Equity and Inclusion Division)
- Health Equity Committee of the Oregon Health Policy Board (OHA Equity and Inclusion Division)
- COVID-19 grants to community-based organizations (OHA Public Health Division)
- Protecting Oregon Farmworkers grants program (OHA External Relations Division)
- Community Partner Outreach Program (OHA External Relations Division)
- COVID-19 informational webinars and regional listening sessions (CRRU)
- Tribal Consultation (OHA Tribal Affairs)

OHA has the opportunity to address several known gaps in developing this committee. The agency has a strong desire but limited experience in assembling advisory groups that prioritize community voices for co-creation (the Cover All Kids Steering Committee development is one example). Prior to the pandemic, OHA did not have a robust, coordinated, agency-wide effort to engage communities. Individual programs and projects utilize their own community engagement strategies, but the lack of agency-wide, ongoing engagement work is a barrier to quick action for this committee development. This work presents an opportunity to develop processes and structures that can be replicated for future community partnership work.

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



The expertise of internal team members is described below. The membership of the COVID-19 Vaccine Advisory Committee has yet to be finalized.

Communications Analyst:

Serves as the Risk Communications Analyst for the Oregon Health Authority and an emergency Public Information Officer. Subject matter expert in crisis and emergency risk communication. Prepares and coordinates the release of risk communication in collaboration with partners and the Oregon Health Authority External Relations division.

- Team Lead for Playbook Section: Vaccination Program Communication
- Playbook Writing Team: Preparedness Planning, Organizational Structure and Partner Involvement, Phased Approach to COVID-19 Vaccination, Vaccination Program Communication, Vaccination Program Monitoring

Compliance Specialist:

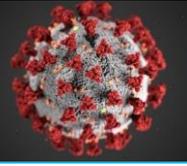
Provides CDC-required compliance site visits, and unannounced vaccine storage and handling site visits.

- Team Lead for Playbook Sections: Vaccine Storage and Handling

Senior Health Advisor:

Trained in internal medicine, then completed a fellowship in infectious diseases. Holds adjunct clinical faculty positions within Oregon Health Sciences University's Department of Public Health and Preventive Medicine and Division of Infectious Diseases. Serves as the Medical Director for Oregon's Immunization Program and served on CDC's Advisory Committee on Immunization Practices during 1997–2011.

- Team Lead: Oregon COVID-19 Vaccine Planning Unit Senior Health Advisor Adverse Event Monitoring
- Playbook Writing Team: Regulatory Considerations for COVID-19 Vaccination, Vaccine Safety Monitoring



Training Coordinator:

Delivers provider training for implementing appropriate vaccine management to improve vaccine accountability and minimize vaccine loss, assisting in the development and implementation of Vaccines for Children (VFC) related policies and procedures. This position leads annual onboarding and recertification process.

- Lead: Oregon COVID-19 Vaccine Planning Unit CARES Flu and VFC Support Grant
- Team Member: Oregon COVID-19 Vaccine Planning Unit Epi and Data
- Team Lead for Playbook Sections: Provider Recruitment and Enrollment, Vaccine Allocation, Ordering, Distribution, and Inventory Management, Vaccination Second-Dose Reminders
- Playbook Writing Team: Organizational Structure and Partner Involvement, Phased Approach to COVID-19 Vaccination, Vaccination Program Monitoring

Health Equity Analyst:

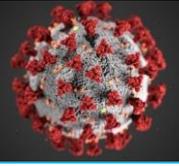
Serves as the Health Equity Planner in the Oregon Health Authority's Health Security, Preparedness and Response program. Identifies, plans for and mitigates the disproportionate effects of disasters and public health emergencies. Co-facilitator of the Disability Emergency Management Advisory Council of Oregon.

- Team Lead: Oregon COVID-19 Vaccine Planning Unit Community Engagement
- Team Lead for Playbook Sections: Organizational Structure and Partner Involvement, Critical Populations

Contract Administrator:

Manages all contracts between the ALERT IIS vendor and the all the required offices within the State of Oregon. Coordinates the ALERT IIS change management team.

- Playbook Writing Team: Requirements for IIS or Other External Systems



Education and Training:

Responsible for education and training of immunization providers and the general public, and leads the IQIP team with planning, best practices, and evaluation.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Community Engagement
- Playbook Writing Team: Phased Approach to COVID-19 Vaccination, Critical Populations, Provider Recruitment and Enrollment

Logistics and Medical Countermeasures:

Subject matter expert on medical counter measures. Acting as lead for point of dispensing (POD) planning, training, and EMS contract team coordination.

- Lead: Oregon COVID-19 Vaccine Planning Unit POD Operations
- Team Lead for Playbook Sections: Vaccine Administration Capacity
- Playbook Writing Team: Preparedness Planning, Organizational Structure and Partner Involvement, Phased Approach to COVID-19 Vaccination, Vaccine Allocation, Ordering, Distribution, and Inventory Management

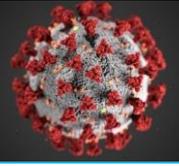
ALERT IIS Program Analyst:

Participates in the ALERT IIS Statewide Recall Project. Interprets laws, rules, policies and procedures and applies interpretations to administer the recall project and assist end users in their use of Reminder/Recall; coordinates the production of provider training materials, and customer service user guides.

- Team Member: Oregon COVID-19 Vaccine Planning Unit CARES Flu and VFC Support Grant
- Playbook Writing Team: Vaccination Second-Dose Reminders

Policy Analyst:

Operations and Policy Analyst with Health Security, Preparedness, and Response Program (HSPR). Has over 19 years of experience in public health with majority of the work being in public health emergency preparedness, Cities Readiness



Initiative and epidemiology. Currently serving as a planner for HSPR for COVID-19 response and vaccine dispensing.

- Team Member: Oregon COVID-19 Vaccine Planning Unit POD Management
- Playbook Writing Team: Preparedness Planning, Organizational Structure and Partner Involvement

Onboarding Coordinator:

Provides administrative coordination for the onboarding and maintenance of data exchange between IIS and external partners.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Provider Onboarding & Training

Education and Training Lead:

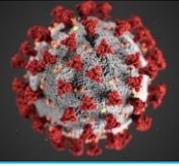
Shares responsibility for education and training of immunization providers and the general public; co-leads the program Education and Training Workgroup; and serves as a subject matter expert for E-learning development.

- Lead: Oregon COVID-19 Vaccine Planning Unit Provider Onboarding & Training
- Team Lead for Playbook Sections: Vaccine Storage and Handling
- Playbook Writing Team: Provider Recruitment and Enrollment

Vaccine Planning Unit Lead:

Supervises staff with oversight of vaccine preventable disease surveillance, program preparedness, outbreak response (including seasonal and pan-flu) and leads the program's communication efforts to raise awareness of immunization initiatives.

- Co-Lead: Oregon COVID-19 Vaccine Planning Unit
- Team Lead for Playbook Sections: Preparedness Planning, Organizational Structure and Partner Involvement, Phased Approach to COVID-19 Vaccination-Operational Planning, Vaccination Program Monitoring



- Playbook Writing Team: Partner Involvement and COVID-19 Advisory Committee

Epidemiologist:

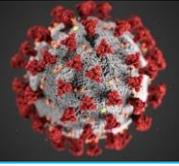
Subject matter expert on data presentation, reporting and visualization. Serves as a technical consultant to staff and partners on all aspects of immunization data and research; responsible for working with IIS and other data sources to identify and report on pockets of need and assist with the design and evaluation of interventions to address them.

- Lead: Oregon COVID-19 Vaccine Planning Unit Epi and Data
- Team Lead for Playbook Sections: Critical Populations, Vaccine Administration Capacity
- Playbook Writing Team: Phased Approach to COVID-19 Vaccination, Vaccine Allocation, Ordering, Distribution, and Inventory Management, Vaccination Program Monitoring

Vaccine Adverse Event Coordinator:

Plans, conducts, reports and presents on vaccine preventable disease (VPD) surveillance, aids local health departments during VPD outbreak investigations and responses, and coordinates VPD outbreak investigation and response when multiple health departments are involved; serves as the program Vaccine Adverse Event Reporting System coordinator.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Senior Health Advisor Adverse Event Monitoring
- Playbook Writing Team: Vaccine Safety Monitoring



ALERT IIS Training Coordinator:

Oversees ALERT IIS training and education activities, collaborates with internal and external partners to identify training and education needs, delivers in person and web-based trainings, and develops training materials.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Provider Onboarding & Training

Vaccine Operations Manager:

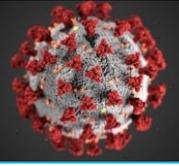
Directs the operations of service provision, vaccine ordering and distribution and manages intersections with Medicaid policy and vaccine manufacturers.

- Interim Program Manager, Oregon Immunization Program
- Team Lead for Playbook Sections: Vaccination Program Monitoring
- Playbook Writing Team: Preparedness Planning, Organizational Structure and Partner Involvement

Public Health Consultant

An independent public health consultant who specializes in immunization program and IIS support to state and local public health agencies. Has worked previously with the Oregon Immunization Program and other state groups to coordinate the planning, implementation, and reporting of large, complex projects, including billing for immunization services, public health modernization, and IIS migration. Has a history of relationships with key state and LPHA contacts and decision makers, often working to expand partnerships in order to achieve project goals.

- Team Member: Oregon COVID-19 Vaccine Planning Unit CARES Flu and VFC Support Grant
- Playbook Writing Team: Provider Recruitment and Enrollment



ALERT IIS Director:

Supports the pandemic and seasonal mass vaccination clinics and exercises through the use of immunization information systems and systems that report to the IIS for tracking influenza doses administered.

- Director, OR ALERT IIS
- Team Lead for Playbook Sections: Vaccine Administration Documentation and Reporting, Vaccination Second-Dose Reminders, Requirements for IISs or Other External Systems

Financial Administrator Coordinator:

Provides administrative coordination, including policy and fiscal coordination of all Billable Vaccine Project accounts, invoicing, and credit requests; CHIP, CAK and VPET processes; process improvement and technical provide administrative and fiscal support to vaccine purchase processes.

- Team Member: Oregon COVID-19 Vaccine Planning Unit

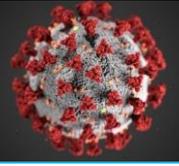
Vaccine Purchasing Manager:

Coordinates purchasing and delivery of vaccine for public/private providers; coordinates writing of all vaccine management policies and procedures.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Provider Onboarding & Training
- Team Lead for Playbook Sections: Vaccine Allocation, Ordering, Distribution, and Inventory Management

Community Engagement Coordinator

Community Engagement Coordinator representing the Public Health Division Community Engagement Team, partnering with over 170 Community Based Organizations across Oregon to provide community specific contact tracing, wrap



around support services and outreach and education efforts to slow the spread of COVID-19.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Community Engagement
- Playbook Writing Team: Critical Populations, Organizational Structure and Partner Involvement

ALERT IIS Policy Analyst:

Provides subject-matter expertise for data quality and improvement, organizational development and participates in the Assessment and Evaluation workgroup.

- Team Member: Oregon COVID-19 Vaccine Planning Unit
- Playbook Writing and Editing Team

Tribal Liaison and Policy Analyst

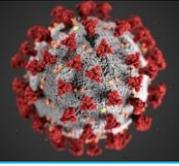
Operations and Policy Analyst with Health Security, Preparedness, and Response Program (HSPP) for fourteen years serving as the Tribal Liaison. Has over 17 years of experience in emergency management, public health preparedness and strategic national stockpile planning. Established the Oregon Tribal Preparedness Coalition several years ago to ensure all plans and needs of the tribes are met.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Community Engagement
- Playbook Writing Team: Organizational Structure and Partner Involvement

Public Health Associate:

Public Health Associate from the CDC public health associate program. She is applying her interests in vaccine planning and epidemiology by working with the Vaccine Planning Unit Epidemiology and Data Team.

- Playbook Writing and Editing Team



Public Health Liaison:

Works with Local Public Health Authority (LPHAs), tribes and other partner entities to assist with social media awareness campaign to provide information regarding vaccine to low-income populations.

- Team Member: Oregon COVID-19 Vaccine Planning Unit CARES Flu and VFC Support Grant

Senior Health Advisor:

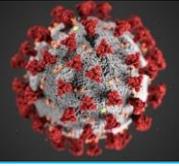
Senior Health Advisor and a general pediatrician with experience in primary care, urgent care, and wilderness medicine. She speaks fluent Spanish, French and English. Her commitment to equity and inclusion is grounded in an educational background in world history, culture and language.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Senior Health Advisor Adverse Event Monitoring
- Playbook Writing Team: Organizational Structure and Partner Involvement, Phased Approach to COVID-19 Vaccination, Vaccination Program Communication, Vaccine Safety Monitoring

Epidemiologist:

Compiles, monitors, and analyses surveillance data using epidemiologic methods to answer data and surveillance questions; develops flu monitoring systems and data tracking during flu season.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Epi and Data
- Playbook Writing Team: Critical Populations, Vaccine Administration Capacity, Vaccine Allocation, Ordering, Distribution, and Inventory Management



Fiscal Analyst:

Coordinates fiscal operations within the Immunization Section; provides oversight and technical assistance for the program's vaccine budgets; reconciling vaccine budgets with state fiscal systems, analyzing purchases and revenue, etc.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Fiscal and Contracts

CARES Flu Project Manager:

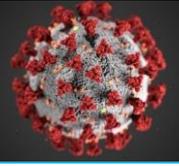
Responsible for planning, execution and evaluation of the 2020-21 Oregon CARES-Flu Prevention Project designed to prevent influenza disease during the time of COVID-19 in order to protect marginalized communities and to preserve the health care system.

- Team Member: Oregon COVID-19 Vaccine Planning Unit CARES Flu and VFC Support Grant

Senior Health Advisor:

Family physician with over 30 years of experience in outpatient and hospital medicine. He has had significant international public health experience in the areas of disease prevention, health education, tropical medicine and vaccination programming in emergency settings. His current interest and focus with the Oregon Health Authority is in vaccinology, public communication and equitable vaccine delivery.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Senior Health Advisor Adverse Event Monitoring
- Team Lead for Playbook Section: Phased Approach to COVID-19 Vaccination
- Playbook Writing Team: Regulatory Considerations for COVID-19 Vaccination, Vaccine Program Communication, Critical Populations, Organizational Structure and Partner Involvement



Clinical Decision Support Analyst:

Provides clinical decision support in ALERT IIS, develops and edits model standing orders and pharmacy protocols for use statewide. This position also provides technical support to clinicians around vaccine timing and administration.

- Team Member: Oregon COVID-19 Vaccine Planning Unit Senior Health Advisor Adverse Event Monitoring
- Team Lead for Playbook Sections: Vaccine Administration Documentation and Reporting, Regulatory Considerations for COVID-19 Vaccination, Vaccine Safety Monitoring
- Playbook Writing Team: Phased Approach to COVID-19 Vaccination

Vaccine Planning Unit Lead:

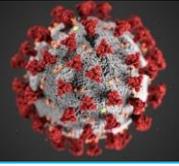
Deputy Program Manager and Senior CDC Public Health Advisor serving as program tribal liaison. This position has oversight of program assessment and evaluation activities, and leadership and coordination of program-wide initiatives to align partnership, and adult vaccination activities across teams.

- Co-Lead: Oregon COVID-19 Vaccine Planning Unit
- Team Lead for Playbook Sections: Preparedness Planning, Organizational Structure and Partner Involvement, Partner Involvement and COVID-19 Advisory Committee, Vaccination Program Monitoring
- Playbook Writing Team: Critical Populations

Data Quality Manager:

Lead for Meaningful Use efforts and is liaison to other MU efforts in the Division, contributes to IIS data quality and strategic planning.

- Playbook Writing Team: Vaccine Administration Documentation and Reporting



Public Health Administrator:

Center Administrator for OHA's Public Health Division Center for Public Health Practice.

Provides oversight for state programs in Immunizations, Communicable Diseases, Vital Records, Emergency Preparedness as well as the Oregon State Public Health Laboratory. From 2009-2015, was a manager in the Acute and Communicable Disease Prevention and Immunizations sections.

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

Home Rule

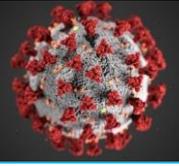
Home Rule is a legal framework that governs the delegation of state authorities to the county level. Through home rule, Oregon counties experience a significant amount of local discretionary authority. Two kinds of home rule apply to Oregon counties: constitutional and statutory. Constitutional home rule, through a 1958 amendment to the state constitution, allows voters in Oregon counties to adopt charters that govern the organization, powers and administration of county governments. Statutory home rule, with legislation adopted in 1973, delegates to counties the power to enact local legislation on matters of county concern.⁴

State and Local Public Health Coordination

The public health system in Oregon is a partnership between the Oregon Health Authority and local public health authorities. There are structures and processes in place to guide the coordination of public health efforts within counties and statewide. Coordination between state and local authorities to plan the allocation and distribution of the COVID-19 vaccine will follow these established processes.

Pre-COVID-19 efforts that support this coordination are described below:

⁴ Tollenaar and Associates. (2005, June). *County Home Rule in Oregon*. Oregon Health Authority. https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/CHRONIC/DISEASE/HPCDPCONNECTION/Documents/TA/policy_change_resources/county_home_rule_paper.pdf

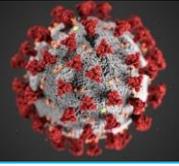


- OHA provides technical assistance to local public health authorities through the Office of the State Public Health Director.
- The Conference of Local Health Officials (CLHO), which includes all local public health administrators, works with OHA to provide recommendations to support a modernized, effective, coordinated and sustainable governmental public health system in the state through its committee structure.
- Financial assistance agreements between OHA and LPHAs and federally recognized Tribes describe the contractual requirements for LPHAs and federally recognized Tribes for the use of state and federal public health funding, which are negotiated with OHA through CLHO.
- OHA holds regular educational and collaborative calls with local and Tribal public health preparedness staff.
- OHA provides regular technical assistance and trainings for immunization and communicable disease data systems.
- OHA coordinates communications to local public health officials through the Office of the State Public Health Director.

COVID-19 Response Coordination

Since the start of the pandemic, the COVID-19 response has built upon these existing structures for coordination. Ongoing efforts to ensure COVID-specific state and local coordination include platforms to share information and collaborate for pandemic response, including:

- Weekly calls between OHA and local public health administrators to ensure opportunities for dialogue and problem-solving between local and state public health leadership, and to address time-sensitive issues
- Weekly calls between OHA and LPHAs and Tribes to provide situation updates to local and tribal leadership and staff, and to ensure local and tribal partners are connected to all aspects of the COVID-19 response
- Weekly calls between OHA and local health and medical Public Information Officers
- OHA participation in LPHA tabletop exercises



- OHA participation in weekly calls with city and county leaders and elected officials
- Weekly webinars with health equity partners
- Weekly webinars with advocates for Migrant and Seasonal Farmworkers (One in English and one is Spanish)

Oregon CARES Influenza Project

Moving beyond information sharing, OHA is leveraging preparations for the 2020 flu season to bolster state and local planning for the COVID-19 vaccine. The Oregon CARES Influenza Project focuses OHA's efforts on promoting immunizations for seasonal influenza, with particular focus on underserved communities and groups who have been hardest hit by COVID-19.

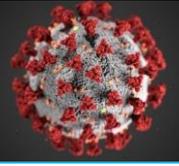
Protecting communities from influenza this fall and the coming winter will save many lives and serve to preserve the healthcare system for those who will become ill with COVID-19. Oregon has received financial support from the CDC and anticipates receiving up to 70,000 additional doses of influenza vaccine.

The project intends to focus influenza prevention efforts in communities most at risk of both influenza and COVID-19, reduce the potential impact of influenza and COVID-19 on the health care system, and prepare providers for receipt and administration of the COVID-19 vaccine.

LPHAs and Tribes will be funded directly to support this work using funding mechanisms that are similar to other public health programs. The funds can be used in many ways, including but not limited to staff, vaccine storage and handling equipment, contractors, education, infrastructure, clinic costs, and local collaborations.

Opportunities

As part of OHA's commitment to co-creation of the state's COVID-19 vaccine strategy, the agency will leverage these existing efforts to ensure that LPHAs can share their perspectives, priorities and lessons learned to inform the statewide



strategy. Gathering and incorporating this feedback will help ensure the support of local public health administrators and health officers that is essential to a successful implementation of this strategy. Regular, iterative opportunities for feedback are crucial to this strategy.

Known Gaps and Opportunities

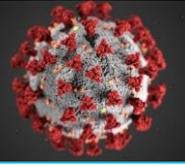
- There is limited capacity of many local public health officials to engage fully in collaborative discussions and planning with OHA as they remain dedicated to their local COVID-19 response, and should inform planning efforts
- The pre-pandemic regional infrastructure has expanded because of the COVID-19 response supports counties with fewer resources, and presents an opportunity to improve coordination across counties and with regional partners

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

OHA Tribal Consultation Policy

Oregon was the first state to pass a state-tribal government-to-government relations law. In 2001, Senate Bill 770 (SB 770) established a framework for communication between state agencies and tribes. Effective government-to-government communication increases our understanding of tribal and agency structures, policies, programs, and history. These state and tribe relations inform decision makers in both governments and provides an opportunity to work together on shared interests.

To establish and maintain a positive government-to-government relationship, communication and consultation must occur on an ongoing basis so that Tribes have an opportunity to provide meaningful and timely input on issues that may have a substantial direct effect on them. This work is conducted in accordance



with the OHA Tribal Consultation and Urban Indian Health Program Confer Policy.

The OHA Vaccine Planning Unit has submitted a Dear Tribal Leader Letter to Oregon's nine federally recognized Tribes and Urban Indian Health Program through the OHA Office of Tribal Affairs.

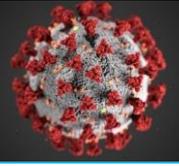
This letter introduced the Oregon COVID-19 Vaccine Planning effort and referenced the Immunization Preparedness MOUs established in 2019, acknowledged the tribes' right to choose between Indian Health Service or state vaccine distribution, requested that Tribal leaders recommend two participants to represent tribal interests on the OHA COVID-19 Vaccine Advisory Committee, and invited Tribal Leaders to a collective Nine Tribes Consultation/Urban Confer meeting to begin discussions around COVID-19 vaccine planning, tentatively scheduled for October 23, 2020.

Tribal preparedness infrastructure

The Health Security, Preparedness and Response program has an agreement with the nine federally recognized Tribes of Oregon, Program Element 31 (PE-31) and includes a Statement of Work describing the deliverables required each year. One of these deliverables includes updating and maintaining an emergency support plan for health and medical services, exercising plans and procedures and ensuring improvements through After-Action Reports (AAR) and Capability Improvement Plans (CIP). Per tribal consultation policy, all nine Oregon Tribes and Urban Indian Health Programs provide input into the state preparedness plan, participate in statewide preparedness exercises and attend weekly calls coordinated by the OHA Tribal Preparedness Liaison.

CARES Flu and COVID-19 Preparation funding

Funding was awarded to Oregon's nine Tribes and the Native American Rehabilitation Association of the Northwest, Inc. (NARA), and the Urban Indian Health Program. These funds were intended to enhance tribal planning, maintenance and enhancement of local and regional immunization infrastructure, communication and training. Tribes will provide education and immunization



services to communities at highest risk of comorbidity from influenza, pneumonia, and COVID-19.

Tribal Immunization Preparedness MOUs

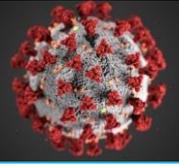
The immunization preparedness memorandums of understanding (MOUs) are voluntary agreements that define roles and responsibilities for signatories during emerging public health events, as well as provisions related to vaccine shortage and, distribution of a novel vaccine. The Oregon Tribes, the Oregon Health Authority, the Northwest Portland Area Indian Health Board (NPAIHB) and the Portland Area Indian Health Service are the defined signatories and 8 of 9 Tribes have established an immunization MOU.

This concept was presented to and approved by tribal leaders and was written in accord with Oregon Immunization Program (OIP) preparedness standard operating procedures (SOPs) so that procedures for IIS reporting, immune globulin (Ig) distribution and vaccine allocation align with existing program procedure, which specifically references the intent to take into account local data and honor communities understanding of their impacted populations.

Because the CDC is working directly with the Indian Health Service (IHS) at the federal level, Tribes will be able to choose to pursue COVID-19 vaccine distribution through the IHS or through OHA. The OHA Vaccine Planning Unit will honor the intent of the MOU when working with the nine Tribes as well as the Urban Indian Health Program and collaborate with MOU signatories to do so under any distribution model.

Updates to Tribes and tribal communities

- NPAIHB/OHA COVID-19 Check-in – bi-weekly meetings between OHA and the Northwest Portland Area Indian Health Board to discuss collaborations and emerging issues related to COVID-19 response
- LPHA and Tribes Calls – weekly calls with LPHA and Tribal Public Health Staff to provide COVID-19 response updates and to answer questions
- Tribal Preparedness Weekly Meetings



- OHA Tribal Monthly Meeting –meetings convened by OHA Tribal Affairs with the agenda set by the nine-federally recognized Tribes and the Urban Indian Health Program. As needed, tribal health directors and OHA staff may request time on the meeting agenda to discuss COVID-19 response issues including vaccine planning.

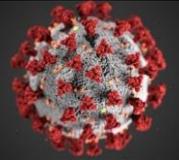
G. List key partners for critical populations that you plan to engage and briefly describe how you plan to engage them, including but not limited to:

Key Partnerships

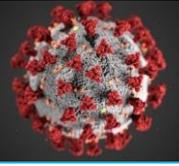
Because of the disproportionate effects of COVID-19, it is essential to identify critical populations to receive vaccine and to engage partners serving these populations to bolster the vaccine planning and distribution effort. Critical populations are described in more detail in Section 4 and referenced in the table below. Engagement strategies will focus on matching key partners with these populations and describe what will be the first step among many for creating lasting partnerships with these entities.

Partnerships and Engagement Strategies

Key Partner	Critical Population Served	Engagement Strategy
Pharmacies	All	Partnering with the Board of Pharmacy to engage pharmacists as COVID-19 vaccine providers and leveraging the public health Pharmacy MOU
Long term care facilities	Long term and community-based facility residents	Work with the CRRU’s Health and Human Services Branch and Interagency Facility Support Team to identify



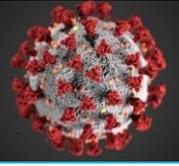
	People living and working in congregate settings	opportunities to leverage existing connection points
Adult foster care homes and group homes	People with intellectual, developmental and other disabilities living in smaller residential homes and larger group homes.	Partner with staff from ODHS's Office of Developmental Disabilities Services and Aging and People with Disabilities program.
Emergency medical service (EMS) agencies	All	Use contracts for CARES flu project work; partner with OHA's EMS and Trauma Systems staff to understand preferred forum for discussion and decision making
Home visiting nurses, home health aides, home care and personal support workers, and other in-home health care and disability support staff	People with chronic conditions People 65 years of age or older People living with intellectual, developmental and physical disabilities	Partner with staff from OHA's Maternal and Child Health and Healthcare Regulation and Quality Improvement sections, and with ODHS's Aging and People with Disabilities program and Office of Developmental Disabilities Services to delineate existing relationships and identify gaps and opportunities for engagement of this workforce
Correctional facilities/vendors	People who are incarcerated	Work with the Oregon Department of Corrections and Oregon



	People living and working in congregate settings	Youth Authority, building on previous work by OHA and ODHS on the reach-in process and isolation and quarantine support
Homeless service providers	People experiencing homelessness People who are under- or uninsured	Work with the Oregon Homelessness Task Force and Oregon Housing and Community Services to tap into existing meetings with providers
Community-based and faith-based organizations	All	Please see Section 4 for a detailed description of current and planned work with community- and faith-based organizations
Employers of essential workers	Essential workers	Work with the Titan Fusion Center and their vetted list of Critical Infrastructure organizations, detailed in Section 4

Known Gaps and Opportunities

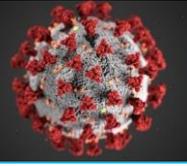
- The key partners listed here represent tremendous diversity, both in the populations they work with and in their organizational structure and capacity. Strategies to engage them will need to be tailored to meet each partner’s situation. The essential first step in engaging these partners is meeting with agency staff who hold these relationships to determine the best way forward for each subset of the list.
- This work presents an opportunity to connect with the Titan Fusion Center’s pre-vetted list of Critical Workforce organizations, and to engage with



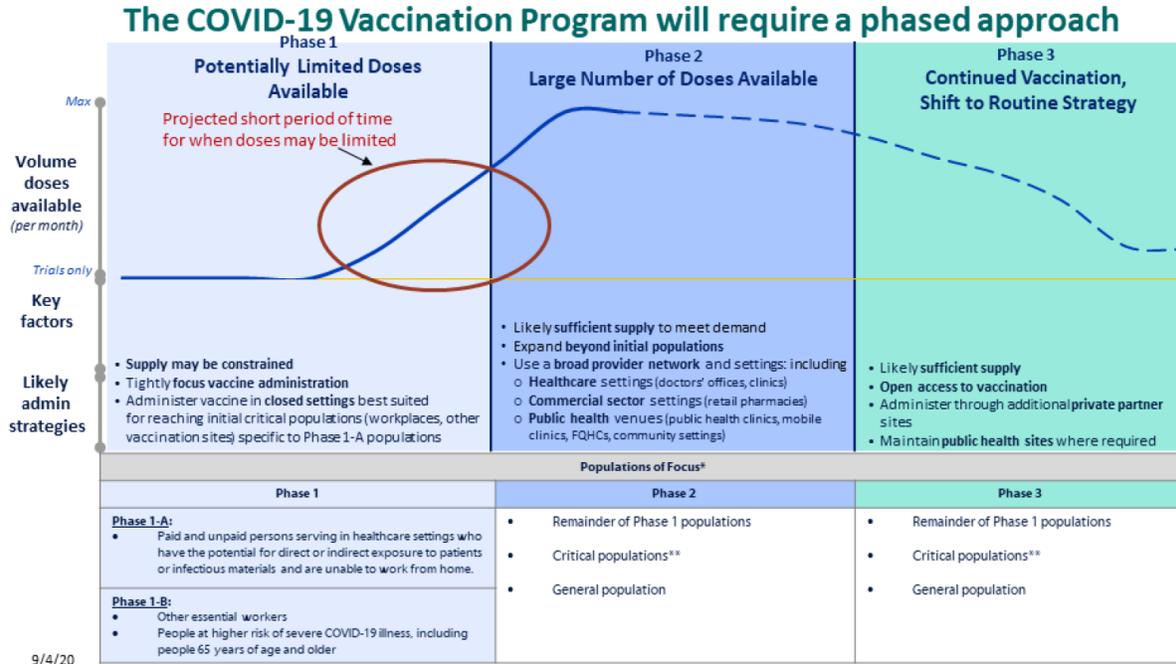
communities around other types of essential workers not traditionally considered critical workforce.

- Closer coordination is needed with ODHS programs to understand the workforce serving older adults and people living with intellectual, developmental, and other disabilities living in the community.

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Section 3: Phased Approach to COVID-19 Vaccination



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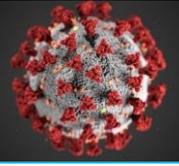
*Planning should consider that there may be initial age restrictions for vaccine products.

**See Section 4: Critical Populations for information on Phase 1 subset and other critical population groups.

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

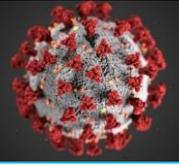
Prior to implementation of Phase 1:

- The OHA COVID-19 Vaccine Advisory Committee will be partially comprised of and work with our community partners to develop the process for identifying gaps in the current delivery system, develop strategies for resolving them, and inform an equitable, ethical vaccine prioritization and delivery program in concert with Advisory



Committee on Immunization Practices (ACIP) guidelines for population prioritization.

- The program will analyze data from CDC-provided survey of health care providers to assess provider capacity, including:
 - Those that can maintain an ultracold chain and serve as regional hubs for vaccine storage
 - More traditional vaccine providers (physician offices, pharmacies, Federally Qualified Health Clinics, etc.) that can handle frozen vaccine at -20°C
 - Nontraditional vaccine providers with contracted medical assistance (such as community-based organizations with EMS support)
- Plan for the delivery of ultracold vaccine via mobile, off-site units that may extend into Phase 2. This may include:
 - Identify additional resources needed for EMS delivery of vaccine into Phase 2 if only the ultracold vaccine is available.
 - Identify providers of ancillary supplies such as dry ice to establish cost and delivery options.
- Develop pricing agreements or contracts to provide dry ice for providers who do not have ultracold capacity.
- Prepare a communication plan and strategy to address serious vaccine-associated adverse events that may be identified after the vaccination program has started.
- Participate in ongoing ACIP discussions and recommendations regarding vaccine safety, efficacy in targeted groups (e.g., persons ≥ 65 years of age) and prioritized groups for vaccination.
- Identify and estimate the volume of each critical population for Phase 1 vaccination in Oregon: health care personnel likely to be exposed to or treat people with COVID-19, people at increased risk for severe illness from COVID-19 (LTCF residents, persons >65 years of age,

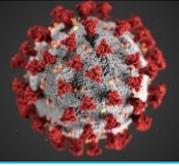


those with underlying medical conditions; see Section 4) and other essential workers.

Phase 1: Potentially Limited Doses Available

Oregon's focus on Phase 1 will be to build vaccination capacity through closed PODs with EMS vaccinators and healthcare and essential worker occupational health vaccination clinics. This will allow Oregon to build upon our work that has already begun with flu season, our healthcare partnerships, essential worker employers, and community-based organizations to reach critical populations and communities disproportionately affected by COVID-19 throughout Oregon.

- Recruit and enroll vaccine providers employed by external partners (hospitals, large clinics, EMS, occupational health serving essential workers) likely to deliver the first available doses of vaccine.
- Identify community-based organizations serving groups in phase 1 vaccination implementation that can host vaccination events in partnership with EMS vaccinators.
- Develop a vaccine transport plan if redistribution is needed, including transportation, storage, security need and delivery of the vaccine.
- Work with communication team and community-based organizations to develop and disseminate culturally responsive and linguistically appropriate information to individuals within the critical populations and inform them of how to acquire the vaccine.
- Ensure that all vaccination providers are aware of cold chain requirements and know the time limitations of the vaccine once thawed.
- Identify and employ facilities with relevant cold-chain capability as regional depots for vaccine storage to ensure delivery to remote Oregon locations and critical populations.
- Use EMS to transport vaccine and to vaccinate in closed point-of-dispensing (POD) and satellite locations.



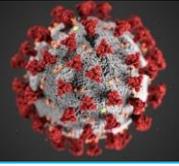
- Ensure that all COVID-19 vaccine providers are enrolled in and trained on Oregon’s ALERT Immunization Information System (IIS).
- Consider enrollment in VAMS if consumer access to records and clinic scheduling modules are needed.

Phase 1B: Potentially limited supply of COVID-19 vaccine doses available AND long-term care residents recommended to receive vaccine.

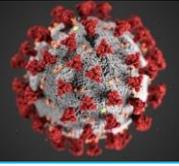
Pharmacy Partnership for Long-term Care (LTC) Program:

Oregon plans to participate in the pharmacy partnership for Long-term Care Program coordinated by CDC.

- Partner through CDC’s Pharmacy Partnership for LTC Program for COVID-19 Vaccine to provide on-site vaccine clinics for residents of long-term care facilities (LTCFs) and any remaining LTCF staff who were not vaccinated in Phase 1-A. The Pharmacy Partnership for Long-term Care Program provides end-to-end management of the COVID-19 vaccination process, including close coordination with jurisdictions, cold chain management, on-site vaccinations, and fulfillment of reporting requirements. The program will facilitate safe and effective vaccination of this prioritized patient population, while reducing burden on facilities and jurisdictional health departments.
 - This program is free of charge to facilities. The pharmacy will:
 - Schedule and coordinate on-site clinic date(s) directly with each facility. Three visits over approximately two months are likely to be needed to administer both doses of vaccine and vaccinate any new residents and staff.
 - Order vaccines and associated supplies (e.g., syringes, needles, personal protective equipment).
 - Ensure cold chain management for vaccine.
 - Provide on-site administration of vaccine.
 - Report required vaccination data (approximately 20 data fields) to the local, state/territorial, and federal jurisdictions within 24 hours of administering each dose.



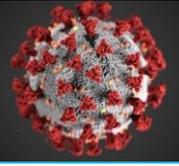
- Adhere to all applicable CMS requirements for COVID-19 testing for LTCF staff.
- If interested in participating, each facility should sign up and indicate their preferred partner from the available pharmacies.
 - Skilled nursing facilities and assisted living facilities will indicate which pharmacy partner (one of two large retail pharmacies or existing LTC pharmacy) their facility prefers to have on-site (or opt out of the services) between October 19–October 30.
 - SNFs will make their selection through NHSN beginning October 19.
 - An “alert” will be incorporated into the NHSN LTCF COVID-19 module to guide users to the form.
 - ALFs will make their selection via online REDCap sign-up form.
 - The online sign-up information will be distributed through ALF and SNF partner communication channels (email, social media, web).
 - After November 1, 2020, no changes can be made via the online forms, and the facility will have to coordinate directly with the selected pharmacy provider to make any changes in requested vaccination supply and services.
 - Indicating interest in participating is non-binding and facilities may change their selection (opt-out) if needed.
 - CDC will communicate preferences to the pharmacy partners and will attempt to honor facility preferences but may reassign facilities depending on vaccine availability and distribution considerations, and to minimize vaccine wastage.
- CDC expects the Pharmacy Partnership for Long-term Care Program services to continue on-site at participating facilities for approximately two months.



- After the initial phase of vaccinations, the facility can choose to continue working with the pharmacy that provided its initial on-site clinics or can choose to work with a pharmacy provider of its choice.

Scenario 1: FDA has authorized vaccine A for Emergency Use Authorization (EUA) in 2020 (requires ultracold [-70°C] storage; for large sites only)

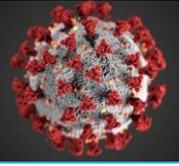
- Inform federal partners of Oregon sites with capability for storing vaccine at -70°C, as identified in the survey cited above. Oregon is currently exploring a regional hub model for smaller clinics unable to administer small volumes of vaccine if the need arises.
 - Manufacturer will ship vaccine at -70°C directly to sites.
 - CDC centralized distributor will ship diluent and ancillary supply kits at room temperature directly to sites.
- Develop plan for allocation given minimal order will be 1000 doses, and distribution of smaller numbers of doses to critical populations, including in remote Oregon locations, while maintaining the ultracold chain and avoiding wastage.
 - Healthcare personnel: closed points of dispensing in hospitals and larger clinics, and local public health departments; mobile vaccination clinics to LTCFs and remote Oregon areas
 - Other essential workers: local public health departments, temporary off-site vaccination clinics, mobile vaccination clinics in remote Oregon areas
 - People at higher risk of severe COVID-19 illness: mobile clinics to LTCFs and remote Oregon areas; closed points of dispensing in hospitals, clinics, local public health departments; outbreak prone locations (Adults in Custody, large food processing plants)
 - Work with community-based and faith-based organizations and community engagement team to identify gaps in access, address historical mistrust and innovative solutions to bring vaccine to communities
- Develop planning tool for expected number of vaccines at each site, ensuring provider awareness of vaccine limitation, including:



- Ultra-cold storage and handling plan consistent with CDC and manufacturer guidance
- Where possible use scheduled appointments at vaccination sites to minimize vaccine wastage
- For providers without an ultracold freezer, have contract and supply of dry ice (ideally pellets) on hand. Inform providers to replenish dry ice within 24 hours from receipt of vaccines from manufacturer and every 5 days.
- Ensure adequate supplies including gloves for ultra-cold storage and handling for each vaccination site.
- Consider security implications for each vaccination site.
- Ensure that vaccine recall system in place to administer dose 2 at 21 days and that client is given EUA fact sheet (or VIS), immunization card with the specific vaccine information and follow-up time and place for booster.
 - For those in Phase 1A who cannot easily come to a medical center to get their vaccine, arrange for mobile sites or drive-through vaccination clinics to be staffed by EMS or other teams.

Scenario 2: FDA has authorized vaccine B for EUA in 2020 (requires storage at -20°C)

- Inform federal partners of Oregon's central distribution sites with capability for storing large amount of vaccine at -20°C and subsequent shipping to sites throughout Oregon.
 - Manufacturer will ship vaccine at -20°C directly to Oregon's central distribution site.
 - CDC centralized distributor ship ancillary supply kits at room temperature directly to sites.
- Develop plan for allocation and distribution of doses to smaller providers including in remote Oregon locations, while maintaining cold chain and avoiding wastage.
 - Healthcare personnel: healthcare clinics, healthcare occupational health clinics, local public health departments, closed points of



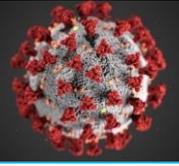
- dispensing, temporary off-site vaccination clinics, mobile vaccination clinics to LTCFs and remote Oregon areas
- Other essential workers: occupational health clinics, hospital clinics, local public health departments, temporary off-site vaccination clinics, mobile vaccination clinics in remote Oregon areas
- People at higher risk of severe COVID-19 illness: mobile clinics to LTCFs and remote Oregon areas; hospitals, medical clinics, local public health departments, pharmacies.
- Develop planning tool for expected number of vaccines at each site, ensuring provider awareness of vaccine limitation, including vaccine storage and handling.
- Ensure adequate supplies for each vaccination site.
- Consider security implications for each vaccination site.
- Ensure that vaccine recall system in place to administer dose 2 at 28 days and that client is given EUA fact sheet (or VIS), immunization card with the specific vaccine information and follow-up time and place for booster.
- For those in Phase 1A who cannot easily come to a medical center to get their vaccine, arrange for mobile sites or drive-through injection centers to be staffed by EMS or other teams.

Scenario 3: FDA has authorized vaccines A and B for EUA in 2020:

- Similar considerations as noted in # 1 and 2 above
- To maximize throughput, allocate vaccine based on
 - Availability of ultracold storage capabilities for vaccine A
 - Considerations of any Phase 3 trial data indicating differences in safety or effectiveness for different groups (e.g., if only one vaccine works for elderly patients or those with comorbidities, prioritize it for LTCF patients)

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

Oregon's focus during Phase 2 will be to employ strategies to maximize vaccine uptake among vulnerable populations through open PODs and community vaccination events in partnership with community-based organizations and clinics serving disproportionately affected communities. Additionally, we'll expand our provider network to reach much larger populations as vaccine supply allows.



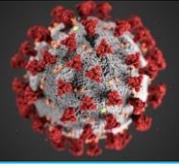
- Using ALERT IIS data and working with community groups identify phase 1 critical populations that have not been immunized during phase 1 for vaccination during Phase 2.
- If cold chain is the limiting factor (mRNA vaccine), and an alternative vaccine type is not available, employ POD-like distribution and EMS delivery of vaccine to rural and other underserved communities. May require additional resources.
- If cold chain is not limiting, begin to broaden provider networks to include as many pharmacies, medical clinics, and other private vaccinators as possible to increase vaccine uptake among critical populations.
- Targeting highly affected communities that have been incompletely vaccinated in Phase 1. Our initial goal in this phase will not be to chase outbreaks but rather to evaluate vaccine uptake in the highest-risk groups and focus on increasing coverage in these groups through our community-based partners and the communication team.

Federal Direct Allocation to Pharmacy Partners:

Oregon plans to participate in the federal direct allocation to pharmacy partner strategy coordinated by CDC.

- Vaccine will be allocated and distributed directly to select pharmacy partners from the federal government.
 - Direct allocation opportunities will be provided to retail chain pharmacies and networks of independent and community pharmacies⁵ (those with a minimum of 200 stores). All partners must sign a pharmacy provider agreement with the federal government.
 - Once the list of federal partners has been finalized, CDC will share the list with jurisdictions.
 - On a daily basis, pharmacy partners must report to CDC, the number of doses of COVID-19 vaccine a) ordered by store location; b) supply on hand in each store reported through Vaccine Finder, and c) number of doses of vaccine administered to individuals in each state, locality, and territory.

⁵Pharmacy services administrative organizations, or PSAOs



- Pharmacy providers will be required to report CDC-defined data elements related to vaccine administration daily (i.e., every 24 hours). CDC will provide information on these data elements and methods to report if stores are not able to directly provide data to jurisdiction IISs.
- All jurisdictions participating in this program will have visibility on number of doses distributed to and administered by each partner store.
- Jurisdictions will be given contact information for each partner participating in this program if they have any questions or concerns related to distribution of vaccine to stores in their jurisdiction.

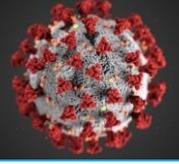
Phase 3: Likely Sufficient Supply, Slowing Demand

Oregon's focus for Phase 3 will be to ensure access to COVID-19 vaccine throughout the health system in primary care offices, retail pharmacies, and traditional routes of receiving preventive care and to ensure that all people in Oregon that have not yet received vaccine have access.

- Ensure broad access to COVID-19 vaccine in place where communities receive preventive care including medical homes and retail pharmacies.
- Continue focus on equitable vaccination access and delivery with close follow-up on vaccine uptake amongst highly affected communities
- Undertake additional vaccination efforts in communities with outbreaks
- Expand to non-traditional vaccine providers with medical support to provide in community vaccinations to all who are interested.

Known Gaps and Opportunities

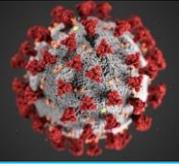
- Community-based organizations and the community engagement team will be asked to identify gaps in access, track and address matters of mistrust of the government system.
- People still face barriers to accessing health care and obtaining health coverage. Vaccination efforts may be coupled with Oregon Health Plan enrollment assistance, information about CAWEM and information on establishing care at an FQHC.
- Community-based organizations are a key connection point with disproportionately affected communities, but they have differing capacity to



host PODs. Some of the CBOs who hold contracts with OHA do not have a health focus. Adequate resources and staffing support should be provided to ensure they are able to serve in this capacity.

- Transportation is a known concern for people living with intellectual, developmental and other disabilities and those in rural Oregon. There is an opportunity to plan with LPHAs and ODHS programs for in-home vaccination services for those residents.

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Section 4: Critical Populations

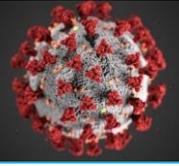
A. Describe how your jurisdiction plans to: 1) identify, 2) estimate numbers of, and 3) locate (e.g., via mapping) critical populations.

Critical population groups may include:

- *Healthcare personnel*
- *Other essential workers*
- *Long-term care facility residents (e.g., nursing home and assisted living facility residents)*
- *People with underlying medical conditions that are risk factors for severe COVID-19 illness*
- *People 65 years of age and older*
- *People from racial and ethnic minoritized groups*
- *People from tribal communities*
- *People who are incarcerated/detained in correctional facilities*
- *People experiencing homelessness/living in shelters*
- *People attending colleges/universities*
- *People living and working in other congregate settings*
- *People living in rural communities*
- *People with living with intellectual, developmental, and other disabilities*
- *People who are under- or uninsured*

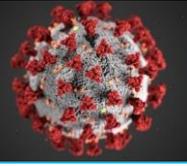
For the critical populations listed, the source of the population estimate is detailed in the table below or indicates "in progress" where data sources are still being identified.

There are two known limitations to the data collection process. One, there is significant overlap in critical population groups, which may overestimate the number of individuals and doses needed for population coverage. Additionally, the sources of information provide a point-in-time prevalence of the population, which

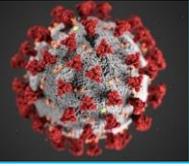


does not take into account seasonal fluctuation and may vary from the estimate at the time of vaccine deployment. Options for mapping population data (including Tiberius, Tableau and ArcGIS) are actively being explored in conjunction with mapping of CDC's Social Vulnerability Index (SVI) to identify overlap and potential areas of greatest need.

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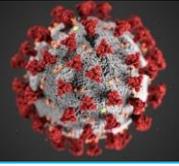


<i>Critical population</i>	<i>Methods for identification and estimation</i>
Health care personnel	These estimates come from two sources: (1) the Oregon Health Care Workforce Reporting Program, which was created to collaborate with health profession licensing boards to collect health care workforce data via the licensing renewal process, and provides detailed county-wide data; (2) county-wide estimates from the American Community Survey (ACS) Labor and Industry (occupational 5 year estimates), which provide estimates for hospital support staff in addition to care providers.
Other essential workers	Essential worker county-wide estimates are obtained from ACS Labor and Industry occupational estimates; Migrant seasonal farmworker estimates are obtained from Migrant and Seasonal Farmworker Enumeration Profiles Study Oregon through a collaborative effort between the Health Policy Analytics Division of Oregon Health Authority and Oregon State University; estimates for county-level childcare providers (emergency and non-emergency) as well as K-12 teacher data are obtained from the Oregon Department of Education, Early Learning Division.
Long-term care facility residents (e.g., nursing home and assisted living facility residents)	County-specific long-term care facility residents and staff estimates are obtained from two sources: the LTCF Testing Progress Report, which is a self-reported survey of 422 sites, and the LTCF Testing Plan from Aging and People with Disabilities (APD) Program of the Oregon Department of Human Services. Adult foster home data are obtained from statewide estimates, and methods for obtaining county-level data are in progress.

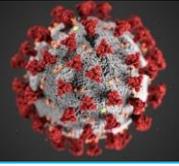


<p>People with underlying medical conditions that are risk factors for severe COVID-19 illness</p>	<p>Using the list of underlying medical conditions that are risk factors for severe COVID-19 illness, Oregon county-wide data are obtained from Health Promotion and Chronic Disease Prevention Section of the Oregon Health Authority. This information provides published estimates of chronic diseases and health risk and protective factors among Oregonians by county (2014-2017), and additional work is in progress to estimate the number of Oregonians impacted by other conditions included in list but not available through this dataset.</p>
<p>People 65 years of age and older</p>	<p>County-wide population estimates by age are obtained from Portland State University Population Research Center (updated July 2019).</p>
<p>People from racial and ethnic minoritized groups</p>	<p>Racial and ethnic county-specific population estimates for Oregon are obtained from the American Community Survey table B03002 (Hispanic or Latino origin by race, 2018 5-year estimates); however, due to concerns of undercounting of marginalized communities by surveys such as the ACS, work is in progress to identify alternative data sources (such as Oregon Vital Records office within the Oregon Health Authority).</p>
<p>People from tribal communities</p>	<p>To ensure that members of tribal communities have access to COVID-19 vaccination services, Oregon is taking a proactive approach to learning about the IHS Distribution planning process. Through outreach to the lead for the national IHS prioritization team, the Vaccine Planning Unit data team has engaged Oregon contacts participating in national IHS efforts to discuss prioritization and align methodologies for critical population estimation.</p>
<p>People who are incarcerated/detained in correctional facilities</p>	<p>Incarcerated and detained population estimates, including staff working in correctional facilities, are obtained from the Oregon Department of Corrections, Oregon Youth Authority and the Oregon State Hospital.</p>

OREGON COVID-19 VACCINATION PLAN



People experiencing homelessness/living in shelters	Work is in progress with Oregon Housing and Community Services (OHCS) to identify appropriate data sources, and include: county-wide estimates from the biannual Point in Time census of homelessness in Oregon, which occurs every 2 years in January (last estimate from January 2019); Homeless Management Information System, which is the data system that collects reporting from ID&P the US Department of Housing and Urban Development Continuum of Care grantees.
People attending colleges/universities	Requests for data have been submitted to the Higher Education Coordinating Commission to estimate college, university, and trade school students and staff by site.
People living and working in other congregate settings	Work is in progress to identify other population groups that are not already addressed and fall within this category.
People living in rural communities	The Oregon Health and Sciences University Office of Rural Health labels each ZIP code with a designation of urban, rural or frontier, and has identified 10 of Oregon's 36 counties as frontier; linking this data with population counts by county and/or ZIP code will allow for rural population estimation.
People living with intellectual, developmental, and other disabilities	The Oregon Department of Human Services Office of Developmental Disabilities Services and Aging and People with Disabilities program is working to provide county-specific estimates of individuals living with disabilities.
People who are under- or uninsured	County-wide estimates of un- and under-insured individuals are obtained from the 2019 Oregon Health Insurance Survey through data managed by Health Policy Analytics Division within the Oregon Health Authority.



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

Oregon will follow recommendations set forth by NAM, ACIP, CISA and associated equity frameworks for vaccine allocation to define critical infrastructure. Oregon will also review documents from the 2009 H1N1 flu pandemic vaccine planning and allocation for guidance. Critical infrastructure will be identified through collaboration with the Oregon Department of Justice TITAN Fusion Center, which maintains the official list of critical infrastructure and is typically used for natural disaster and counter-terrorism planning.

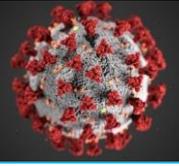
C. Describe how your jurisdiction will determine additional subset groups of critical populations if there is insufficient vaccine supply.

Anticipating the potential for limited vaccine supply at any point during phased allocation, detailed breakdowns of critical populations, to the extent available, will be obtained to define those subsets. For example, if childcare providers may be categorized between those deemed emergency care providers and those that are not; health care workers may be categorized by category of work, and college or university student enrollment may be stratified by online and in-person attendance.

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

OHA will establish points of contact (POCs) and communication methods for vaccine planning through existing relationships and programs in place through OHA, ODHS, and government relationships, as we learn from and collaborate with those serving critical populations. Any opportunities to participate in vaccine planning work will be shared with critical population partners through their existing, trusted agency relationships wherever possible. A Vaccine Planning Unit Critical Population POC inventory will be developed to identify current agency points of contact and determine where new relationships need to be prioritized.

The starting point for the POC inventory will be identifying existing relationships with key partners, external organizations, and other state agencies. Collaborative



relationships with critical populations will be developed through their respective OHA division, including the following:

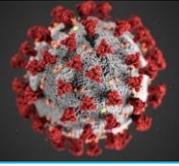
OHA Equity and Inclusion Division

Using CAREs Act Funds this division is administering \$45 million in COVID-19 Health Equity Grants to community organizations. These grants are intended to address the disproportionate impact the COVID-19 pandemic has had on Oregon's tribal communities and communities of color. Grants were awarded to 208 organizations and tribes serving critical populations to address health and economic disruptions, food insecurity and housing, and safety and violence prevention, among other aspects of need.

In addition, the division works closely with a broad range of community partners including Regional Health Equity Coalitions (RHECs). RHECs are autonomous, community-driven, cross-sector groups. The RHEC model works by building on the inherent strengths of local communities to meaningfully involve them in identifying sustainable, long-term, policy, system and environmental solutions to increase health equity for communities of color, and those living at the intersection of race/ethnicity and other marginalized identities. Meaningfully impacting health equity issues requires redistribution of resources, and in the context of the RHEC program, sustained, long-term efforts with dedicated fiscal investment is critical for success. The RHECs receive funding from several sources, but primary support comes from the OHA Equity and Inclusion Division budget. Engaging RHECs and other Equity and Inclusion Division partners such as Traditional Health Workers and Health Care Interpreters will be important to the development of an equity-focused vaccine plan.

OHA Public Health Division

Much of the Public Health Division's work intersects with organizations, employers and communities that work with critical populations. During the COVID-19 pandemic response, the division created a COVID-19 Community Engagement Team, as described in detail in Section 2 of this plan. This team works with community-based organizations that are



recipients of COVID-19 grants for outreach and education, wraparound support, and contact tracing.

The division also houses regulatory units within the Health Care Regulation and Quality Improvement program. These regulatory units have established POCs with different provider and facility types. The EMS and Trauma program will share essential connections with emergency medical services across the state, connecting especially in rural areas.

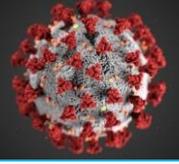
Additionally, as Oregon implements universal home visiting through its Maternal and Child Health program, home visiting nurses are an important link in the connection chain to critical populations. These staff sustain one-on-one connections with families and are seen as public health representatives within their communities. Working with established POCs in each county and LPHA will allow OHA to deepen this working relationship to the benefit of families and children, especially those who belong to disproportionately affected communities.

OHA External Relations Division

The Community Partner Outreach Program has been instrumental in collaborating with critical population-serving organizations throughout the pandemic. This program develops working relationships with community partners to enroll people who are eligible for the Oregon Health Plan, the state's Medicaid program. The ongoing work with these partners has created natural POCs for this work and communication channels that can be utilized for collaboration. This program has also administered COVID-19 grants to organizations serving migrant and seasonal farmworkers under the Protecting Oregon Farmworkers program; these grantees represent another group of contacts for vaccine planning in this critical population.

COVID-19 Response and Recovery Unit (CRRU)

As described above, the CRRU is the joint response division between OHA and the Oregon Department of Human Services (ODHS). It is the locus of

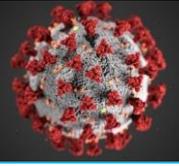


non-grant-driven efforts for community engagement. Groups working with critical populations that will be engaged in these efforts include strategic planning groups for migrant and seasonal farmworkers, Asian and Pacific Islanders, Latino/a/x, Black and African American, and Tribes, which will be facilitated through the information and feedback process developed with community partners. The staff also includes a Faith Community Liaison to work specifically with these key partners, recognizing that faith communities are the preferred source of trusted information for many of the critical populations.

Relationships with critical populations and programs through ODHS require more attention to identify and develop. ODHS holds essential connections to people living with disabilities, older adults, people with low income and others receiving services. Key partners to prioritize for developing POCs and feedback processes include the following:

- ODHS district offices
- ODDS Community Developmental Disabilities Programs (CDDPs) and Brokerages
- Relevant ODHS programs:
 - Aging and People with Disabilities, especially as related to Long Term and Community Based Facility licensing and regulation
 - Office of Developmental Disabilities Services
- Oregon Disabilities Commission
- State Independent Living Council
- Oregon Developmental Disabilities Council
- Area Agencies on Aging
- Long term care facilities, home health, and associations of home care workers and personal support workers

Serving critical populations also requires close collaboration with government partners. In some cases, OHA lacks well-established relationships with the critical populations themselves, but these connections can be mediated by our partners

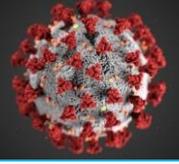


elsewhere in state and local government. OHA will rely on existing relationships and POCs for the following government partners to ensure full inclusion of critical populations in vaccine planning:

- Local public health authorities (as mentioned in Section 2)
- Tribal health authorities and the Northwest Portland Area Indian Health Board (as mentioned in Section 2)
- Oregon Department of Corrections and Oregon Youth Authority
- Oregon Department of Education and Higher Education Coordinating Commission
- Oregon Homeless Populations Task Force and Oregon Housing and Community Services

Through existing grant requirements, Local Public Health Authorities maintain a Public Health Emergency Preparedness and Response (PHEPR) coordinator in each county. This position serves as the primary point of contact for public health preparedness and response activities and, in coordination with their public health administrator and health officer, can assist the state in identifying other key contacts within the local health authority and community as needed.

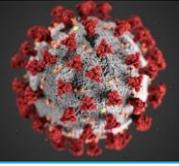
In addition to leveraging OHA's own community outreach and engagement efforts through the programs outlined above, Community Partnership Outreach Program, Community Engagement Coordinators and Faith Liaison, OHA will work with sister agencies who have established communications channels in communities. As described previously in this plan, the Oregon Department of Human Services is a key partner in outreach to long-term care facilities, group homes and foster care homes. Business Oregon and the Oregon Department of Agriculture have networks that reach employers, including employers of hard-to-reach populations and minority-owned businesses. Schools are trusted institutions in the communities they serve, making the Oregon Department of Education a key partner as vaccine distribution shifts from critical populations to the general population. Other state agency partners include the Oregon Department of Transportation, the Oregon Department of Energy and Oregon State Police. OHA has established working relationships with each of these agencies to facilitate information exchange and coordination. Coordination typically occurs through regular inter-agency Public



Information Officer calls, which will be re-established to facilitate vaccine communication.

Known Gaps and Opportunities

- Existing community engagement efforts may not be broadly visible within and across state agencies. This silo effect will make it harder to determine whether state agencies already have POCs within partner organizations. It raises the risk of duplicating efforts and of missing partners working with critical populations.
- The vaccine planning effort presents an opportunity to create internal processes that support open communication, coordination and collaboration within in and across agencies when it comes to working with critical population partners.
- Closer coordination between OHA and ODHS will support efforts to better understand the needs of workforce associated with critical populations, including home health, home care and personal service workers for older adults and people living with intellectual, developmental and other disabilities. These workers may themselves face challenges in obtaining health coverage and accessing culturally responsive and linguistically appropriate health information.



Section 5: COVID-19 Provider Recruitment and Enrollment

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

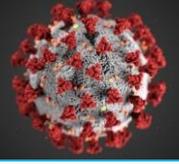
The Oregon Immunization Program is in the process of developing an online enrollment system that will capture the data defined in the CDC COVID-19 Provider Agreement forms. Providers will enroll with OR ALERT IIS first, then enroll to become a COVID-19 vaccine provider. Each application will be reviewed and prioritized for enrollment according to the provider's ability to reach target populations.

Oregon intends to partner with a variety of organizations to assist with recruitment:

- Leverage existing relationships with currently enrolled Vaccines for Children (VFC) and public access providers, including those within the Oregon Department of Corrections, to enroll providers to receive and administer the COVID-19 vaccine.
- Engage Local Public Health Authorities to assist in recruitment.
- Partner with the Oregon Association of Hospitals and Health Systems, the Academy of Family Physicians, community-based organizations who work with critical populations, the Coalition for Community Health Clinics and Oregon Primary Care Association to advise us on prioritizing enrollment.
- Partner with Coordinated Care Organizations (CCOs), which are contracted by OHA to provide health services for Medicaid members.

Messaging platforms for recruitment include:

- existing distribution channels such as the Oregon Vaccine Provider listserv, that reaches all currently enrolled vaccine providers and interested stakeholders such as pharmacies and industry associations



- OHA social media, with amplification through partners' social media accounts, such as local public health, CCOs and health systems
- the statewide media campaign will also serve as a recruitment tool.

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

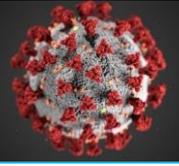
Data collected during COVID-19 provider enrollment will be used to identify provider types who can serve critical populations.

Enrollment priorities will be based on the planning scenarios provided in the COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations:

Scenario 1: Vaccine A is available first: Hospitals and occupational health with capacity to manage vaccine at ultra-cold temp (-80C for mRNA vaccines) and deliver 1000+ doses to serve health care workers, or are able to vaccinate health care workers from other facilities or are willing to serve as a hub and redistribute vaccine to other providers serving health care workers

Scenario 2: Vaccine B is available first: Vaccine would be distributed to large facilities such as hospitals, occupational health and health care systems in more populated areas; distributed to LPHAs as hubs (where necessary) or directly to providers in less densely populated areas; distributed to FQHCs and Tribes in both densely and less densely populated areas.

Scenario 3: Vaccine A and Vaccine B available at the same time: Facilities capable of managing ultra-cold vaccines without the need for major redistribution would receive ultra-cold vaccine according to Scenario 1 above. Other facilities included in both Scenario 1 and Scenario 2 would receive Regular Frozen or Refrigerated vaccine.



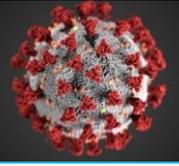
C. Describe how provider enrollment data will be collected and compiled to be reported electronically to CDC twice weekly, using a CDC-provided Comma Separated Values (CSV) or JavaScript (JSON) template via a SAMS-authenticated mechanism.

The online COVID-19 enrollment system will create an extract that meets the specification supplied by CDC for uploading provider enrollment data. Staff will log in to SAMS twice weekly to perform the upload.

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

As required by the CDC, OHA staff will verify provider licensure with the licensing boards, including medical, pharmacy, nursing, naturopath, veterinarian and dental. As required by the CDC, this validation process will occur at least twice weekly, prior to the provider enrollment file being uploaded to CDC via SAMS. Providers without valid licenses will be removed and notified. If a provider organization does not have at least one prescribing provider with a valid license, their enrollment will not be approved.

Additionally, staff will maintain current processes to respond to any notification of a provider with a staff member or subcontractor who has been excluded from participation in the Medicaid or Medicare program, using the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) database. Health care providers are required to screen prospective and current employees against the LEIE. Oregon providers on that list will be excluded from participation immediately.



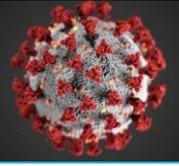
E. Describe how your jurisdiction will provide and track training for enrolled providers and list training topics.

Training will be provided through online tutorials that provide instruction on managing, storing and preparing vaccine, and will be updated to provide specific details related to the handling and administration of the COVID-19 vaccine provided by manufacturers and/or CDC. The CDC's online vaccination and education module, *You Call The Shots*, or the Oregon-specific education module will be required by all providers as part of the onboarding process. These platforms will track training progress and provide a certificate of completion that will be retained by each individual enrolled. By signing the COVID-19 provider agreement, provider organizations are attesting to the completion of required training. Provider trainings will be translated into alternate languages as gaps are identified.

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

Enrollment using the CDC Supplemental COVID-19 Vaccine Redistribution Agreement will identify providers who intend to redistribute vaccine. A compliance specialist will be assigned to work with each of these providers to develop and approve a plan for proper storage and handling. The CDC Supplemental COVID-19 Vaccine Redistribution Agreement does not require advance approval of planned redistribution once the provider is approved to enroll as a redistributor.

Through CARES funding, Oregon will provide transport coolers with phase-change material that will keep vaccine at 2-8C for three days with no power.



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

The distribution of enrolled providers will be compared to GIS maps of critical populations to identify regions that are underserved. We will enroll Federally Qualified Health Centers (FQHCs) and other safety net providers who serve low-income, marginalized populations to fill unmet needs. Additional access will be provided through statewide EMS contracts to do off-site vaccination clinics along with COVID-19 testing events, through partnership with CBOs, and to assist Local Public Health Authorities that have unmet resource needs. Additionally, OIP will use data from ALERT IIS to identify regions with low vaccination coverage and/or few enrolled providers and partner with social services, faith-based and other community organizations to reach individuals who have not been served.

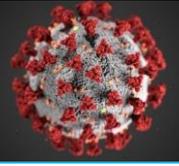
We will conduct culturally and linguistically appropriate media campaigns. Patient-focused materials will be translated into the languages used by our populations.

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

To develop COVID-19 vaccination infrastructure, the immunization program will utilize the CARES flu funding infrastructure and a longstanding partnership with the state Board of Pharmacy to reach out to pharmacy providers with guidance on enrolling to become a COVID-19 provider. To support the dissemination of COVID-19 vaccination planning and enrollment information, state pharmacy organizations and pharmacy schools will be engaged during this process.

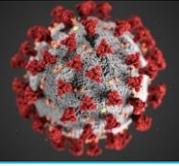
Known Gaps and Opportunities

- The role of naturopaths and complementary care providers can be more clearly defined. In Oregon, administering vaccinations is within the scope of



practice for naturopathic doctors (NDs). Enrolling them as providers may help expand vaccine access.

- Access to culturally and linguistically appropriate care is a known gap for many communities of color in Oregon. OHA can build out the process for ensuring enrollment of culturally and linguistically competent providers by working with LPHAs, community-based and faith-based organizations to better understand where these populations receive care and what support is needed to bolster access.
- In Oregon, adults living with intellectual, developmental, and other disabilities live in a variety of settings including small congregate settings with 3 or 4 residents, at home with elderly parents, in adult foster care homes or independently. OHA needs more information on the number of individuals in the various settings to identify the strategies most likely to result in the highest number of vaccinated at-risk people.



Section 6: COVID-19 Vaccine Administration Capacity

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

In 2019 and 2000, Oregon conducted a series of workshops on the CDC PAN VAX tool, which provided an estimation of overall vaccination capability in Oregon. The major take-away from the workshops was the untapped vaccination ability of pharmacies. Additional throughput estimation was conducted looking at peak flu season max weekly vaccination numbers (about 5% per week).

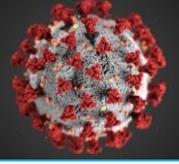
Through relationships with the Oregon Association of Hospitals and Health Systems, Oregon is requesting site-level information on storage capabilities, including the availability of Ultra-cold storage. From this data we expect to improve our understanding of the most appropriate locations to host vaccination events and locations for distribution hubs.

As providers are enrolled, they will be mapped to maintain awareness of regional and local capacity. Work is in progress to model the impact of different delivery methods on capacity, such as local versus regional immunization sites or drive-through immunization events.

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

Enrollment will focus on the following provider groups to administer vaccine: including pharmacies of all sizes to allow for statewide coverage, onboarding EMS-based agencies, some of which were contracted to administer H1N1 vaccines, and providers with recently expanded scope of practice to administer vaccines.

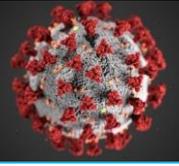
Oregon will use past flu season peak administration capacity data from ALERT IIS as well as current CARES flu vaccination planning, provider recruitment and vaccine administration to identify providers who are able to store and administer vaccine to the greatest number of individuals. Additionally, providers who are



enrolling in the CARES flu vaccination project are identifying the populations that they intend to serve who are most at risk for COVID-19. The information received from CARES flu providers will show where gaps remain in reaching critical populations.

Known Gaps and Opportunities

- Some populations will be harder to find and reach, such as people experiencing homelessness and some individuals living with disabilities. The strategies intended to maximize throughput will not necessarily benefit these groups. Alternate strategies will need to focus on delivery of vaccines to some populations in smaller, localized venues.



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

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

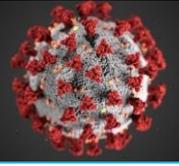
During provider enrollment using the CDC's COVID-19 Vaccination Program Provider Agreement, Oregon will collect data about each provider's ability to reach priority populations and map to Oregon's counties to ensure complete geographic coverage. For populations with transportation challenges, or who are not represented in provider reach data, contracted arrangements with ambulance and EMS services will provide immunizations locally.

Allocation will be performed based on population size, but the methodology will ensure that an equitable geographic distribution is also considered for each phase. Providers serving rural communities and Tribal communities, and providers with the ability to reach populations disproportionately impacted by COVID-19, will be prioritized for enrollment (see Section 5) and prioritized for allocation.

The allocation methodology will be dependent on ACIP recommendations as well as vaccine recommendations and any applicable safety limitations. Final allocation methods will be co-created with community input and through partnership with Oregon's COVID-19 Vaccine Advisory Committee.

Data from the following systems will inform allocation system development:

- Tiberius
- ALERT IIS
- VTrckS
- Multiple Oregon population data sources

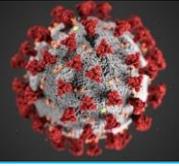


B. Describe your jurisdiction’s plan for assessing the cold chain capability of individual providers and how you will incorporate the results of these assessments into your plans for allocating/assigning allotments of COVID-19 vaccine and approving orders.

When providers apply for enrollment, they are required to indicate their ability to manage cold chain parameters for each of the vaccine candidates. During enrollment, Compliance Specialists will perform spot checks and monitor temperature logs of all providers. Vaccines will be allocated according to provider capacity, and providers with sufficient administration and storage capacity will order vaccine through the IIS and receive it directly from the manufacturer. For providers with limited vaccination capacity, such as some rural providers, a hub system is under consideration for vaccines requiring ultra-cold storage, where providers with ultra-cold storage capacity receive vaccine and for other providers without the required storage capability but who can use the vaccine within the 5 days it can be stored at refrigerator temperature. Cold-chain capacity data will be mapped to identify gaps in capacity across the state and prioritize the allocation of vaccine to providers who can fulfill the need.

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

Only approved COVID-19 vaccine providers will have access to the ordering module or prebooking systems in the IIS. Orders will be approved by matching each request with approved provider-level allocations, which will be tracked. Approval will take into account the number of doses available to Oregon, the type of vaccine, storage and handling requirements, the current phase of vaccine distribution, and the provider’s ability to reach populations equitably. Orders and provider data will be communicated to VTrckS via our ExIS system.

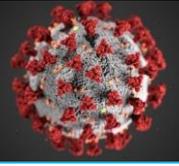


D. Describe how your jurisdiction will coordinate any unplanned repositioning (i.e., transfer) of vaccine.

Providers who have not signed the COVID-19 Vaccine Redistribution Agreement will not be allowed to reposition COVID-19 vaccine, and all vaccine transfers must be entered into ALERT IIS for program visibility.

Providers are not required to obtain advance approval of transfers. To redistribute COVID-19 vaccine, constituent products, and ancillary supplies to secondary sites, all enrolled providers and organizations agree to:

- Sign and comply with all conditions as outlined in the CDC COVID-19 Vaccination Program Provider Agreement.
- 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.
- Comply with vaccine manufacturer instructions on cold chain management and CDC guidance in CDC's Vaccine Storage and Handling Toolkit, which will be updated to include specific information related to COVID-19 vaccine, for any redistribution of COVID-19 vaccine to secondary locations.
- Document and make available any records of COVID-19 vaccine redistribution 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.

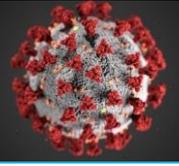


E. Describe jurisdictional plans for monitoring COVID-19 vaccine wastage and inventory levels.

Inventory of COVID-19 vaccine will be managed in ALERT IIS in accordance with Oregon state law. As shipments are received and doses administered or marked as wasted or spoiled, ALERT IIS will track inventory at the lot number level. Providers are expected to reconcile inventory routinely to ensure that the ALERT IIS virtual inventory matches their physical inventory, and an inventory reconciliation is required prior to submitting an order in the IIS. Any wastage that is reported can be monitored using the Vaccine Provider Accountability report. Unreported wastage can be detected using the same report to identify discrepancies between inventory in stock and reported doses given, wasted, spoiled, etc. Accountability reports are monitored routinely for discrepancies and providers are prioritized for technical assistance from compliance staff as issues are identified.

Known Gaps and Opportunities

- As information on vaccine candidates is made public allocation plans will be adjusted to account for recommendation changes from the Advisory Committee on Immunization Practice and other regulatory agencies.



Section 8: COVID-19 Vaccine Storage and Handling

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

a. Vaccine Storage Equipment

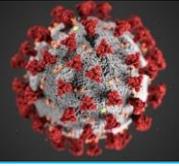
As required by the COVID-19 Vaccine Provider Agreement, all clinics participating in the administration of the COVID-19 vaccine must meet CDC standards for storage and temperature tracking. In the case of COVID vaccine requiring ultra-low storage temperatures, clinics must submit a written plan for storing and maintaining COVID-19 vaccine temperatures at or below -70C. Vaccine storage plans will be adapted from the Oregon Vaccine management guide and adapted to account for changes as published in the COVID-19 Vaccine Storage and Handling Toolkit: <http://bit.ly/OregonVMG>

Clinics will be required to document suitable and stable min/max temperatures daily. A weekly download and review by supervisory staff will be required, and temperature logs will be published at the following location: <http://bit.ly/VFCProviderResources>

Data loggers must be compliant with ultra-low temperature recording, able to store digital data (for later review) and NIST certified.

b. Immunization Staff Training

At least two immunization staff at every site must be assigned to oversee this work. These individuals will be responsible for all aspects of vaccine storage, handling and documentation. The assigned staff will be required to complete immunization education training. These trainings are provided by CDC and/or the Oregon Immunization Program and will include information related to appropriate vaccine storage (including ultra-low temperature), preparation, administration and documentation. Trainings will be posted on the Oregon Immunization program page. For OIP trainings, participation will be tracked at the user level using Adobe



Connect, and will be available at the following location:

<http://bit.ly/ORVFCtraining>

Note: Oregon intends to use manufacturer and/or CDC-created training specific to ultra-low storage. The current status and availability of this training is unknown. If CDC approved training is not available within an appropriate timeframe, existing Oregon-specific training will be adapted.

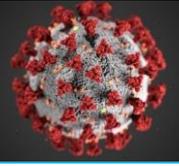
B. Describe how your jurisdiction will assess provider/redistribution depot COVID-19 vaccine storage and temperature monitoring capabilities.

Oregon hospitals are currently being surveyed to evaluate capacity for provider redistribution and depot capacity for ultra-cold vaccines. Providers enrolled in the COVID-19 vaccination program must follow the Oregon COVID-19 VMG as their storage and handling guidebook and adopt any special measures to accommodate ultra-low storage. The applicable documents will available at the following location: <http://bit.ly/VFCProviderResources>

Special attention must be paid to each site's vaccine emergency plan to ensure thoughtful pre-planning. To spot check VMG compliance, random temperature logs will be requested for review. Additional requirements may be added as CDC guidance evolves.

Known Gaps and Opportunities

- Training materials will be made available in languages other than English for use by culturally responsive workforce as training needs and gaps are identified.



Section 9: COVID-19 Vaccine Administration Documentation and Reporting

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

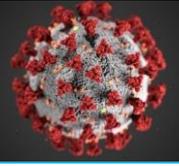
All providers, current and new, will submit records of all doses administered to Oregon's Immunization Information System (IIS), ALERT IIS, within 24 hours of administration. ALERT IIS is based on the Wisconsin Immunization Registry (WIR) platform and is used by 17 jurisdictions in the U.S. Data typically enters the system through automated processes through electronic health records using health-level seven (HL7) messaging.

Historically, 88% of all vaccines given are reported to the system within 24 hours of being administered to a patient. For vaccine providers that are not connected to the system via HL7, quick entry screens are available and can be implemented rapidly. OIP is currently exploring the use of the CDC's Vaccine Administration Management System (VAMS) as a supplement to ALERT IIS.

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

Submission of COVID-19 data to the CDC will be conducted through the Immunization (IZ) Gateway, the testing of which is underway. The MOU and data use agreements (DUA) required to share data are currently under review in Oregon. Final acceptance of these documents is expected by the end of November 2020. HL7 messages have already been tested with CDC and are currently undergoing formatting changes. Data submission will go live as soon as the MOU and DUA approvals are received.

C. Describe how your jurisdiction will ensure each COVID-19 vaccination provider is ready and able (e.g., staff is trained, internet connection and equipment are adequate) to report the required



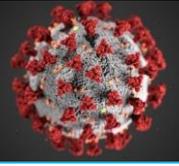
COVID-19 vaccine administration data elements to the IIS or other external system every 24 hours.

Oregon ALERT IIS is already in use by the majority of vaccination providers, including mass, mobile and employment clinic organizations. Oregon is currently working with internal IT resources to enhance the provider enrollment system to include the CDC-provided COVID-19 agreement. This will include links to training on IIS, and vaccine administration and reporting. Vaccination partners will assume the responsibility once agreements are signed. Technical assistance for data exchange set up and ongoing maintenance, as well as training and help desk support will be available to enrolled providers. Planning for additional staffing to support the onboarding and validation of provider data reporting is in process, and training for temporary staff is under development.

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

In the case of all providers utilizing ALERT IIS, standard reporting procedures currently in place will continue to be used. This will include all enrolled off-site, satellite or novel vaccination settings. For new providers, ALERT IIS will make available the event module in ALERT IIS, which contains a quick entry screen that requires only an internet connection to report vaccinations. When codes are established for COVID-19 vaccines, these can be incorporated into ALERT IIS as they enter the marketplace. As Oregon identifies and recruits contractors such as EMS agencies to perform off-site vaccination, CDC COVID-19 vaccine provider agreement requirements are built into the contracts.

E. Describe how your jurisdiction will monitor provider-level data to ensure each dose of COVID-19 vaccine administered is fully documented and reported every 24 hours as well as steps to be taken

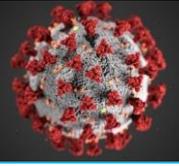


when providers do not comply with documentation and reporting requirements.

ALERT IIS establishes data parameters and will reject submitted data that does not meet the parameters. This will ensure correct vaccination coding is used. In addition, routine tests are performed to measure improbable doses (e.g., when a vaccine appears to have been administered to a person ineligible to receive it, for example due to age). Data flow from providers is evaluated to ensure submissions have not ended unexpectedly. For COVID-19 vaccine administration, data quality reports to monitor completeness and accuracy will be reviewed daily. Acceptance thresholds, while varying based upon data elements, are very high; a trained provider who is reporting properly should have virtually no errors in reporting. Technical assistance will be provided to partners as needed, with plans currently underway to hire and train additional staff to assist with this work.

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

Oregon will adapt the weekly process to review influenza coverage reports to meet the needs of the COVID-19 implementation. This process reviews the records of influenza vaccination across Oregon and reports uptake by region, age group and race/ethnicity. These reports are posted regularly to the State of Oregon website using a program called Tableau, which can be updated quickly and efficiently as new data are acquired. Although the reports are used in a static manner for influenza reporting, they can easily be adapted for use by decision-makers to adjust vaccination supply and resources when pockets of need are identified.



Section 10: COVID-19 Vaccination Second-Dose Reminders

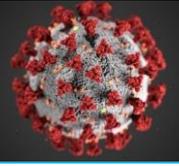
A. Describe all methods your jurisdiction will use to remind COVID-19 vaccine recipients of the need for a second dose, including planned redundancy of reminder methods.

Oregon uses a Reminder/Recall (RR) process routinely for two-year-old children who have fallen behind on their vaccination schedule. This process can be adapted easily to apply to vaccines for all ages. Oregon will hire additional staff to access automated reports of COVID-19 vaccination to perform this function. These reports can also be generated by providers. Currently the RR products are only available in English, but the ability to translate this process into other languages is being explored. Providers are recommended to employ electronic health record reminder recall activities in addition to state IIS functions to build redundancy into the system. Provider level reminders are often able to use email, text or phone-based notifications that will increase the reach of reminders.

In addition, ALERT IIS can use reminder cards provided by vaccine manufacturers. Printed cards would be comparatively easy to translate into the languages spoken in Oregon. ALERT IIS will procure cards that are available, pursue translation and have hard copy print materials ready to be ordered by partners. These translations will also be available online for partners to print themselves.

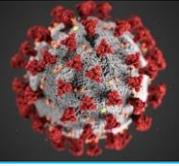
Media campaigns about COVID-19 vaccination will include messaging about vaccine types and dose requirements as well as other possible vaccine impacts. Vaccination materials given to providers will include notes to share with patients regarding the number and timing of doses required for full immunization against COVID-19. Media campaign materials will be created in both English and Spanish, and printed materials in multiple languages.

Oregon is currently evaluating budget requirements for media translation, printing and mail costs for RR letters/cards, and staffing resources for technical assistance and IIS data quality.



Known Gaps and Opportunities

- There are several gaps related to access for migrant and seasonal farm workers:
 - Some migrant and seasonal farmworkers speak indigenous languages that are primarily spoken, not written. Radio PSAs and other audio/spoken reminders in these languages about vaccine types and dose should be considered in addition to printed materials in English and Spanish.
 - Some of these workers do not have domestic phone numbers, and instead use international numbers. A reminder system that relies on phone calls should take this into account and alternate communication methods should be considered, such as on-site clinics.
 - Depending on the cycle of work, some of these workers may leave Oregon between their first and second doses of vaccine.



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

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

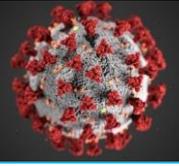
Quick entry screens are available as an option in ALERT IIS for those organizations who do not have a current EHR process. The use of regular processes with data exchange between EHRs and ALERT IIS have built-in disaster recovery and backup queueing processes in place. See Section 9, A for further details.

Oregon is currently exploring the use of the CDC’s Vaccine Administration Management System (VAMS) as a supplement to ALERT IIS. During network or power outages paper vaccine administration records will be used by mobile vaccinators as the primary means of documentation and entered into ALERT IIS when connection is restored.

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

ALERT IIS currently captures all data elements on the list of required elements, and in addition collects data on race, ethnicity, and the refusal of all vaccines. Gaps in data generally occur due to a lack of reporting (e.g., a provider who doesn’t include race/ethnicity data) rather than the inability to store the information.

ALERT IIS is establishing COVID-19 vaccination data requirements for all providers and will be ready to accept and process this information automatically.



Starting on October 1, 2020 health care providers in Oregon were required to begin gathering and reporting expanded data on race, ethnicity, language, and disability (REALD) for the treatment of COVID-19 according to Oregon House Bill 4212. As vaccination planning efforts continue, REALD data collection will be implemented wherever possible.

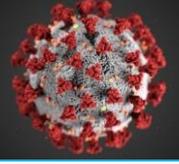
C. Describe your jurisdiction's current capacity for data exchange, storage, and reporting as well as any planned improvements (including timelines) to accommodate the COVID-19 Vaccination Program.

Currently 95% of immunization data received in ALERT IIS is populated via real-time data exchange. Data are submitted from EHRs as well as larger data service hubs, which report for multiple provider sites.

Improvements that are planned for ALERT IIS include the addition of COVID-19 vaccine codes, and adjustments to accommodate the COVID-19 vaccine within the forecaster once the vaccine is available. In an upcoming ALERT IIS enhancement scheduled for release on November 22, 2020, there will be functionality added to indicate a vaccine provider is a pandemic-response organization.

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

ALERT IIS already incorporates streamlined onboarding processes. The prioritization of COVID-19 only providers will occur when that information is available, such as when it is indicated by local organizations and health authorities. Improvements are underway to the local provider tracking system and include an internal provider website (POST) that tracks provider status, issues and requirements. A new version of POST was recently released and its new functionality is being incorporated into ALERT IIS processes.



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

Currently testing connectivity between ALERT IIS and IZ Gateway Connect and Share, with implementation planned when the documents referenced below are signed.

F. Describe the status of establishing:

A data use agreement (DUA) with the Association of Public Health Laboratories to participate in the IZ Gateway.

Status: A prior version of the agreement was signed in 2016 and the new version is currently under review by the Oregon Department of Justice.

The approval process for the Data Use Agreement with CDC, to include Oregon data in national coverage analyses.

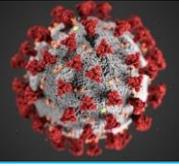
Status: Awaiting the final version from CDC. Once received, Oregon's review process will begin.

The Memorandum of Understanding to share data with other jurisdictions via the IZ Gateway Share component.

Status: Currently under review by the Oregon Department of Justice.

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

Should connectivity be broken prior to data reaching the IIS, paper forms for recording vaccinations will be available for use in the event of a loss of connectivity. ALERT IIS quick entry screens are available to ease data entry when the connectivity returns.

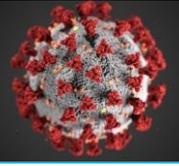


H. Describe how your jurisdiction will monitor data quality and the steps to be taken to ensure data are available, complete, timely, valid, accurate, consistent, and unique.

Data quality measures will prioritize COVID-19 vaccination reports. Existing data quality processes will be used which are automated to reject data of insufficient quality, and pre-designed reports will be reviewed daily to assess issues with data acceptance. The review will include timeliness, accuracy, and completeness of data. Providers with inadequate data will be contacted and trained through the quality improvement process. Sub-standard data will be removed from ALERT IIS and replaced with higher quality data as needed. Additional staff will be hired to focus on COVID-19 vaccination report data quality and provider contact.

Known Gaps and Opportunities:

- ALERT IIS is built on a national platform shared with 16 other states. OHA will explore options for incorporating REALD data in the IIS, but implementation may not be possible until changes are made to national standards.

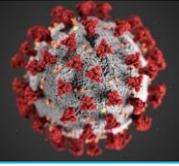


Section 12: COVID-19 Vaccination Program Communication

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

COVID-19 Vaccine Specific Communications Objectives:

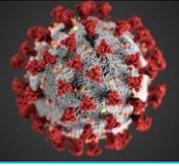
- Provide information to the public about planning, policy, operations using crisis and emergency risk communication principles:
 - Be first. Communications will be proactive and timely. Being first is always balanced by the accuracy needed to maintain credibility, and to be right and respectful in our approach.
 - Be right.
 - Promote action.
 - Be credible.
 - Show respect.
 - Express empathy.
- Ensure messaging and communications are culturally responsive and linguistically accessible.
- 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. Provide tools that leverage the CDC Vaccine with Confidence Framework.
- Track and monitor public receptiveness to COVID-19 vaccination messaging.

Internal Audiences

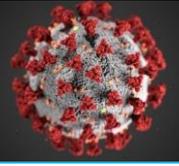
OHA agency staff, agency leadership and state agencies supporting vaccine distribution are important audiences that are internal to the response. Maintaining communications internally allows staff to be well informed as they represent the agency informally in their communities, to allow leadership to be well informed formal spokespersons, and to help sister agencies identify areas of needed information coordination and opportunities to serve channels of communication to external audiences.



Governor’s office	Oregon Health Authority	Supporting State Agencies and Entities
Health Policy Advisor Communications Medical Advisory Group Office of Equity	OHA Director’s office Public Health Division Director OHA Equity and Inclusion Division OHA Community Partnership Outreach Program Tribal liaisons PHD Community Partnerships Program OHA-DHS shared services COVID-19 Response and Recovery Unit (CRRU) OHA Staff Immunization Policy Advisory Team (IPAT)	Multi-agency Equity Workgroup OR Department of Human Services (OR-DHS) OR Department of Agriculture OR Department of Education OR Department of Transportation OR Department of Energy OR State Police OR Department of Corrections OR Occupational Safety and Health Business Oregon

External Audiences

Phase 1A: External audiences are identified as health care workers. These are broken into two categories, those who will be vaccinated and those who will not only be vaccinated but need additional information to support planning, logistics, operations and administration of vaccine. Communication plans assume that health care workers who could become vaccinated include the above groups as well as other paid and unpaid health care workers, such as medical reserve corps volunteers and workers that support people living with intellectual, developmental, and other disabilities.

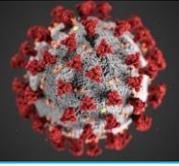


Potential vaccinators		
Geriatric providers	Primary care physicians	Emergency medical service (EMS) providers
Long-term care facilities	Nurse practitioners and Registered nurses	Dentists
Federally Qualified Health Center staff	Medical assistants	Obstetricians & Midwives
Pharmacists	Physician's Assistants	Pediatricians
Naturopaths	Hospitalists	School-based health center staff
	College Health Center staff	

Health care workers who do not serve in a vaccinator role will need much of the same information that the public will be interested in. Needs include information on safety and effectiveness of the vaccine, vaccine development process, emergency use authorization and how to access vaccine.

Phase 1B: Audiences in this grouping include essential workers and those at highest risk of exposure or severe COVID-19 illness. Individuals in this category include those with chronic conditions, persons living with intellectual, developmental and other disabilities, and those age 65+, especially those living in long-term care facilities and other congregate care settings. Audience definitions and identification will be further refined as vaccine recommendations are finalized.

Phase 2: Communication to audiences in phase 1 will continue. Efforts will expand to cover critical populations and gradually the broader public. The need for accessible, linguistically and culturally appropriate information will continue. Audiences will increasingly need tailored information to address psychological factors that contribute to vaccine uptake and receipt of information in a crisis.



Phase 3: All audiences will need continued information to increase vaccine uptake and to encourage return visits for multi-dose vaccines.

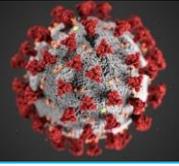
Channels of Communication

OHA uses channels of communication that allow for both targeted and mass communication to reach its various audiences.

Healthcare providers and health partners are the most trusted source of vaccine information. OHA will equip providers with information understand patient's possible questions and concerns and provide materials to support patient education. Partnerships with health professional organizations, health systems and other health care partners will be important channels of communication to individual health care providers.

Tribal and local health authorities are also trusted sources of information at the local level. This channel of communication will be supported through regular conference calls, technical support and updated information and communications toolkits.

Community and faith-based organizations are trusted by the communities they serve. These partners not only serve as important channels of communication but carry knowledge and expertise about their own community that others do not have. OHA values the contributions and knowledge of these partners and their feedback. The COVID-19 response has created opportunities to increase meaningful engagement. The OHA agency operations Joint Information Center will work with community engagement program and faith liaison staff and to identify opportunities to more deeply engage these trusted partners in creation of messaging, design materials and support them as third-party validators and spokespersons.



Sister state agencies and unions will be key partners in reaching essential workers. OHA will begin state PIO calls with these agencies to ensure coordination.

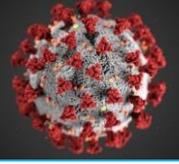
Earned media will be leveraged for rapid and routine public notification and information. This is largely a mass communications tool. Limited segmentation is possible based on the geographic coverage area, demographics served and the specific story content offered.

Paid media will be leveraged to deliver mass communication alongside tailored messaging for specific segments of the population. Campaigns extend the reach and visibility of vaccine recommendations and resources.

- Feedback from community partner listening sessions along with formal audience polls, surveys and focus groups support tailored messaging that accounts for psychology of audience in the context of the pandemic and historic traumas; knowledge, attitudes, beliefs and practices; accessibility of information, cultural and linguistic needs.
- Targeted campaigns will follow a phased approach to reflect populations identified for each phase of vaccine distribution.
- Forms of paid media may include broadcast, digital, outdoor advertising, social media influencer campaigns, and print materials based on the needs of the audience.
- OHA will work with media firms with unique cultural and linguistic perspectives when possible to ensure that messaging is co-created with communities.

Digital platforms will be used to reach large audiences to deliver information and materials in alternate formats, and languages.

- OHA social media accounts reach English- and Spanish-speaking audiences quickly and directly. The social media channel also creates the opportunity for social listening and direct engagement with the audience.



- The website reaches primarily English- language audiences with features to support language access. Digital versions of print materials are available online in 14 languages. Buttons to these translated materials indicate the language in standard English and the translated language’s script. A degree of accessibility to the full website is achieved including a built-in Google translation feature.
- E-newsletters and various email list-servs that can be leveraged for mass and targeted communications.

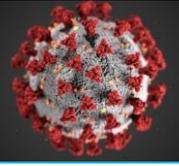
Information lines will be used to support response to questions from the public and health care providers. 211 info will be used for the public. The information line offers information in multiple languages through its own multi-lingual staff when possible, and through language lines when necessary. OHA is currently exploring adding the Oregon State University School of Pharmacy to the 211 information line to answer questions from the general public requiring clinical knowledge. Oregon Poison Center will be contracted to serve as a healthcare provider helpline.

Sister agencies may be more familiar with communicating with certain audiences than OHA and have well established channels of communication with a given target audience. Leveraging these agencies’ existing channels to disseminate information can broaden reach, provide redundancies that ensure message penetration and offer important feedback loops.

Partner Activation

Pre-Phase 1: Leverage OHA communication platforms to educate the public about vaccine development processes, and to monitor and correct misinformation.

Phase 1: Activate and leverage Tribal and Local Public Health Authorities, hospitals and health systems, potential vaccinators, Long-Term Care Facilities, health professional associations, Oregon Poison Center, 211, other state agencies representing essential workers, unions and communications contractors supporting public information work.



Phase 2: Continue working with partners from Phase 1. Activate community and faith-based partners in community outreach and education.

Phase 3: Transition all partners from a response operations framework to a steady state operations framework. Routinize COVID-19 vaccine communications and make sure products developed during the response are adapted to be evergreen in nature.

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

Procedures:

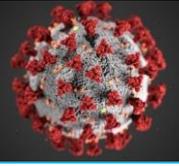
Activation and organizational structure

OIP COVID-19 Communication

The Communications Coordinator will develop and coordinate internal communications projects and support the development of vaccine program materials. The Risk Communication Analyst will serve as liaison to the AOC JIC; risk communications subject matter expert; liaise with LPHAs, CBOs and equity partners; and will serve on the leadership of the communications strategy. OIP staff will support education of vaccine providers.

Agency Joint Information Center (AOC-JIC)

Throughout the response the AOC-JIC has been referred to as the Health Information Center (HIC). Key positions include the Communications Director, Lead Public Information Officer (PIO), Deputy PIO for Media Relations, Deputy PIO for Content Strategy, Deputy PIO for Equity Review, Deputy PIO for Partnerships. This organizational structure will remain intact throughout the vaccine distribution and eventually demobilize to return to steady state communication.



In case of an emergency communication, this group would receive a call-down message and convene virtually or in-person, with appropriate COVID-19 precautions. Deputy PIOs would be expected to cascade communications to remaining HIC staff members as needed.

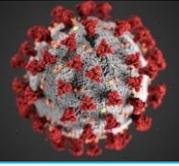
For public health messaging the role of the HIC will be supportive in the production of health and vaccine education materials, distribution and campaign project management. The HIC will take a leadership role in communicating and supporting the OHA leadership and Governor's policy decisions related to COVID-19 vaccine. The HIC will liaise with the Governor's communication team.

Product development and approval process:

- Templates for rapid message development are available for use in emergency communications.
- Routine requests for new products are submitted to the joint information center through Smartsheets and tracked using this tool.
- Once emergency or routine product content has been developed, approval is sought in the following order:
 - Senior Health Advisor
 - Public Information Officer or Deputy Public Information Officer
 - Incident Manager
- Approved items are submitted to OHA-DHS Shared Services Publications for formatting, language access statement, graphic design and translation.
- Publications are returned to the health information center with a forms server link for dissemination through the appropriate channels.

Language access: Guiding policies

Adherence to the following criteria as described by: Americans with Disabilities Act, Rehabilitation Act; Patient Protection and Affordable Care and Affordable



Care Act; Plain Language Act; and state and agency language access policies and procedures.

Language access: Printed materials

Language access is facilitated through the agency's Joint Information Center and in collaboration with the Oregon Health Authority- Department of Human Services Shared Publications Service.

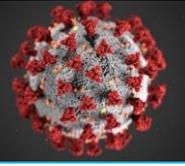
Publications has access to several translators and the ability to support alternate formats. The graphic design services support infographic development to support overall ease of information uptake and low-literacy populations.

Public facing materials are automatically translated in to the top 10-14 languages requested. Language access statements are placed on public-facing materials to provide information about how to request additional translations and formats.

Phase 1A: English is generally recognized as the common language for technical information in the health sector. Information delivering technical information to vaccinators will be provided in English, unless otherwise requested.

The range of individuals included in the paid and unpaid health care workforce indicates a need to consider language access even the initial phase of vaccine distribution. Starting language access at this early phase is intended to build trust through accessible, transparent information that facilitates informed consent when receiving the vaccine.

Additional data are needed to identify the language access needs of non-licensed health care workers. Initial data from the licensed workforce indicates that Spanish, French, Tagalog, Chinese (Simplified and Traditional), Vietnamese and Russian materials should be produced. In previous events,



Marshallese has also been requested to support the health care workforce. Additional translations will be made available upon request and may be done as a matter of routine for materials that can be used for other audiences during subsequent phases of distribution.

Alternate formats are available upon request during this phase and as the agency prepares materials that will carry over to subsequent phases.

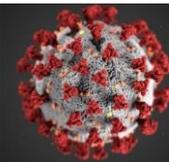
Phase 1B: Language data are not available at this time for this specific population, and it is assumed that the language preferences of this group begin to mirror the larger population. At this stage language access will routinely include the top 10-14 most requested languages. These currently include Spanish, Russian, Vietnamese, Chinese (simplified and traditional), Somali, Marshallese, Chuukese, Arabic, Hmong, Mam, Burmese, Portuguese, Khmer and Mein.

Alternate format needs will be more pronounced in this phase to accommodate Deaf/hard of hearing populations and populations with low vision. Large print materials will be produced along with mixed audio-visual formats. ASL is routinely used at press conferences and will be considered when producing educational materials, as appropriate. Television and the online service YouTube facilitate options for closed captioning.

Phase 2 & 3: Language access initiated in phases 1A and B will be available throughout the distribution phases. Additional languages and formats will be made available upon request.

Language access: Media Events

American Sign Language (ASL) interpreters and Spanish simulcast are requested through the agency's Joint Information Center. Critical news releases, particularly emergency notices, public health recommendations that prevent morbidity and mortality for the public and information about access to points of care will be translated.



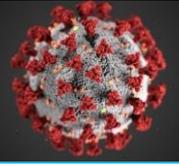
Notification of partners prior to a media release

Tribal and local public health partners, health care partners and, depending on the events, community partners serve as important spokespeople in their communities, and often receive questions related to state communications. To ensure we can speak with one voice, it is important to coordinate and notify partners in advance of a media release and provide relevant talking points.

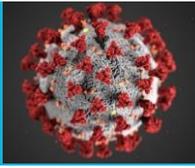
When announcing outbreaks at workplaces, schools and other settings there are occasionally opportunities to issue joint communication or coordinate messaging and timing of communications. Advanced notification of a media release helps identify these opportunities. In some instances, such as when the partner cannot be reached within a timely fashion or when enforcement notification is needed, it may be appropriate to conduct a media release without advanced notification.

Delivery methods

Method of Delivery	Application
Health Alert Network	Rapid and emergency notification system
ALERT IIS	Vaccine registry facilitates information sharing among vaccinators and patient recall for multi-dose vaccines
Tableau	Web-based delivery of data and data visualization
Flash Alert	Rapid and routine media notification to media outlets (broadcast and print)
GovDelivery	Mass and targeted communication for rapid and routine notifications in newsletter/email formats
Constant Contact	Targeted communication for rapid and routine notifications in newsletter/email formats



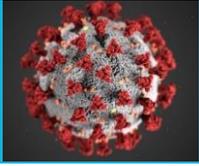
OHA Website healthoregon.org/coronavirus	Mass notification via banners; delivery of targeted information through web-page audience segmentation
OIP Website	COVID-19 vaccination information for providers and the general public
Social media: Facebook (English) Facebook (Spanish) Twitter	Rapid notification to the public; delivery of routine health information, education and news
Social media: YouTube	Real-time online delivery of press conferences, online simulcast in Spanish; delivery of routine health education in an audio-visual format w/ closed caption options to support access needs
211 Information Line	Provides public information through a call center platform
Clinicians' Information Line	Provides clinical information to health care providers through a helpline- type format
Zoom, Skype and GoToWebinar	Hosting online conference calls, meetings and webinars
Printed materials	Printable materials in multiple languages are available online to support tribal and local partners and health care providers in delivering printed communications materials to their communities and patients
Routine Emails	Internal coordination; limited targeted communications
Direct mail	Health education and vaccine 2 nd dose reminders



OIP Provider listserv	Email communications with COVID-19 Vaccination program enrolled providers
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Communication monitoring

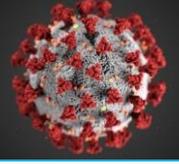
Monitoring Tool	Application
Crosswalk comms data w/ ALERT IIS immunization data	When health outcomes data is paired with information about the timing of communications, polling data surveys and focus group information, reach and other communications data, it may be possible to determine whether communications is correlated with behavior change.
211 Information Reports	Reports include total number of calls, geographic distribution of calls, languages requested, topic of calls and questions call takers were unable to answer. This can be used to identify rumors, detect changes in public interests and identify opportunities to support call takers with information not currently offered in the talking points given to 211.
Google web analytics	Helps monitor traffic and use patterns of visitors to the website and related pages. This allows web-editors to adjust strategy to maximize the website's effectiveness and reach.
Hootsuite	This social media monitoring tool helps OHA monitor for common themes, identify misinformation and understand social media demographic patterns to support message development and targeted audience communication. When capacity allows it can also support evaluation of audience sentiment.
Meltwater	Meltwater allows OHA to monitor for accuracy in reporting and coverage of stories released.
Social media account metrics	Metrics from Facebook, Twitter and YouTube help determine reach and engagement of messages released through the organizational accounts.



Gov Delivery	Gov Delivery metrics allow us to monitor receipt of message by tracking open rates.
Statewide Polling, surveys and focus groups	Audience evaluation provide opportunities to test messaging and better understand audience knowledge, beliefs, attitudes and self-reported behavior. This monitoring and evaluation tool facilitates understanding of misperceptions, knowledge gaps, beliefs and attitudes that can be influenced through communication. When compared with health outcomes data, it helps determine correlations between communication and quantitatively measured health behaviors.
Health Alert Network	Metrics offer the option to have recipients indicate whether they have received the message and number of recipients.
Informal qualitative information through partnership engagement	Community engagement and equity partners participate in regular calls with OHA. Listening session notes and summaries create a communication feedback loop.
Informal and formal qualitative staff reports	OHA staff interacts with several audiences on a routine basis. Conversations with partners can serve as an important piece of the communications feedback loop.

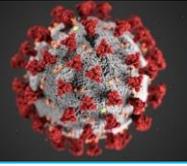
Known Gaps and Opportunities

- Timely translation of written materials and interpretation of spoken word information is already a target for improvement within the agency. Throughout the COVID-19 response, there has been measurable process improvement but there is still room to grow. Transcreation of materials would be preferable to translation and this option is also being explored to build internal staff capacity.
- OHA has the opportunity to develop an agency approach to engaging trusted messengers in difficult to reach populations. This approach will require extensive coordination with LPHAs, CBOs and faith-based organizations to



identify these populations and their formal and informal leaders and trusted sources of health information, such as traditional health workers.

DRAFT



Section 13: Regulatory Considerations for COVID-19 Vaccination

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

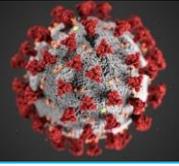
Oregon routinely publishes immunization standing orders, required to be used by local public health authorities and other public clinics, and pharmacy protocols for immunization which are legally required to be used by immunizing pharmacists statewide. These orders are publicly available at: <https://www.oregon.gov/oha/ph/preventionwellness/vaccinesimmunization/immunizationproviderresources/pages/stdgordr.aspx>.

Pharmacy protocols are publicly available at: <https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRESOURCES/Pages/pharmpro.aspx>.

These orders and protocols include a requirement to provide a VIS to the patient or guardian before vaccine administration. To ensure a current EUA or VIS is provided, our COVID-19 vaccine standing orders and pharmacy protocols will contain a link to the EUA or VIS. We will also include a link to the EUA or VIS on our standing orders and pharmacy protocol websites. Each order and protocol lists the main phone number of the Oregon Immunization Program to contact for questions or clarification. Questions will be routed to immunization program staff and Senior Health Advisors to be answered.

The CD Summary is a publication of the Oregon Health Authority, Public Health Division (PHD) whose target audience is licensed health care providers, public health and health care agencies, media representatives, medical laboratories, hospitals, and others with an interest in epidemiology and public health. It is distributed to over 4,000 subscribers and is posted at: www.healthoregon.org/cdsummary.

In addition to subscribers, when information of public health importance needs to be pushed to all licensed health care providers, the CD Summary can be mailed using mailing lists available to the PHD. The PHD will mail out a CD Summary newsletter on COVID-19 vaccine, including information on the conditions of



authorization to use COVID-19 vaccine, vaccine distribution and storage, reporting doses administered to ALERT IIS and on how to report to VAERS. Additionally, instruction will be included on how to use the EUA or VIS and that it is required to be given to the patient before each dose of vaccine is administered.

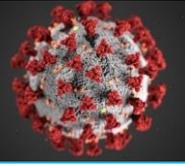
Training of vaccine providers regarding their legal obligations will be incorporated into the provider application process. Applicants will need to attest that they have followed links that demonstrate the location of the relevant EUA fact sheet or VIS in addition to a site outlining the legal obligation to provide either the EUA fact sheet or VIS, whichever is applicable to each vaccine recipient.

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

As described in part A, the standing orders and pharmacy protocols will contain a step that directs the vaccinator to give the patient or guardian an EUA or VIS, as appropriate. A link to the EUA or VIS will be listed in the order and protocol. The CD Summary, described in part A, will provide instruction to licensed health care providers about the requirement to provide a current EUA or VIS to every patient, or their guardian, prior to the administration of COVID-19 vaccine.

Known Gaps and Opportunities:

- EUA fact sheets and VIS may not be available from CDC or manufacturers in languages other than English and may need to be translated by OHA.



Section 14: COVID-19 Vaccine Safety Monitoring

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

Oregon routinely publishes standing orders, required to be used by local public health authorities and other public clinics, and pharmacy protocols which are legally required to be used by immunizing pharmacists statewide. These orders are publicly available at:

<https://www.oregon.gov/oha/ph/preventionwellness/vaccinesimmunization/immunizationproviderresources/pages/stdgordr.aspx>.

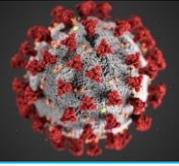
Pharmacy protocols are publicly available at:

<https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRESOURCES/Pages/pharmpro.aspx>.

These orders and protocols will include information on the legal requirement to report to VAERS, that a determination of causality is not necessary for reporting and a link to the VAERS reporting website. A link to VAERS will also be included on our standing orders and pharmacy protocol websites. Each order and protocol list the main phone number of the Oregon Immunization Program to contact for questions or clarification. Questions will be routed to immunization program staff and Senior Health Advisors to be answered.

The CD Summary is a publication of the Oregon Health Authority, Public Health Division (PHD) whose target is licensed health care providers, public health and health care agencies, media representatives, medical laboratories, hospitals, and others with an interest in epidemiology and public health. It's emailed to over 4,000 subscribers and is posted at: www.healthoregon.org/cdsummary.

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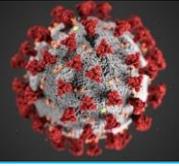
authorization to use COVID-19 vaccine, vaccine distribution and storage, reporting doses administered to ALERT IIS and on how to report to VAERS, with a link to the online reporting portal, <https://vaers.hhs.gov/reportevent.html>.

The Oregon Immunization Program has an existing contract with a local pediatric infectious disease specialist who gives grand rounds presentations on current issues in immunization to health care providers around Oregon. The Oregon Immunization Program will request that she add information on the purpose of VAERS to her presentations and stress the importance of reporting all significant adverse events occurring after vaccination, regardless of whether the provider considers the adverse event associated with vaccination.

Providers enrolling in the COVID-19 vaccination program will be provided an Oregon COVID-19 vaccine management plan template during the enrollment process. In addition to storage and handling requirements this document will provide an overview of VAERS requirements and the vaccine safety monitoring system. This document will be modeled after the Oregon Vaccine Management Guide located here: <http://bit.ly/OregonVMG>

Known Gaps and Opportunities

- To ensure reach of this information to disproportionately affected communities, there is an opportunity to develop a targeted outreach program to enrolled providers serving these populations. Using a trauma informed approach and strength-based methodology to adverse event reporting will be a critical strategy.



Section 15: COVID-19 Vaccination Program Monitoring

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

Provider enrollment

Staff will monitor provider recruitment data bi-weekly as data is uploaded to the IZ-gateway data lake. Data will indicate providers in progress, completely enrolled or declined enrollment. Provider enrollment progress will be compared to data on critical populations, GIS population data at the county level and needs identified through our community engagement processes to ensure that we have a provider network able to meet the needs of the community.

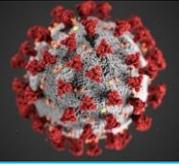
Access to COVID-19 vaccination services by population in all phases of implementation

Staff will use ArcGIS and Tiberius to visualize enrolled providers and overlay it with critical population density at the county and local level. This work will be piloted through the CDC CARES FLU grant work. Additionally, Oregon will work with OHA-contracted community-based organizations to identify access gaps and will partner to address them through additional provider recruitment or through the use of EMS vaccinators to improve community access or through other community-based solutions.

IIS or other designated system performance

Oregon will rely on two primary data systems to monitor provider enrollment and vaccination data, ALERT IIS and the provider onboarding system, PMI.

- ALERT IIS is supported and hosted by Gainwell Technologies (formally DXC Technology) and is currently hosted in their virtual private cloud, which provides flexibility to easily expand needed storage to meet increased demand. Our contract Service Level Agreement (SLA) specifies system performance standards and the vendor provides monthly reporting of actual system metrics compared to the standards. Critical system parameters are



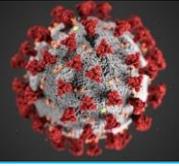
continually monitored, and automated emails are sent to both Oregon and the vendor team if there are issues. Additionally, load testing is performed prior to every system release to validate that functionality changes do not have a significant performance impact.

- The PMI system is housed internally and monitored by state Office of Information Services (OIS) staff. PMI servers are monitored in real time for both unusual perimeter activity and performance issues and staff are notified immediately when they occur. PMI servers are backed up nightly to protect against information loss and allow for rapid recovery if needed.
- Both ALERT IIS helpdesk and Provider Services helpdesks will monitor calls regarding issues that the systems and their users are having. Systems issues identified through the helpdesk will be immediately elevated to external software vendors and OIS staff for troubleshooting. User issues will be collected and routinely reviewed to determine possible systems improvements and identify user training needs.

Data reporting to the CDC

Oregon is currently working towards meeting several CDC data reporting requirements.

- Updates are in process to ALERT IIS to indicate pandemic provider status with an expected release of 11/22/2020 to be automatically reported to CDC in the EXIS master data file. In advance of that, pandemic provider status will be manually indicated in the EXIS file beginning 10/16/2020.
- Enrollment data submission will be tested beginning on 10/19/2020 with CDC data exchange specialists and should be ready for implementation following testing. This data file will be an extract from the Oregon PMI system and include enrollment information for all COVID-19 vaccine providers
- The data connection has been successfully tested with IZ Gateway for the submission of dose-level data to CDC. Minor modifications to HL7 messaging format are currently underway to optimize data submission. The MOU and data use agreement are currently under review by the Oregon Department of Justice and implementation is expected shortly after approval.



Provider-level data reporting

ALERT IIS has two standing reports which are available to OHA staff and IIS users to monitor the accuracy and completeness of data reporting.

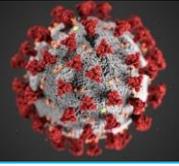
- The ALERT IIS Data Exchange Report can be run at the provider level for sites who have their data submitted using HL7 messages; this report summarizes errors that occur upon import of the HL7 immunization messages.
- The ALERT IIS AdHoc List Report extracts demographic and immunization detail that has been imported into the IIS; this report can be used to confirm that information in the IIS reflects what was entered in the EHR.
- IIS data exchange staff work closely with EHR Vendors and clinics statewide and rely on these partnerships to help identify data exchange issues quickly through clinic level vaccine inventory deduction errors or vendor identified issues. These user-identified issues often serve as early indicators of data quality issues that can be easily addressed.

Vaccine ordering and distribution

Vaccine ordering and distribution will be monitored through ALERT IIS and reported directly to CDC's VTrckS system through EXIS file submission. Staff will monitor ALERT IIS data, doses distributed at the state and clinic level and doses allocated but not yet shipped, as well as shipping files uploaded to VTrckS to identify potential issues and organize follow up. Providers with large allocations that have not yet been shipped will be prioritized for follow up to ensure rapid deployment of COVID-19 vaccine throughout the state. Additionally, data on doses distributed and administered will be monitored at the county level to ensure that access throughout Oregon matches expected numbers of priority populations.

1- and 2-dose COVID-19 vaccination coverage

1 and 2 dose COVID-19 vaccine uptake will be monitored using ALERT IIS data. Tableau dashboards are under development to post data to the OHA website weekly including coverage at the county level and by key demographic characteristics.



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

Budget

All expenditures are tracked and monitored using the states State Financial Management Application (SFMA). Program Fiscal staff and Management ensure that only allowable expenditures are applied to the grant, following CDC guidance and requirements along with any applicable Oregon State Administrative Rule.

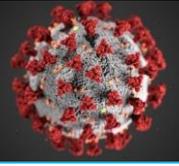
Staffing

The OIP Vaccine Planning Unit organizational structure discussed in Section 2 is designed to ensure that all core work is accomplished through a collaborative team with a designated lead. All groups have multiple positions built in and no work will be assigned to just one individual. This redundancy allows staff to develop familiarity with the work of other staff within their workstream and allows coverage if staff are not available. Redundancy is also built into the leadership structure and Senior Health Advisor structure.

The state of Oregon adheres to all rules and guidelines on time and activity reporting required by federal funders. Public Health staff adhere to all Oregon Administrative Rules and OHA/OHDS policies, processes and guidelines in place for accurate reporting of time. There are several reporting and tracking tools in place for staff and managers to track time and activity including staff entry into ePayroll, Workday, Oregon State Payroll Application (OSPA), etc.

Supplies

All services and supplies expenditures are tracked and monitored using the states State Financial Management Application (SFMA). Program Fiscal staff and Management ensure that only allowable expenditures are applied to the grant, following CDC guidance and requirements.



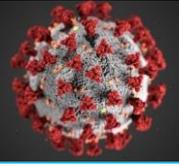
In addition to supplies used by the Vaccine Planning Unit, OIP will work in partnership with the Coronavirus Response and Recovery Unit to monitor PPE and other essential supply availability throughout the state, and identify potential needs that may impact vaccination. The state emergency operations center will also notify OIP of any unmet resource requests that come through the emergency management system.

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

Oregon will use multiple tools and techniques to monitor communications delivery and reception throughout the state.

Message delivery

- Enrolled provider communication - Oregon Immunization Program listserv message delivery warnings and message open rates will allow OIP to monitor messaging for key communications that are sent to enrolled providers. Monitoring these communications ensures that each clinic has a point of contact that is enrolled in the listserv and receiving key pandemic provider communications.
- Oregon Health Alert Network for emergency provider communications - HAN analytics allows OIP and the HSPR program to monitor and ensure that critical time sensitive messages are delivered to healthcare providers and emergency management agencies throughout the state.
- Communications with community-based organizations – The OHA Community Engagement Team has representatives assigned as key points of contact for specific regions and CBOs. These relationships, among other with community partners will be used to monitor communications with CBOs and ensure that messages are delivered and understood.



Reception of communication messages and materials among target audiences throughout jurisdiction

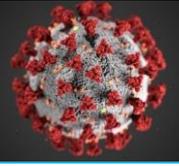
The OIP Vaccine Planning Unit communications team will use the following mechanisms to monitor COVID-19 vaccine messaging reception, identify key issues to be addressed, levels understanding and receptivity among communities disproportionately by COVID-19, and measure public sentiment. Communication reception monitoring systems will be cross walked with ALERT IIS vaccine uptake to help determine campaign efficacy and make recommendations on communication changes. ALERT IIS data indicating low vaccine uptake regionally, or in critical populations may indicate a need to revise communication approaches or increase public communications efforts.

Other methods to monitor communications include:

- Communication polling through DHM and Lara Media on vaccine messaging and reception throughout the state will be used to monitor message perception and reception among critical populations.
- Google web analytics
- Facebook analytics
- Meltwater for media monitoring
- Hootsuite metrics including engagement, reach, and sentiment will be used for general social media monitoring on immunization program and OHA pages
- 211 statewide information referral service – daily reports on number of calls, geographic coverage, topic of call, questions that can't be answered, and demographics of callers will be reported to identify emerging issues and key public questions

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

Local situational awareness will be monitored through several mechanisms. OIP will work with local partners to establish clear roles and responsibilities for local



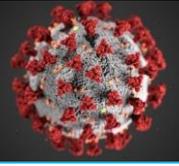
jurisdictions, encourage the establishment of Incident Management Teams or other clear organizational structures for distribution at the local level, designation of a clear point of contact for each jurisdiction, and establish clear planning processes that ensure coordination between state and local partners. The following approaches will be used to monitor progress:

- Standing weekly statewide Local public Health Administrator call
- Monitoring vaccine uptake dashboards at the local level and communicating with local jurisdictions as issues are identified
- Monitoring resource requests through the state emergency operations center to ensure that local resource needs are met
- Monitoring of local jurisdictions incident response reports to track progress on vaccine plan implementation and identify barriers
- Additional funding to support local and tribal vaccine planning and implementation efforts is currently being explored. If made available to local jurisdictions, funding will be tied to specific deliverables and workplans including routine progress reporting.

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

OHA will track several metrics and publish them on the immunization program and COVID-19 websites at <https://govstatus.egov.com/OR-OHA-COVID-19> OIP has significant experience with this type of monitoring through our annual real-time flu vaccine uptake monitoring. The following metrics have been identified as candidates for publication:

- Dashboards on specific metrics related to 1 and 2 dose vaccine uptake by the following characteristics:
 - State and county level



- Race and ethnicity
- Age
- Gender
- Priority populations such as healthcare workers, essential workers, and high-risk conditions are currently being explored
- Additional reports on doses distributed at the state and county level are in planning for weekly release
- Maps of priority population density statewide and at the county level and enrolled providers serving those populations

Known Gaps and Opportunities

- Collaboration with CBOs will be essential to early identification of access gaps and actions needed to support vaccine uptake. A clear process is not yet established for OIP to work with the OHA Community Engagement Team; the development of this process is a priority for the Community Engagement staff in the OIP Vaccine Planning Unit.

[Appendix](#)

Instructions: Jurisdictions may choose to include additional information as appendices to their COVID-19 Vaccination Plan.

Section 1, Appendix 1

[H1N1 After Action Report](#)

Section 2, Appendix 1



TRIBAL AFFAIRS

Kate Brown, Governor

Oregon
Health
Authority

500 Summer Street NE, E-86
Salem, OR 97301-1118
Desk: 503-945-9703

October 13, 2020

Dear Tribal Leader:

In an ongoing effort to consult with Oregon's nine Federally-recognized Tribes and confer with the Urban Indian Health Program on issues that may impact the Tribes and the health of their members, this letter is being sent to inform you of an identified critical event.

Critical Event:

OHA is beginning the COVID-19 vaccination planning process. While routine systems for vaccine delivery will provide the foundation for COVID-19 vaccine allocation, distribution, administration and information, these systems must be informed by planning inclusive of Tribal Governments and Oregon Communities. Tribal Health Centers have a relationship, working with the Oregon Immunization Program to deliver vaccine to tribal community members of all ages and an immunization preparedness Memorandum of Understanding (MOU) has been established to guide allocation of novel vaccine to individual tribes with the following signatories: Tribes, the Northwest Portland Area Indian Health Board, the Indian Health Service (IHS) and the Oregon Health Authority (OHA).

As a part of this planning OHA is convening a COVID-19 Vaccine Advisory Committee and requests that the Tribes and Urban Indian Health Program recommend two representatives to serve on this statewide committee to represent tribal interests in vaccine allocation, distribution, administration, data management and communication. We hope these representatives can assist in informing the planning process and, in partnership with OHA, actively share information with all tribal governments and communities in Oregon.

How the Critical Event Impacts Tribes:

As of right now our understanding is that Tribal Governments may be offered a choice by the federal government for how they wish to receive vaccine, through the state allocation or through the IHS allocation. OHA would like to engage with Tribal Leaders and discuss the options for receiving vaccine as well as hear tribal concerns and priorities to support state and tribal planning efforts. Additionally, OHA recognizes that tribal health facilities, urban Indian facilities and other organizations supporting tribal communities may have unique needs and considerations related to vaccine distribution.

Identify Affected/Potentially Affected Tribes:

All Tribes and the Urban Indian Health Program will be affected by COVID-19 vaccine distribution and the decisions made related to vaccination allocation. Similarly, tribal members who are a part of identified critical populations such as healthcare workers, essential workers, people with underlying health conditions and elders will also be affected by vaccine planning decisions.

Regardless of whether a Tribe chooses to receive state or IHS vaccine, OHA seeks tribal input through consultation, ongoing conversations and representation on the agency's COVID-19 Vaccine Planning Advisory Committee so the unique needs of tribal communities are addressed.

Timeline:

The Oregon Health Authority must submit a pre-planning document outlining planning considerations in 15 key areas to the Centers for Disease Control and Prevention by October 16, 2020. Tribal engagement efforts and a general participant list for the COVID Vaccine Planning Advisory Committee will be included in this pre-planning document. After the pre-planning document has been submitted, the Oregon Immunization Program will provide information to and request input from all Advisory Committee members, on at least a monthly basis, as vaccine development efforts continue at the national level.

OHA would like to invite you to a collective Nine Tribes Consultation/Urban Confer meeting to begin to discuss this topic on October 23, 2020 from 9:00-11:00 am. Zoom meeting details will be sent out in a calendar invite.

From there we can decide how we would like to continue the conversation moving forward. If this date and time does not work for you or if you would like an individual tribal consultation, please let me know.

We also invite you to provide any comments, suggestions and questions to OHA COVID Vaccine Planning Unit Leads, Rex Larsen Rex.A.Larsen@dhsoha.state.or.us and Cecile Town cecile.town@dhsoha.state.or.us as well as the Interim Oregon Immunization Program Manager, Lydia "Mimi" Luther Lydia.luther@dhsoha.state.or.us.

Sincerely,



Julie Johnson
Tribal Affairs Director

Section 2F Appendix 2

TRIBAL AFFAIRS



Title:	Tribal Consultation and Urban Indian Health Program Confer Policy
Effective Date:	3-1-18 
Nine Federally Recognized Tribes of Oregon:	Burns Paiute Tribe Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians Confederated Tribes of Grande Ronde Confederated Tribes of Siletz Indians Confederated Tribes of the Umatilla Indian Reservation Confederated Tribes of Warm Springs Coquille Indian Tribe Cow Creek Band of Umpqua Tribe of Indians Klamath Tribes
Urban Indian Health Program:	Native American Rehabilitation Association

I. Purpose

The State of Oregon and the Oregon Health Authority (OHA) share the goal to establish clear policies establishing the tribal consultation and urban confer requirements to further the government-to-government relationship between the State and the nine federally recognized Tribes of Oregon (Tribes) as well as strengthen the relationship with the Urban Indian Health Program (UIHP).

This policy:

- Identifies individuals within OHA who are responsible for developing and implementing programs that affect Tribes.
- Establishes a process to identify the OHA programs that impact Tribes.
- Promotes communication between OHA and the Tribes.
- Promotes positive government-to-government relations between OHA and Tribes.
- Establishes a method for notifying OHA employees of ORS 182.162 to 182.168 and this policy.

Meaningful consultation between tribal leadership and or designee and agency leadership shall result in information exchange, mutual understanding, and informed decision-making on behalf of the Tribes and the State. The goal of this policy includes, but is not limited to: eliminating health and human service disparities of Indians; ensuring that access to critical health and human services is maximized; advancing and enhancing the social, physical, behavioral and oral health of Indians; making accommodations in State programs when possible to account for the unique nature of Indian health programs and ensuring that the Tribes are consulted to ensure meaningful

and timely tribal input as required under Federal and State law when health and human service policies have an impact on Indians and the Tribes. To achieve this goal, and to the extent practicable and permitted by law, it is essential that the Tribes, and OHA engage in open, continuous, and meaningful consultation.

This policy applies to OHA and all its divisions, programs, services, projects, activities, and employees and shall serve as a guide for the Tribes to participate in OHA policy development to the greatest extent allowable under Federal and State law. The relationship between OHA and the Tribes is built on a foundation of trust and mutual respect. It is important for OHA to work closely with Tribes on issues related to Medicaid, Children's Health Insurance Program (CHIP), Oregon State Hospital, the Public Health Division the Health Insurance Marketplace (Oregon Department of Consumer and Business Services), and the Department of Human Services, Oregon Department of Housing and Community Services, Youth Development Council, Oregon Department of Veteran's Affairs to promote the participation of Indians in these programs.

II. Background

The United States Government has a unique legal relationship with American Indian tribal governments as set forth in the Constitution of the United States, numerous treaties, statutes, Federal court decisions and Executive Orders. This relationship is derived from the political and legal relationship that Indian Tribes have with the federal government and is not based upon race.

Section 1902 (a) (73) of the Social Security Act which requires a state in which one or more Indian health programs or UIHP furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the ISDEAA, or UIHP under the Indian Health Care Improvement Act (IHCA). Section 2107 (e)(1) of the Act was also amended to apply these requirements to CHIP.

The importance of tribal consultation with Indian tribes was affirmed through various statutes and Presidential Executive Orders including, but not limited to:

- Older Americans Act, P.L. 89-73, as amended;
- Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended;
- Native American Programs Act, P.L. 93-644, as amended;
- Indian Health Care Improvement Act, P.L. 94-437, as amended;
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193;

- Presidential Executive Memorandum to the Heads of Executive Departments, April 29, 1994;
- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000;
- Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004;
- Presidential Memorandum, Tribal Consultation, November 5, 2009;
- American Recovery and Reinvestment Act of 2009, P.L. 111-5, 123 Stat. 115, February 17, 2009;
- Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, 123 Stat. 8, February 4, 2009;
- Patient Protection and Affordable Care Act of 2010, P.L. 111-148, 124 Stat. 119, March 23, 2010;
- "Medicaid and CHIP Managed Care Rule CMS-2390-F, 42 CFR §438.14 and §457.1709;
- Department of Health and Human Services Tribal Consultation Policy, December 14, 2010; and
- Centers for Medicare and Medicaid Services Tribal Consultation Policy, Section 8, December 10, 2015.

In addition, there are statutory and regulatory requirements for states to consult with federally recognized tribes and to obtain advice from Indian health providers.

III. OHA Commitment to Tribal Consultation

OHA was established by the Oregon State Legislature and is accountable to the people of Oregon, acknowledges this unique relationship, the statutory and regulatory framework for states to consult with Tribes, and recognizes the right of Indian tribes to self-determination and self-governance. The special government-to-government relationship between the Tribes and federal and state governments will be respected in all dealings with the Tribes and OHA. Relationship of State Agencies with Indian Tribes, ORS 182.162 to 182.168.

The State specifically acknowledges the State Tribal consultation process for new and renewal submissions of: Medicaid and CHIP 1115 demonstration waivers; other Medicaid waivers, such as, 1915 waivers; 1332 waivers and changes to the Health Insurance Marketplace; and any amendments to the State Plan, waivers, or demonstrations that are considered to have an impact on AI/ANs and Indian health programs if the changes impact eligibility determinations, payment rates, payment methodologies, covered services, or provider qualifications and requirements that it is driven by federal law and regulations and/or guidance issued by CMS. These requirements are set forth in: Section 5006(e) of the American Recovery and Reinvestment Act; Section 1115 Transparency Regulations, as found in 42 CFR Part 431;

July 17, 2001 State Medicaid Director Letter #01-024; April 27, 2012 State Medicaid Director letter, SHO # 12-001; and CMS Regulations regarding State/Partnership Marketplaces; Department of Health and Human Services Tribal Consultation Policy, December 14, 2010; Centers for Medicare and Medicaid Services Tribal Consultation Policy, Section 8, December 10 2015.

In order to fully effectuate this consultation policy, OHA will:

1. Ensure inclusion of the Tribes prior to the development of policies and program activities that impact Tribes, utilizing a formal notice that provides descriptive content and a timeline;
2. Create opportunities for Tribes to raise issues with OHA and for OHA to seek consultation with Tribes;
3. Establish a minimum set of requirements and expectations with respect to consultation and participation of OHA leadership;
4. Conduct tribal consultation regarding OHA policies and actions that have tribal implications;
5. Establish improved communication channels with Tribes to increase knowledge and understanding of OHA programs;
6. Enhance partnerships with Tribes that will include technical assistance and access to OHA programs and resources;
7. Support tribal self-determination in programs and resources made available to the Tribes and in working with the Tribes;
8. Include tribal representatives on advisory committees and task forces when subject matter is relevant.

IV. Tribal Consultation Principles

Consultation is an enhanced form of communication that emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making, with the ultimate goal of reaching consensus on issues and better outcomes.

To establish and maintain a positive government-to-government relationship, communication and consultation must occur on an ongoing basis so that Tribes have an opportunity to provide meaningful, and timely input on issues that may have an impact on Tribes. This government-to-government relationship applies between the Tribes and the State.

Consultation with the Tribes is important in the context of health programs because the Tribes serve many roles in their communities:

- Tribes and tribal governments are sovereign nations with inherent authority over their internal affairs; have a government-to-government relationship with the federal government, state governments, and other sovereigns; and have the responsibility to ensure the health and well-being of their tribal citizens, among various other governmental responsibilities.
- Tribal governments operate businesses, are employers, and are health care providers, through administration of clinics and other health programs, which includes public health
- Tribal members are beneficiaries of services provided by the Indian Health Services (IHS), tribal health programs operating under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and by urban Indian health programs operating under Title V of the Indian Health Care Improvement Act.
- Tribal members are also eligible to enroll in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, (Oregon Department of Consumer and Business Services) and other health and human services programs in the state.

Tribal consultation is not invoked when this policy is not followed. For example, sending an email to Tribes is not considered tribal consultation or discussing a topic that involves Tribes without proper notice is not tribal consultation.

V. Conferring with Urban Indian Health Program

The Tribes direct OHA and all its divisions, programs, services, projects, activities, and employees to confer with the Urban Indian Health Program (UIHP) to ensure the exchange of information, mutual understanding, and informed-decision making on behalf of American Indians and Alaska Natives living in Oregon. UIHPs serve an important role in Oregon by providing critical health and wellness services to members of Oregon Tribes as well as members of other federally recognized Tribes.

UIHPs, authorized by Title V of the Indian Health Care Improvement Act P.L. 94-437, exist as a direct response to the Termination and Relocation Era policies which left American Indians and Alaska Natives displaced to urban centers across the country with few resources and little access to the Federal programs. UIHPs exist as a critical part of the Indian health system in the provision of health care to American Indians and Alaska Natives which is part of the Federal government's trust responsibility and treaty obligations to Tribes.

State agrees to notify UIHP when all Oregon Tribes are provided notice of Tribal consultation under this policy and/or as specified in Addendum A- Conferring with UIHP.

VI. Policy

It is the intent of OHA to meaningfully consult with Tribes on any policy that will impact the Tribes before any action is taken.

Such policies include those that:

1. Have Indian or Tribal implications; or
2. Have implications on the Indian Health Service, tribal health programs or urban Indian health program, or
3. Have a direct effect on one or more Tribes, or
4. Have a direct effect on the relationship between the state and Tribes, or
5. Have a direct effect on the distribution of power and responsibilities between the state and Tribes; or
6. Are a federally or statutorily mandated proposal or change in which OHA has flexibility in implementation.

If the proposal or change directly affects Indians, the Indian Health Service, tribal health programs or urban Indian health program, but is federally or statutorily mandated with no state flexibility in implementation, no consultation will be required; however, the proposal or change will be communicated through written updates from OHA to individuals on Official Notification List and pursuant to communication mechanism and communication method requirements described in Section VII.

VII. Tribal Consultation Process

An effective consultation between OHA and the Tribes requires trust between all parties which is an indispensable element in establishing a good consultative relationship. The degree and extent of consultation will depend on the identified Critical Event. A Critical Event must be formally identified by OHA or Tribes.

A Critical Event includes, but is not limited to:

- Policy development impacting the Tribes;
- Program activities that impacting Tribes;
- A State Plan Amendment (SPA), demonstration proposal or renewal, waiver proposal or renewal, or state Medicaid regulations changes with a compliance cost or impacting Tribes;
- Results of monitoring, site visits or audit findings impacting Tribes;
- Data collection and reporting activities impacting Tribes;
- Funding or budget developments impacting Tribes;
- Rule making impacting Tribes; or
- Any other event impacting Tribes.

Upon identification of a Critical Event impacting one or more Tribes OHA will initiate consultation regarding the event.

To initiate and conduct consultation, the following serves as a guideline to be utilized by OHA and the Tribes:

1. Identify the Critical Event: complexity, implications, time constraints, deadlines and Issue(s).
2. Identify how the Critical Event Impacts Tribes.
3. Identify affected/potentially affected Tribes.

Determining Consultation Mechanism: The most useful and appropriate consultation mechanisms can be determined by OHA and Tribes after considering the Critical Event and Tribes affected/potentially affected. Consultation mechanisms include but are not limited to one or more of the following:

- a. Mailings, including electronic mail;
- b. Teleconferences;
- c. Webinars;
- d. Face-To-Face Meetings at SB 770 Health and Human Service Cluster Committee Meetings and other meetings;
- e. Roundtables;
- f. Annual meetings;
- g. Other regular or special OHA or program level consultation sessions.

OHA will post and maintain electronic information on the agreed upon consultation mechanism on OHA Tribal Affairs site for Indian health programs.

Communication Methods: The determination of the Critical Event and the level of consultation mechanism to be used by OHA shall be communicated to affected/potentially affected Tribes using all appropriate methods and with as much advance notice as practicable or as required under this policy. These methods include but are not limited to the following:

1. **Official Notification:** Upon the determination of the consultation mechanism, proper notice of the Critical Event and the consultation mechanism utilized shall be communicated to affected/potentially affected Tribes using all appropriate methods including mailing and broadcast e-mail. Such notice shall be provided to:
 - a. Tribal Chairman or Chief and their designated representative(s)
 - b. Tribal Health Clinic Executive Directors of Oregon's 638/FQHC providers
 - c. IHS Clinic(s) Executive Director

- d. Tribal Organization(s) Health Director and/or designated representative(s)
- e. Tribal Organizations established to represent IHS and Tribal health programs and such as the Northwest Portland Area Indian Health Board Executive Director or designee(s)
- f. UIHP Executive Director or designee(s)

State must annually update their mailing/email list to ensure notice is being provided to designated leadership. Each Tribe is responsible for providing this information to OHA's Tribal Affairs Director to regularly update the list.

2. **Correspondence:** Written communications shall be issued within 14 calendar days of an identified Critical Event except that state plan amendments, waiver and rule making changes require additional notice as described below. The communication should clearly provide affected/potentially affected Tribes with detail of the Critical Event, clear and explicit instructions on the manner and timeframe in which to provide comments. A "Dear Tribal Leader Letter" (DTLL) format should be used to notify individual Tribes of consultation activities. The written notice DTLL will include, but is not limited to:

- a. Purpose of the proposal/change and proposed implementation plan;
- b. Anticipated impact on Indians and Indian health programs and the UIHP as determined by OHA;
- c. Method for providing comments/questions; and
- d. Timeframe for response.

In addition to the DTLL requirements above, state plan amendments, waivers, and rule making have additional requirements that must be included in the DTLL:

- a. **State Plan Amendments:** Prior to a State Plan submission to CMS, OHA must distribute documents describing the proposed Medicaid State Plan Amendment (SPA). The DTLL will include the proposed change; anticipated impact; method for providing comments/questions; timeframe for feedback; and an opportunity for discussion. This process will include a 90-day timeline. OHA will provide the draft SPA and related documents to Tribes 90 days prior to state's submission to CMS. This will allow Tribes 30 days to review the draft SPA and documents, 30 days to request formal consultation, if needed, and 30 days to provide written comments. For tracking purposes OHA will share a status report of pending, upcoming and approved SPAs on a monthly basis. OHA will also share an ongoing report of all SPA's that have been approved.
- b. **Waivers:** Pursuant to the CMS's transparency regulations at 42 CFR 431.408(b), State Medicaid Director Letter #01-024 and Section 8 of CMS's Tribal Consultation Policy, OHA must consult with Tribes prior to

submitting any Section 1115 and 1915 waiver request to CMS, OHA must consult with Tribes at least 60 calendar days before OHA intends to submit a Medicaid waiver request or waiver renewal to CMS. The DTLI or notification required by SMD #01-024 must describe the purpose of the waiver or renewal and its anticipated impact on tribal members. For Tribes to understand the impact on its tribal members, the notification should include the actual language from the demonstration waiver or renewal that has tribal implications and should not be in summary or outline form.

- c. **Rulemaking:** OHA must consult with Tribes at least 60 calendar days notice before OHA intends to propose new rules or changes to rules that impact Tribes. Tribes will also be invited to attend Rule Advisory Committee meetings to provide additional input on rule concepts and language. In addition, OHA will provide tribes with bi-weekly updates on new rules or changes to rules impacting tribes.
3. **Meeting(s):** OHA shall convene a meeting within 30 calendar days' notice of an identified Critical Event with affected/potentially affected Tribes (or sooner with affected/potentially affected Tribe(s) approval), to discuss all pertinent issues when the Critical Event is determined to have an impact.

SB770 Health and Human Services Cluster Meeting: In addition, when Tribal Consultation is scheduled at an SB 770 Health and Human Services Cluster Meeting, the agenda must clearly indicate that the item is a Tribal Consultation request and clearly state on the agenda "Tribal Consultation: [agenda item]. Such request at an SB 770 Health and Human Services Cluster meeting must provide at least 30 days' advance calendar notice.

4. **Creation of Committees/Work Group(s):** Round tables and work groups should be used for discussions, problem resolution, and preparation for communication and consultation related to a Critical Event but do not replace formal tribal consultation. Round tables and work groups will provide the opportunity for technical assistance from OHA to Indian health programs and the UIHP to address challenges or barriers and work collaboratively on development of solutions to bring to the meetings. OHA will work with Indian health programs and the UIHP to designate technical representation on special workgroups as needed or recommended.

Reporting of Outcome: OHA shall report on the outcomes of the consultation within 30 calendar days of final consultation by letter or email. For ongoing issues identified during the consultation, OHA shall provide status reports throughout the year to the Tribes, and prepare an annual tribal consultation report.

Implementation Process and Responsibilities: The process should be reviewed and evaluated for effectiveness every 3 years, or as requested.

VIII. Tribal Consultation Performance Evaluation

OHA is responsible for evaluating its performance under this Tribal Consultation Policy. To effectively evaluate the results of the consultation process and the ability of OHA to incorporate tribal recommendations, OHA will assess its performance on a quarterly and annual basis in tribal consultation reports. The State will provide performance data in its reports.

IX. Meeting Records and Additional Reporting

OHA is responsible for making and keeping records of its tribal consultation activity. All such records shall be made readily available to Tribes an annual tribal consultation report and all data. OHA shall make and keep records of all proceedings and recommendations, and will have these records readily available upon request and/or posted online.

X. Role of Tribal Affairs Director

The OHA Tribal Affairs Director is responsible for coordinating with OHA staff including directors, Tribal Liaisons, and other designated staff in developing and implementing programs that affect Tribes. The Tribal Affairs Director will communicate with staff on a regular basis to identify the OHA programs that affects Tribes. Tribal Affairs will convene quarterly with all staff working with Tribes to assure that they are aware of the current Tribal Affairs practices, and policies as well as an opportunity to communicate about ongoing work with Tribes. Tribal Affairs will provide training to notify OHA employees of ORS 182.162 to 182.168 and this policy.

XI. Tribal Technical Advisory Board

Through ongoing communications (e.g., emails) and during a standing meeting on a quarterly basis, the State will solicit advice and guidance from the Board on policies, guidelines, and programmatic issues affecting the delivery of health care for tribal members and to ensure that Indians receive quality care and access to services. The role of the Tribal Technical Advisory Board is not meant to replace the tribal consultation process.

XII. Definitions

1. **Indian or American Indian/Alaska Native (AI/AN).** Indian and/or American Indian/Alaska Native (AI/AN) means any individual defined at 25 USC 1603(13),

1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

- a. Is a member of a Federally recognized Indian Tribe;
 - b. Resides in an urban center and meets one or more of the four criteria:
 - i. Is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
 - ii. Is an Eskimo or Aleut or other Alaska Native;
 - iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - iv. Is determined to be an Indian under regulations issued by the Secretary;
 - c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - d. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
2. Tribe. Tribe means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. Oregon's nine Federally Recognized Tribes include:

Burns Paiute Tribe
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
Confederated Tribes of Grande Ronde
Confederated Tribes of the Siletz Indians
Confederated Tribes of the Umatilla Indian Reservation
Confederated Tribes of Warm Springs
Coquille Indian Tribe
Cow Creek Band of Umpqua Tribes of Indians
Klamath Tribes

3. Urban Indian Health Program (UIHP). Urban Indian Health Program means an urban Indian organization which is a nonprofit corporate body situated in an urban center

governed by a board of directors of whom at least 51 percent are AI/ANs, who have been contracted through Title V of Public Law 94-137. Oregon's UIHP is the:

Native American Rehabilitation Association (NARA)

4. Technical Advisory Board. This board will consist of Tribal Health Directors and or designated representatives from each of the nine federally recognized tribes, NARA, and the Northwest Portland Area Indian Health Board.

XIII. Disclaimer

OHA respects the sovereignty of each of Oregon's Tribes. In executing this policy, no party waives any rights, including treaty rights; immunities, including sovereign immunities; or jurisdictions. This policy does not diminish any rights or protections afforded other Indian persons or entities under state or federal law. Through this policy, the parties strengthen their collective ability to successfully resolve issues of mutual concern. While the relationship described by this policy provides increased ability to solve problems, it likely will not result in a resolution of all issues. Therefore, inherent in their relationship is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, that party's executive office.

XIV. Effective date

This policy will be effective on March 1, 2018 and may be reviewed at the request of the Tribes or OHA.

Addendum A

Conferring with Urban Indian Health Program (UIHP)

The objective of conferring with the UIHP is to ensure the open and free exchange of information and opinions that leads to mutual understanding and comprehension; and emphasizes trust, respect, and shared responsibility. See 25 USC §1660d (a). It is the intention of OHA] to confer with the UIHP on any policy or decision that would impact the urban Indian community before any such policy or decision is put into effect.

A policy or decision that would trigger conferring with the UIHP includes those that:

1. Have implications for the urban Indian community; or
2. Have implications on the Indian Health Service or urban Indian health program, or
3. Are a Federally or statutorily mandated proposal or change in OHA has flexibility in implementation.

If the proposal or change directly affects Indians, the Indian Health Service, the urban Indian community or urban Indian program, but is Federally or statutorily mandated with no State flexibility in implementation, conferring will not be required; however, the proposal or change will be communicated through written updates from OHA] to the UIHP Health Director within 30 days.

The basis of the conferring process is mutual trust between OHA and the UIHP. The nature of the Critical Event will determine the depth of the conferring process. A Critical Event may be identified by either OHA or the UIHP.

A Critical Event includes, but is not limited to:

- Policy development impacting the UIHP;
- Program activities that have an impact on the UIHP;
- A State Plan Amendment (SPA), demonstration proposal or renewal, waiver proposal or renewal, or state Medicaid regulations changes with a compliance cost or impact on the UIHP;
- Results of monitoring, site visits or audit findings impacting the UIHP;
- Data collection and reporting activities impacting the UIHP;
- Funding or budget developments impacting the UIHP; or
- Any other event impacting the UIHP.

Once a Critical Event has been identified by OHA or the UIHP the OHA] will initiate the conferring process.

Initiation of the conferring process by either OHA or the UIHP will be guided by the following outline:

1. Identify the Critical Event: complexity, implications, time constraints, and issue(s)
2. Identify how the Critical Event impacts the UIHP.
3. Identify affected/potentially affected the UIHP.

Determining the method of conferring: the process of conferring will be agreed upon by OHA and the UIHP after the determination of the Critical Event. Mechanisms for conferring will include any options that provide the opportunity for an open and free exchange of information and opinions that lead to mutual understanding and comprehension, and emphasize trust, respect, and shared responsibility.

Acronyms

ACDP	Acute and Communicable Disease Prevention
ACIP	Advisory Committee on Immunization Practices
ACS	American Community Survey
AMR	American Medical Response (ambulance service)
AOC- JIC	Agency Operations Center Joint Information Center
ArcGIS	Geographic Information System/Mapping Software
ASL	American Sign Language
CARES	Coronavirus Aid, Relief and Economic Security (Act of Congress)
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CLHO	Conference of Local Health Officials
CPHP	Center for Public Health Practice
CRRU	COVID-19 Response and Recovery Unit
DHS	Oregon Department of Human Services
DOJ	Oregon Department of Justice
DUA	Data Use Agreement
EHR	Electronic Health Record (system)
EMS	Emergency Medical Services
EUA	Emergency Use Authorization
FQHC	Federally Qualified Health Center
HCW	Health Care Worker
HIC	Health Information Center
HIS	Indian Health Services
HL7	Health-level seven
HSPR	Health Security Preparedness and Response Program
Ig	Immune globulin

IIS	Immunization Information System
IMT	Incident Management Team
IPAT	Immunization Policy Advisory Team
IZ	Immunization
JIC	Joint Information Center
LEIE	List of Excluded Individuals and Entities
LPHA	Local Public Health Authority
LTCF	Long term and community-based care facility
MOU	Memorandum of Understanding
NARA	Native American Rehabilitation Association of the Northwest, Inc.
ND	Naturopathic doctor
NPAIHB	Northwest Portland Area Indian Health Board
ODHS	Oregon Department of Human Services
OEI	Oregon Office of Equity and Inclusion
OHA	Oregon Health Authority
OHCS	Oregon Housing and Community Services
OHP	Oregon Health Plan
OIG	Office of Inspector General's
OIP	Oregon Immunization Program
OIS	Office of information Services
OSPA	Oregon State Payroll Application
PE-31	Program Element 31
PHD	Public Health Division
PIO	Public Information Officer
POC	Point of Contact
POD	Point of Dispensing
POST	Oregon's internal provider website
REALD	Race, ethnicity, language, and disability
RHECs	Regional Health Equity Coalitions

RR	Reminder/Recall
SFMA	State Financial Management Application
SVI	Social Vulnerability Index
VAERS	Vaccine Adverse Event Reporting System
VAMS	Vaccine Administration Management System
VFC	Vaccines for Children (Federal program)
VIS	Vaccine information statements
VMG	Vaccine Management Guide
VPD	Vaccine preventable disease
WIR	Wisconsin Immunization Registry