

Phase 1A Allocation Guidance for COVID-19 Vaccine in the State of Wisconsin

The Vaccine Subcommittee (“Subcommittee”) of the State Disaster Medical Advisory Committee (SDMAC) was established to develop guidance for Department of Health Services (DHS) plan for allocation of limited numbers of vaccine doses during the COVID-19 pandemic, especially in the first months following vaccine release. At the present time, no SARS-CoV-2 vaccine is available in the United States, but several candidate vaccines are in development and under study in phase 3 clinical trials. It is realistic to assume that one or more vaccine products will be approved for use in the United States during the next six months. Once approved, the quantity of vaccine doses available will be small in relationship to the number of people eligible to receive it, and therefore rationing of available vaccine will be necessary as production and distribution increases.

The Wisconsin vaccination program will unfold in a series of phases, and it will begin with Phase 1A corresponding to the period when the vaccine supply is most restricted. In accordance with the SDMAC charge, the co-chairs and Subcommittee conducted a review of high profile guidance documents including the National Academies of Sciences, Engineering, and Medicine¹, the World Health Organization², and Johns Hopkins Bloomberg School of Public Health³ and the Advisory Committee on Immunization Practice (ACIP). The Subcommittee identified healthcare workers as the most common priority group for Phase 1A (Table 1).

The CDC COVID-19 Vaccination Program Provider Agreement requires all immunizers to follow all ACIP *recommendations and requirements*. **At the current time, the ACIP has not issued any recommendation for use of COVID-19 vaccines.** This federal advisory committee will meet as soon as a vaccine is authorized or licensed by the Food and Drug Administration (FDA) to review policy options and make a formal recommendation for the use of COVID-19 vaccines. Until ACIP recommendations are available, existing language from CDC will be highlighted in this guidance, while the remainder of the definitions and prioritization criteria are provided for organizations to consider when facing inadequate supply to vaccinate their healthcare work force.

The Subcommittee agreed to define **healthcare personnel (HCP)** as:

“individuals who provide direct patient service (compensated and uncompensated) or engage in healthcare services that place them into contact with patients who are able to transmit SARS-CoV-2, and/or infectious material containing SARS-CoV-2 virus.”

The CDC/ACIP guidance for prioritization within this group is:

“frontline HCPs in hospitals, nursing homes, home care who i) work where transmission is high or ii) at increased risk of transmitting to pts at high risk of severe morbidity and mortality. The HCP

¹ National Academies of Sciences, Engineering and Medicine. A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus. <https://www.nap.edu/catalog/25914/discussion-draft-of-the-preliminary-framework-for-equitable-allocation-of-covid-19-vaccine>

² World Health Organization. WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination. <https://apps.who.int/iris/bitstream/handle/10665/334299/WHO-2019-nCoV-SAGE-Framework-Allocation-and-prioritization-2020.1-eng.pdf>

³ Johns Hopkins University. Interim Framework for COVID-19 Vaccine Allocation and Distribution in the United States. <https://www.centerforhealthsecurity.org/our-work/publications/interim-framework-for-covid-19-vaccine-allocation-and-distribution-in-the-us>

category includes clinicians; environmental services; nursing assistants; staff in assisted living, long term care and group care; and home caregivers if meet 1a risk criteria⁴.

Given the high level of SARS-CoV-2 circulating throughout the state of Wisconsin, the Subcommittee agreed that all HCP with patient contact meet the definition of “being placed into contact with patients who are able to transmit SARS-CoV-2.” The Subcommittee provided evidence based review of literature and provided guidance to organizations which is broken into organizational and individual patient level decision making.

Organizational decisions for making prioritization decisions within their healthcare personnel *might consider one or more of the following*^{5,6,7}:

Essential nature of a position and ability to restaff: organizations may wish to prioritize staff with essential skills and knowledge and/or staff who would be difficult to replace in the event of need to isolate and/or for time to recover from moderate to severe illness, thus resulting in an inability to work.

HCPs on designated COVID-19 units may be prioritized over HCPs who are not working on non-COVID-19 units: COVID-19 units are serving individuals who are the most severely ill as a direct result of the pandemic. Illness and/or absence on the part of the HCP serving these patients would represent a significant negative impact for both individual organizations and the overall ability of the health system to respond to this crisis.

High risk procedures: individuals who perform high risk procedures, such as intubation, respiratory treatments, and other aerosol-generating procedures, may be prioritized.

Known patient COVID-19 status: while asymptotic spread is a significant challenge for all healthcare personnel, prioritization may be considered for individuals who are caring for known COVID-19 patients and HCP testing patients for to determine COVID-19 status.

Duration of exposure: HCP who are exposed to COVID-19 positive patients for longer durations might be prioritized over those who have shorter durations of exposure.

Work in ICU prioritized over non-ICU: as ICU beds in Wisconsin reach capacity, maintaining staffing for those beds that are occupied by acutely ill patients from both pandemic and non-pandemic causes ensures that hospitals can continue to serve patients.

⁴ Centers for Disease Control and Prevention. *COVID-19 Vaccine Program Interim Playbook for Jurisdictional Operations (2)*. https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf

⁵ Nguyen, L, Drew D, Graham M, et al. *Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study*. The Lancet. July 31, 2020. [https://doi.org/10.1016/S2468-2667\(20\)30164-X](https://doi.org/10.1016/S2468-2667(20)30164-X)

⁶ Centers for Disease Control and Prevention. *Strategies for Optimizing the Supply of N95 Respirators*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

⁷ Centers for Disease Control and Prevention. *Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic*. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

Access to appropriate PPE/other non-pharmaceutical interventions (NPI): Some HCP may be patient facing but may have access to and training for additional non-pharmaceutical interventions. Examples of members who might receive a lower priority in this group might include: providers conducting telemedicine appointments, registration staff who have 6 foot distance markers and Plexiglas for protection.

Environmental containment measures: HCP in makeshift wards with inadequate ventilation might be prioritized over those working in wards without environmental mitigations in place.

Density of workplace/patient care environment: HCP exposure to high volumes of individuals or groups might be prioritized over individuals who have fewer contacts.

Individual demographic and health status characteristics of HCP have been identified in the available evidence that may place a HCP at higher risk of severe illness from the virus that causes COVID-19^{8,9}; therefore, organizations *might* consider using them as an additional prioritization criteria:

Demographic

- Age 65+¹⁰
- Black
- Latinx
- Native American
- Socioeconomic class

Health Status

- Hypertension
- Chronic metabolic disease
- Diabetes
- Chronic lung disease
- Asthma
- Cardiovascular disease
- Pregnancy
- Immunocompromised condition
- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 kg/m² or higher but < 40 kg/m²)
- Severe Obesity (BMI ≥ 40 kg/m²)
- Sickle cell disease
- Smoking

⁸<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

⁹ Kambhampati AK, O'Halloran AC, Whitaker M, et al. COVID-19–Associated Hospitalizations Among Health Care Personnel — COVID-NET, 13 States, March 1–May 31, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1576–1583. DOI: <http://dx.doi.org/10.15585/mmwr.mm6943e3>

¹⁰ Self WH, Tenforde MW, Stubblefield WB, et al. Seroprevalence of SARS-CoV-2 Among Frontline Health Care Personnel in a Multistate Hospital Network — 13 Academic Medical Centers, April–June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1221–1226.

Type 2 diabetes mellitus
Intellectual or developmental disability¹¹

In addition, vaccinators may choose to implement lottery systems and/or first come/first served options. The subcommittee encourages that however vaccine is prioritized that it be clear and transparent for staff with efforts to reduce rather than reinforce inequalities whenever possible.

Finally, the Subcommittee did not feel there was enough evidence to confirm durable, long term immunity in cases with prior infection with SARS-CoV-2¹². Therefore, the Subcommittee's guidance is to exclude prior infection as a consideration when prioritizing vaccine. Should a vaccinator anticipate vaccine waste (vaccine approaching the end of a shelf life or stability guidelines) they must alert DHS immediately to ensure the vaccine is used.

Table 1

Categories of HCP job titles and settings

- Nurse
- Transportation services
- CNA/Nursing assistant/Nurse aide
- Patient aide/Care aide/Caregiver/Personal care assistant
- Phlebotomist/Technician
- Housekeeping/Maintenance
- Nursing home/LTCF/Assisted living
- In home care, including home health
- Social work/Behavioral health/Counseling/Spiritual care provider/Clinical ethicist
- Human resources/Administration
- Physician (MD/DO)/Physician assistant/Advanced practice nurse/Nurse practitioner
- Dentist/Dental hygienist
- Medical assistant
- Physical therapist/Occupational therapist/Speech therapist
- Chiropractor
- Emergency medical technician/Paramedic
- Food service
- Pharmacist/Pharmacist assistant
- Security personnel
- Respiratory therapist
- Environmental services
- Laboratory personnel
- Public health workers providing vaccines and testing for COVID-19
- Other healthcare personnel who have CDC defined exposure
- Other professionals and lay people who provide services as defined above

¹¹ A FAIR Health, West Health Institute and Marty Makary, MD, MPH. (2020). *Risk Factors for COVID-19 Mortality among Privately Insured Patients*. New York, New York: FAIR Health 2020.

¹² Wallace. *Updates to COVID-19 Immunity and Epidemiology to Inform Vaccine Policy*. ACIP meeting. October 30, 2020