

Pandemic COVID-19 FE: Vaccination for Critical Workforce Groups and Disproportionately Impacted Populations (VAC)

In the fall of 2020, CDC issued [COVID-19 Vaccination Program Interim Operational Guidance for Jurisdiction Operations](#) and outlined how state, local, tribal, and territorial jurisdictions and their partners must plan and operationalize a COVID-19 vaccine campaign in response to the pandemic. Public health plans needed to consider a phased approach to vaccination, identification of critical populations, provider recruitment and enrollment, capacity to administer, and vaccine storage and handling.

Submitting sufficient evidence via the PHEP ORR Pandemic COVID-19 Functional Exercise: Vaccination for Critical Workforce Groups and Disproportionately Impacted Populations (VAC) satisfies the PHEP program exercise requirement to conduct a functional exercise for critical workforce group vaccination given a pandemic influenza scenario with a limited supply of vaccine.

Element	Data Entry Guidance	Significance
<p>VAC1 <i>Critical Workforce Groups (CWG) and Disproportionately Impacted Populations (DIP) Prioritized for COVID-19 Vaccine (select all)</i></p>	<p>VAC1 Select all priority CWG and DIP included in pandemic vaccination planning regardless of prioritization status during the limited vaccine distribution. COVID-19 initial authorization of vaccine began in December 2020 and availability increased incrementally until May 2021 when vaccine was more widely available to all eligible persons 16 years and older.</p>	<p>VAC provides information about allocating and targeting vaccine for CWG and DIP during limited early phase vaccine rollout until general population availability.</p> <p>Several authorities established guidance for prioritizing populations for COVID-19 vaccine eligibility including the</p> <p>Cybersecurity and Infrastructure Security Agency; the National Academy of Medicine, Engineering, and Science; and CDC’s Advisory Committee on Immunization Practices (ACIP). ACIP specified priority groups as the pandemic evolved and recommendations changed based on emergency use authorizations (EUA). However, initial vaccine supply required jurisdictions to prioritize further within their jurisdictions.</p>

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<p>VAC1 Review submitted COVID-19 vaccination plans and additional evidence about how jurisdictions selected CWG and DIP for targeted vaccination during the early phase of COVID-19 vaccine availability. Plans must include at least one group based on CDC’s COVID-19 Vaccination Program Interim Operational Guidance Jurisdiction Operations.</p>	<p>COVID-19 Vaccination Plans must be submitted as evidence. Jurisdictions must work closely with immunization program counterparts to support best practices and procedures for vaccine protocols. Collaboration with CWG and DIP must be reported and inclusion of nontraditional prioritized CWGs in the private sector, grocery chains, and other sectors must be documented.</p> <p><u>Examples of acceptable evidence</u></p> <ul style="list-style-type: none"> • COVID-19 vaccination plans. • AARs. • Incident corrective actions. 	<p>Satisfactory evidence meets the PHEP five-year exercise requirement to conduct an FE for CWG vaccination given a pandemic influenza scenario with a limited supply of vaccine.</p>

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<p>VAC2.a-b <i>Role determining prioritized populations for limited supply of COVID-19 vaccination</i></p> <p>a. <i>At the start of vaccine availability and administration (Lead, Support, No Role),</i></p> <p>b. <i>During the refinement of priority vaccination groups (Lead, Support, No role)</i></p>	<p>VAC2.a Select the PHEP program staff role in determining prioritized CWG and DIP <u>prior to vaccine</u> authorization and distribution (March 2020–December 2020).</p> <p>VAC2.b Select the PHEP program staff role and provide evidence documenting how public health refined vaccine priority groups. Expanding edibility required consideration for vaccine allocation shifts based on supply, demand, vaccine characteristics, and disease epidemiology. Evidence must account for shifts from the initial vaccine rollout and throughout the limited vaccine availability distribution (December 2020–May 2021).</p> <p><u>Lead</u>: Primary responsibility for funding and preparedness planning and/or response activities</p> <p><u>Support</u>: Shared funding and collaboration for preparedness planning and/or response activities</p> <p><u>No role</u>: No direct involvement in preparedness funding, planning, or response activities</p>	<p>Initial vaccine supply increased incrementally throughout the pandemic. This required effective allocation and administration of vaccine to reduce pandemic-related morbidity and mortality.</p>
<p>VAC2.c <i>Vaccine administration capacity (Lead, Support, No Role)</i></p> <p>VAC2.d <i>Equitable access to vaccine services (Lead, Support, No Role)</i></p>	<p>VAC2.c Select the PHEP program staff role in determining vaccine administration capacity, which is defined as the maximum achievable vaccination throughput regardless of public demand for vaccination. Considerations for calculating administration capacity include available vaccine providers, locations, and storage and handling capacity.</p> <p>VAC2.d Select PHEP program staff role planning for equitable vaccine access across the jurisdiction. Equitable access requires information about populations within the jurisdiction and partners who are familiar with how these populations obtain health care and essential services.</p> <p><u>Lead</u>: Primary responsibility for funding and preparedness planning and/or response activities</p> <p><u>Support</u>: Shared funding and collaboration for preparedness planning and/or response activities</p> <p><u>No role</u>: No direct involvement in preparedness funding, planning, or response activities</p>	

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<p>VAC2.a-b Evidence must document the lead agency, public health or other, and substantiate the roles and responsibilities for identifying targeted CWG and DIP. Evidence must also support how the jurisdiction refined targeted vaccination for CWG and DIP based on vaccine availability, uptake, and epidemiologic data.</p>	<p>VAC2.a-b Document how prioritized groups were identified prior to vaccine availability and as supply increased. Consideration for the process to refine targeted populations based on real-time feedback from partners and key stakeholders must also be presented. Jurisdictions must provide evidence of PHEPs role in creating and refining COVID-19 vaccination plans for CWG and DIP when vaccine supply was limited during the early phase of vaccine availability.</p> <p>If public health had no role, documentation must describe how prioritized populations were selected and refined throughout the campaign for the jurisdiction.</p> <p><u>Examples of acceptable evidence</u></p> <ul style="list-style-type: none"> • COVID-19 vaccination plans. • Stakeholder communications. • AARs. • Incident corrective actions. 	
<p>VAC2.c Calculation of administration capacity involves an inventory of both public and private vaccination settings, population estimates, and vaccine storage and handling capacity. Evidence must document consideration for the following when estimating vaccination capacity: number of existing provider locations, provider participation rate, storage capacity throughout the jurisdiction, and past administration capacity calculations for other vaccine (e.g., influenza).</p> <p>VAC2.d Evidence must describe how vaccination coverage was monitored throughout the COVID-19 vaccination campaign and must address considerations for equitable vaccine access across the whole jurisdiction including CWG and DIP.</p>	<p>VAC2.c Estimates of vaccination capacity will yield the maximum achievable vaccination throughput for a designated period of time.</p> <p><u>Examples of Acceptable Evidence</u></p> <ul style="list-style-type: none"> • Population estimates for different CWG, DIP, and localities. • Estimates of existing providers. • Known vaccination locations. <p>VAC2.d Vaccination activities must be continuously monitored across all populations within the jurisdiction to support equitable access to COVID-19 vaccine while vaccine is in limited supply.</p> <p><u>Examples of Acceptable Evidence</u></p> <ul style="list-style-type: none"> • Plans to provide access to underserved populations. • MOU with representatives from community groups. • Maps or other information regarding identification and vaccine coverage of CWG and DIP. 	

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<p>VAC3.a-e PHEP role communicating targeted vaccination plans with</p> <ul style="list-style-type: none"> a. Incident management stakeholders (Lead, Support, No Role) b. Vaccine administrators (Lead, Support, No Role) c. CWG employers for directed outreach (Lead, Support, No Role) d. DIP community partners for culturally sensitive message development (Lead, Support, No Role), e. DIP community partners to amplify directed outreach (Lead, Support, No Role) 	<p>VAC3.a Select the PHEP program staff role developing and implementing messaging for incident management stakeholders regarding COVID-19 priority vaccination and current vaccine availability. Incident management staff from both public health and partner agencies must be considered.</p> <p>VAC3.b Select the PHEP program staff role in communicating with vaccine administrators. Vaccine administrators might include public health staff, physicians, nurses, pharmacists, and other staff responsible for administering vaccine to targeted CWG and DIP.</p> <p>VAC3.c Select the PHEP program staff role engaging CWG employers, such as hospitals, long term health care facilities, and pharmacies, to identify, educate, and vaccinate employees in targeted vaccination groups. CWG engagement must identify trusted sources among employers, unions and professional organizations, health insurance issuers, and employees.</p> <p>VAC3.d Select the PHEP program staff role working with DIP community leaders and partners to develop culturally sensitive messaging about eligibility for targeted vaccine distribution. Inclusion of DIP community partners knowledgeable about the targeted population’s health care and other essential service utilization can help promote meaningful messaging to facilitate equitable vaccine dissemination.</p> <p>VAC3.e Select the PHEP program staff role collaborating with community partners to amplify and disseminate public health messaging to targeted populations. Dissemination and amplification of messages regarding the development, authorization, and distribution of vaccines helps build public trust and confidence in vaccination. Strong partnerships with stakeholders can facilitate timely, accessible, and effective messaging. The Disabilities/AFN coordinator or equivalent staff is often the PHEP point person for engagement with community partners and trusted sources.</p> <p><u>Lead</u>: Primary responsibility for funding and preparedness planning and/or response activities</p> <p><u>Support</u>: Shared funding and collaboration for preparedness planning and/or response activities</p> <p><u>No role</u>: No direct involvement in preparedness funding, planning, or response activities</p>	<p>Pandemic vaccination planning requires collaboration between public health, external agencies, and community partners. Planning for communication with vaccine stakeholders and the public is essential for a successful vaccination campaign. Additionally, reaching intended vaccine recipients is essential to achieving high vaccination coverage.</p>

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<p>Evidence must document the lead agency, public health or other, and substantiate the roles and responsibilities for communicating targeted vaccination plans.</p> <p>VAC3.a Communication evidence must identify how key incident management leaders were involved in message development and dissemination.</p> <p>VAC3.b Evidence must document how information about vaccine development, safety, targeted groups, and availability was communicated with vaccine administrators, including health care personnel responsible for administering vaccine. Communication evidence must cover disseminating key considerations related to vaccine program implementation and updated messaging.</p> <p>VAC3.c Evidence about messaging to employers must document vaccine eligibility and describe engagement with targeted CWG regarding safety, effectiveness, availability, and targeted dissemination.</p> <p>VAC3.d-e Jurisdiction must provide evidence regarding its role in identifying and engaging community partners and trusted sources to integrate culturally appropriate messaging that is tailored to targeted communities and DIP. Messaging must be inclusive, respectful, and use non-stigmatizing, bias-free language.</p>	<p>VAC3.a-e Clear and effective communication with multiple stakeholders is essential for a successful COVID-19 vaccination campaign. Effective communication is timely and tailored for each intended audience.</p> <p>If public health had no role, documentation must describe how these activities were accomplished in the jurisdiction.</p> <p><u>Examples of Acceptable Evidence</u></p> <ul style="list-style-type: none"> • COVID-19 vaccination plans. • Pandemic communication plans. • Stakeholder communications. • AARs. • Incident corrective actions. 	

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<p>VAC4.a-k. Vaccine management and administration activities (Lead, Support, No Role)</p> <ul style="list-style-type: none"> a. Vaccine supply b. Vaccine shipment c. Vaccine transport d. Vaccine storage and handling (including cold chain management) e. DVC preparation and supplies f. DVC locations g. Vaccine preparation h. Vaccine administration i. Vaccine documentation j. Vaccine adverse event tracking k. Post DVC actions, documentation, or demobilization 	<p>VAC4.a-k Select the role that the PHEP program staff had for each of the vaccine management and administration activities. Distribution, administration, and tracking of vaccine required careful planning and implementation to make equitable vaccine available where needed.</p> <p><u>Lead:</u> Primary responsibility for funding and preparedness planning and/or response activities</p> <p><u>Support:</u> Shared funding and collaboration for preparedness planning and/or response activities</p> <p><u>No role:</u> No direct involvement in preparedness funding, planning, or response activities</p>	<p>The COVID-19 pandemic response was nationwide impacting local, state, territorial, and tribal governments. Pandemic influenza vaccine plans were adapted to accommodate the changing landscape given the COVID-19 pandemic. Cross-cutting plans drew upon jurisdictional knowledge and prior response planning to implement successful COVID-19 vaccination campaigns.</p>

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<p>VAC4.a-k Evidence must document the lead agency, public health or other, and substantiate the roles and responsibilities for each component of vaccine management and administration for the duration of the vaccination campaign.</p>	<p>VAC4.a-k</p> <p><u>Examples of acceptable evidence</u></p> <ul style="list-style-type: none"> • COVID-19 vaccine planning. • MOU or equivalent documentation of agreements for vaccine management. • AAR or interim AAR documenting vaccine management. 	

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<p>VAC4.i. <i>Public health emergency preparedness and response capabilities supported COVID-19 vaccination efforts (select all)</i></p>	<p>Due to the scope and complexity of the development and allocation of the COVID-19 vaccine, special considerations regarding vaccine allocation, ordering, distribution, storage and handling, and inventory management were needed for a successful vaccination campaign.</p> <p>VAC4.i Select all national preparedness capabilities that the jurisdiction leveraged to support the COVID-19 pandemic response. The COVID-19 response relied upon the underlying preparedness infrastructure to support the distribution and administration of a population-based vaccine campaign.</p>	
<p>VAC4.m. <i>Monitored best practices for temporary, off-site, or satellite clinics (Lead, Support, No Role)</i></p>	<p>VAC4.m. Select PHEP role for monitoring best practice use for temporary, off-site, or satellite clinics. At least one Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations must be submitted as evidence when public health was in a lead or support role. If public health had no role, provide evidence that documents how the lead agency maintained oversight for storage, handling, and administration practices.</p> <p>Evidence for additional considerations necessary during the COVID-19 pandemic, including social distancing, PPE use, and enhanced sanitation efforts, are encouraged.</p> <p><u>Lead</u>: Primary responsibility for funding and preparedness planning and/or response activities</p> <p><u>Support</u>: Shared funding and collaboration for preparedness planning and/or response activities</p> <p><u>No role</u>: No direct involvement in preparedness funding, planning, or response activities</p>	

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<p>VAC4.i A successful vaccination campaign involves elements from multiple preparedness capabilities. Jurisdictions must provide evidence of plans used to support and sustain the vaccination campaign.</p> <p>VAC4.m Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations follows CDC guidelines and best practices for patient safety and vaccine effectiveness including vaccine shipment, transport, storage, handling, preparation, administration, and documentation. Evidence must document alignment with federal guidance; administration must also comply with any provisions outlined in the EUAs and CDC recommendations.</p> <p>At least one checklist must be submitted as evidence when PHEP is in the lead or support role. Otherwise, if PHEP had no role, evidence must describe how vaccination clinics held at satellite, temporary, or off-site locations were supervised.</p>	<p>VAC4.i-m Evidence must document how each selected capability was integrated into COVID-19 vaccination planning and implementation. Evidence of pandemic plans that supported the campaign rollout and sustainment are required.</p> <p>Provide evidence for aspects of vaccine management for which public health had a lead or support role. If public health had no role in certain aspects, provide evidence to document oversight for those activities.</p> <p><u>Examples of Acceptable Evidence</u></p> <ul style="list-style-type: none"> • AARs. • Incident corrective actions. • Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations (one checklist required at a minimum). 	

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<p>VAC5.a-d Vaccine Administrators</p> <ul style="list-style-type: none"> a. Recruitment (Lead, Support, No Role) b. Credentialing (Lead, Support, No Role) c. Training (Lead, Support, No Role) d. Safety and Health Monitoring (Lead, Support, No role) 	<p>VAC5.a-d Select the PHEP role for each element. Volunteer management is the ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support the jurisdictional public health agency’s preparedness, response, and recovery activities during pre-deployment, deployment, and post-deployment.</p> <p>Volunteers can include both routine and surge staff for vaccine administration and for oversight purposes all vaccine administrators must be credentialed. Training vaccine administrators in appropriate administration of COVID-19 vaccine includes education about proper dosage, storage, and handling.</p> <p><u>Lead</u>: Primary responsibility for funding and preparedness planning and/or response activities</p> <p><u>Support</u>: Shared funding and collaboration for preparedness planning and/or response activities</p> <p><u>No role</u>: No direct involvement in preparedness funding, planning, or response activities</p>	<p>Rapid vaccine administration requires planning to identify, recruit, credential, and train vaccine providers to administer vaccine. The number and location of vaccine providers likely shifted as vaccine supply increased and eligibility expanded. Recruitment of vaccine providers from multiple settings can support equitable access to vaccines. Inclusion of surge staffing, or nontraditional vaccination partners, also requires additional credentialing and training for proper oversight and administration of vaccine.</p>
<p>VAC5.e Vaccination administrators were recruited from (select all)</p>	<p>VAC5.e Select all locations that providers were recruited from to maximize and provide accessible vaccination services to CWG and DIP. During the COVID-19 pandemic response, a network of trained, technically competent COVID-19 vaccination providers in accessible settings was</p> <p>critical to the COVID-19 vaccination campaign. Jurisdictions were encouraged to leverage providers at central locations that served a broad area.</p>	

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<p>VAC5.a-e Engaging vaccination administrators and providing proper training, credentialing, and monitoring the health and safety are critical for a successful COVID-19 vaccination program. Jurisdictions were encouraged to engage with both traditional and nontraditional vaccine providers in multiple settings to maximize the number of individuals administering vaccine equitably across the jurisdiction. Review evidence for documentation about recruitment, credentialing, and training related to standardized vaccine administration including:</p> <ul style="list-style-type: none"> • eligible populations for each authorized vaccine, • vaccine-specific storage and handling, • appropriate vaccine administration, • vaccination documentation and reporting, • vaccine wastage procedures, and • adverse event reporting. 	<p>VAC5.a-e Evidence must address considerations for appropriate level of safety monitoring and health surveillance for volunteers based on identified risks, roles, and subject matter expert recommendations.</p> <p>If public health had no role, evidence must document how the activity was managed.</p> <p><u>Examples of Acceptable Evidence</u></p> <p>Vaccine providers were recruited from multiple entities. Examples include:</p> <ul style="list-style-type: none"> • Large hospitals or health care systems. • Pharmacies and other commercial partners. • Occupational health care settings. • University or technical schools training medical, pharmacy, or nursing students. • MOU, executive order, or other appropriate evidence of recruitment strategy. • Staffing plans for vaccine implementation. • Documentation of completed required trainings for COVID-19 vaccine administration. • Credentialing process for traditional and nontraditional vaccine administrators. 	

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<p>VAC6.a <i>COVID-19 Vaccination Activities</i></p> <ul style="list-style-type: none"> a. <i>Vaccine supply</i> b. <i>Vaccine shipment</i> c. <i>Vaccine transport</i> d. <i>Vaccine storage and handling (including cold chain management)</i> e. <i>DVC preparation and supplies (equipment)</i> f. <i>DVC locations</i> g. <i>Vaccine preparation</i> h. <i>Vaccine administration staff (personnel resources)</i> i. <i>Vaccine documentation (monitoring and tracking)</i> j. <i>Vaccine adverse event tracking</i> k. <i>Post DVC actions, documentation, or demobilization</i> 	<p>VAC6.a Select how well the vaccination activity was performed with respect to obtaining the targeted vaccination goal, regardless of the public health role (VAC4.a-k). Documenting performance will help prioritize corrective actions and improve pandemic plans and response actions.</p>	<p>In May 2021, the President of the United States set a target to vaccinate 70 percent of U.S. adults by July 4, 2021. The 70% goal was seen by federal health officials as a crucial step toward obtaining herd immunity, when enough people in the community have antibodies against a specific disease.</p>
<p>VAC6.I <i>COVID-19 Vaccination Campaign Strength</i></p>	<p>Create an observation statement for each vaccination activity that was performed without challenges or adequately (VAC6.a-k) when public health was in a lead role (VAC4.a-k). The statement should reflect a successful response action or attribute.</p>	<p>Evaluation and documentation of achievements validate the preparedness capability and follow best HSEEP principles.</p>
<p>VAC6.m <i>COVID-19 Vaccination Campaign Area for Improvement</i></p>	<p>Create an observation statement for each vaccination activity that was performed with major challenges or was not able to be performed (VAC6.a-k) when public health was in a lead role (VAC4.a-k). The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action.</p>	<p>Analyzing and identifying areas for improvement will help focus corrective actions and follow best HSEEP principles.</p>
<p>VAC6.n <i>COVID-19 Vaccination Campaign Root Cause Analysis</i></p>	<p>Provide a root cause analysis or a summary statement about why the vaccination activity was not fully achieved and cite relevant pages to align statements when referencing the document library for supporting evidence.</p>	<p>Root cause analysis identifies the most basic causal factor for why an expected action did not occur or was not performed as expected.</p>

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<p>VAC6.I-n Review statements for clarity and conclusions. Conclusions must align with strengths, findings, and corrective actions documented in submitted evidence. Statements should help improve existing pandemic plans and prevent or reduce morbidity and mortality from public health incidents whose scale, rapid onset, or unpredictability stresses the public health and health care systems.</p>		