

# Health System/Hospital COVID-19 Vaccination Tabletop

*The following is a **fake scenario** to be used by hospitals and health systems to plan for a future COVID-19 vaccine.*

## SITUATION

Your hospital is experiencing a substantial shortage of patient care staff. The number of COVID-19 patients is high, and the hospital is over capacity based on staffed beds. Multiple factors are affecting workforce availability. Some patient care providers are out due to lack of child-care or care of a sick family member; some have quit due to stress and exhaustion; some have quit due to fear of COVID-19 infection; and some are sick or in quarantine after close exposure. Staffing is hitting all patient care areas (ER, ICU, wards) and the shortage includes nurses, aides, physicians and respiratory therapists as well as ancillary support staff. Some of the sick employees have been seriously ill and a small number of deaths have occurred among staff with underlying conditions.

You are going to receive your first allocation of vaccine. The number of doses is sufficient to vaccinate 20% of your employees but this is dependent on your having advance consent/registration from targeted staff. Over the subsequent two weeks, you will likely receive additional vaccine that will allow your facility to vaccinate an additional 20%. Second doses will need to be administered 21 days after the first, so additional doses received during the subsequent few weeks may be entirely consumed by providing second dose.

The vaccine is available under FDA emergency use authorization (EUA) which means staff cannot be required to accept it. The vaccine appears to be safe in clinical trials but there is a substantial rate of flu-like illness during the 24 hours following vaccination. This is more common with the second dose. The efficacy rate is estimated at 70% but little immunity is provided by the first dose.

Paid and unpaid healthcare workers will be prioritized first for COVID-19 vaccination. The state has decided that hospitals can follow one of two models for selecting which employees to vaccinate or can use a combination of the two models. All doses must be documented as to why the persons to be vaccinated were selected.

#### Prioritization Methods:

1. Critical infrastructure staff can be selected for first vaccination.
2. Patient care staff with underlying conditions that predispose them to adverse outcomes with COVID-19 can be selected for first vaccination.

#### QUESTIONS:

**Each question is independent. Do not assume that prior questions impact what is stated in the question under discussion.**

1. What is your planning structure for making vaccination decisions? Have these people engaged in contingency planning related to the outbreak?
2. Given the current situation, how will you decide how to allocate the vaccine? What are the pros and cons of each approach?
3. If you were going to mix the approved prioritization methods (see options above), how might you do that?
4. How will you communicate to employees the decisions related to prioritization, vaccination risk and expectations, and requirements for receiving vaccine (e.g., advanced consent).
5. Your administration decides that senior staff and incident command are critical infrastructure and should be prioritized for first doses along with high priority patient care vaccinees. How would that decision be received by employees?
6. Might employees who haven't decided to get vaccinated themselves be upset at the prioritization of doses if they disagree with it?
7. How or will you document reasons for why each employee was selected for vaccination and maintain the records?
8. What process will you use to rapidly obtain advanced consent/registration for vaccination from staff?
9. If you decide to vaccinate patient care staff who have underlying conditions, how will you verify that any particular staff member is eligible? Are there certain underlying conditions you will target? What about pregnancy?
10. You have decided to start by vaccinating ICU, ER staff and respiratory therapists. Getting these workers protected is a priority of administration. However, because these persons will be among the first vaccinations in the country given to persons other than study participants, you are finding considerable reluctance to agree to vaccination. More than half of these target groups are refusing the vaccine at this point. They don't want to be the "guinea pigs." How will you respond?
11. Some patient care providers that quit are willing to return to work two weeks after second dose if they can receive the vaccine. How would you respond?
12. Patient care staff with underlying conditions who are not part of the initial target group are very aware that a decision was made to pass them over at this point in preference for vaccinating other units (e.g., ICU, ER) and they are agitated. Everyone is under stress and this is making things worse. How will you handle this?

13. If you vaccinate all ICU, ER and respiratory therapists on the same day and a substantial number become ill with flu-like symptoms, will this pose a problem? Do you want to stagger vaccinations?
14. How will you conduct vaccinations?
  - a. Where will you set up?
  - b. How will employees be scheduled?
  - c. Is social distancing a concern?
  - d. What PPE will vaccination staff wear?
  - e. Who will manage the vaccine? Who will dilute and draw up the vaccine?
  - f. Who will perform the vaccinations?
  - g. How many hours would you need to perform vaccinations on 20% of your staff (on a single day or multiple days.)
  - h. How many days would you want or need to complete the vaccination?
  - i. How will you reach staff who normally work shifts over nights and weekends?
  - j. How many staff will you need? What roles will you need to assign?
  - k. What equipment will you need?
  - l. What PPE will each person staffing the clinic be expected to wear?
15. What if you had vaccine to vaccinate half of you staff at one time? How would that impact your need for staff, resources and time to vaccinate? How would it impact scheduling?
16. Uptake of the vaccine is less than originally anticipated. How would you ensure doses do not go to waste? Who would be the next groups for vaccination?
17. How will you track each employee's due date for a second dose? How will you ensure each employee receives a second dose?
18. As colleagues are frequently reporting flu-like symptoms with the second dose, some staff are reluctant to complete the series. How will you respond?
19. If an employee refuses the second dose, the first dose has been wasted. Will you obtain a commitment to complete the series before you give the first dose? Will you be able to enforce it?
20. How will you report doses to the North Dakota Immunization Information System (NDIIS) within 24 hours of administration? Is your occupational health electronic medical record connected to NDIIS? Is your electronic medical record set up to track COVID-19 vaccine?
21. Assuming you are receiving the vaccine ([vaccine A](#)) that requires ultra-cold chain storage or can only remain in the refrigerator for 5 days, what additional planning needs to be done to ensure cold chain is maintained and vaccine isn't wasted?
  - a. Ultra-cold chain freezer capacity
  - b. If you plan to use shipping container, do you have access to dry ice pellets? Do you have instructions and supplies to handle dry ice?
  - c. Completing vaccination within 5 days after refrigeration
22. Do you have temperature data loggers that are able to monitor refrigerator, frozen or ultra-cold temperatures (if applicable)? Do you have data loggers for transport if planning off-site clinics?
23. Have you identified someone to report daily inventory to [vaccinefinder.org](https://vaccinefinder.org)?
24. Are you billing an administration fee for the vaccine?