



Washington State  
Hospital Association



# WSHA COVID-19 Member Call with State Leaders

December 14, 2020

# Agenda

**Epi Report – Dr. Kathy Lofy, DOH**

**Eastern and Central Washington Level Loading – Taya Briley, WSHA**

**COVID Only SNF Availability – Kristin Byrne, DSHS**

**Vaccine Update – Darcy Jaffe, WSHA**

**Association of Washington Business PPE Portal – Tommy Gantz, AWB**

**State Money to Hospitals – Chelene Whiteaker, WSHA**

**Update on Ventilators – Kristin Peterson, DOH**

**Q&A**

# Epi Report

Dr. Kathy Lofy, DOH



# Eastern and Central Washington Level Loading

Taya Briley, WSHA



# COVID-Only SNF Availability

Kristin Byrne, DSHS



# Vaccine Update

Darcy Jaffe, WSHA



## WSHA/DOH COVID-10 Vaccine Distribution Planning Meeting

- Every other Tuesday from 3:30 – 5:00pm
- Hosted by WSHA, DOH Presenting
- If you are interested in attending, please contact Josh Russell  
[JoshR@wsha.org](mailto:JoshR@wsha.org)

**[INSERT HOSPITAL OR CLINIC INFORMATION HERE: NAME, ID, FACILITY TYPE, ADDRESS – INCLUDING COUNTY]**

### Pfizer-BioNTech COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First): \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
(This information will be used to contact you for your second dose reminder.)

Address: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

**Information collected in this section helps ensure we deliver equitable and patient-centered care:**

Sex listed at birth (check one):

Male:  Female:

Gender identity (check one):

Male:  Female:  Non-Binary  Unspecified/Indeterminant:

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc.)  Not-Hispanic A person not of Spanish culture or origin

Race: (Check all that apply):

Black or African American <input type="checkbox"/>	Asian <input type="checkbox"/>	Hawaiian or Pacific Islander <input type="checkbox"/>
White <input type="checkbox"/>	American Indian or Alaska Native <input type="checkbox"/>	

Vaccine Dose (check one): 1<sup>st</sup>  2<sup>nd</sup>  If this is your second dose, what vaccine was your first? Pfizer  Moderna  Don't know  If this is your second dose, when did you receive your first dose? (date): \_\_\_\_\_

**Exclusion Questions: Answering yes to either of these questions excludes you from receiving the vaccine.**

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose? (Full list is available in the <i>Fact Sheet for Vaccine Recipients and Caregivers</i> or from your health care provider.)	Yes	No
Are you under the age of 16 years?	Yes	No

**Screening Questions: Immunizer: If patient answers "yes" to any of the below, provide patient counseling or instruct them to consult with their caregiver prior to receiving the vaccine.**

In the past two weeks have you tested positive for COVID-19?	Yes	No
In the past two weeks have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	Yes	No
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No
In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	Yes	No
Are you pregnant or breastfeeding or do you plan to become pregnant?	Yes	No
Are you immune compromised or on a medicine that affects your immune system?	Yes	No
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication: _____	Yes	No



**Insurance Information:**

Insurance company: \_\_\_\_\_ Are you the primary card holder? Y N

If no, what is the primary card holders name and date of birth? \_\_\_\_\_

Cardholder ID: \_\_\_\_\_ Rx Group ID: \_\_\_\_\_

BIN: \_\_\_\_\_ PCN: \_\_\_\_\_

Are you Medicare eligible? Y N If yes, Medicare Part A/B number: \_\_\_\_\_

If you are not insured and you do not want to pay for administration of the vaccine yourself, you must provide the information below. If you do not provide this information you may be billed for vaccine administration.

*I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients please provide (a) a valid Social Security number, or (b) state identification number and state of issuance, or (c) a driver's license number and the state of issuance: \_\_\_\_\_*

**Acknowledgements:**

- I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers) for this vaccine. The fact sheet has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*
- I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*
- I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions.. If I have a history of severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I must stay for 15 minutes*
- I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*
- I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or <https://vaers.hhs.gov/reportevent.html>.*
- I know I must get two doses of the COVID-19 vaccine and receive the same vaccine each time. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.*

**Authorization to Request Payment:** *I authorize the organization providing my vaccine to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.*

**Disclosure of Records:** *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website. If I am an employee of [insert name of health care provider] I understand that it will keep records of this vaccination for me in [insert name of electronic health record] and may keep my vaccination records in [insert name of health care provider]'s employee occupational health records, to the extent required or permitted by law.*

Patient (or Parent/Guardian/Authorized Representative) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Parent, Guardian or Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

*If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.*

All sections below are for official use only:

**Vaccine Administration Information for Immunizer:**

Administration date: \_\_\_\_\_ Administration time: \_\_\_\_\_  
 CVX (Product): \_\_\_\_\_  
 Dose number: \_\_\_\_\_  
 IIS Recipient ID: \_\_\_\_\_  
 IIS vaccination event ID: \_\_\_\_\_  
 Lot number: \_\_\_\_\_  
 Unit of Use MVX (Manufacturer): \_\_\_\_\_  
 Sending organization: \_\_\_\_\_  
 Vaccine administering provider suffix: \_\_\_\_\_  
 Vaccine administering site on the body: Left deltoid  Right deltoid  Other  (indicate location) \_\_\_\_\_  
 Vaccine expiration date: \_\_\_\_\_  
 Vaccine route of administration: \_\_\_\_\_  
 Vaccination series complete (date): \_\_\_\_\_  
 Fact Sheet for Vaccine Recipients and Caregivers version date: \_\_\_\_\_

Notes about this form:

- ***This form should only be provided to a patient if it is accompanied by the Fact Sheet for Vaccine Recipients and Caregivers*** <https://www.cvdvaccine.com/>.
- This form should only be used by clinicians well versed in the CDC's provider education materials who are able to counsel patients who answer "yes" to the screening questions or make referrals for counseling for those patients.
- This form is intended as a resource. It is not a mandatory form.
- This form was developed based on the best available information at the time it was created. Its accuracy is not guaranteed. Organizations and individuals choosing to use this form should do so in consultation with their own clinicians and attorneys.
- This form is subject to update without notice.
- For convenience, some elements in this form may be pre-recorded in electronic health records or other databases.
- Resources used in creating this form:
  - COVID-19 Vaccination Training Programs and Reference Materials for Healthcare Professionals for information about screening questions and *Fact Sheet for Vaccine Recipients and Caregivers* <https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-Clinical-Training-and-Resources-for-HCPs.pdf>
  - Global Information About Pfizer-BioNTech COVID-19 Vaccine (also known as BNT162b2): <https://www.cvdvaccine.com/>
  - V-Safe Program; <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html>
  - COVID-19 Vaccination Communication Toolkit: <https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html>
  - Washington State's COVID-19 Vaccine Plan for vaccine reporting requirements. <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/WA-COVID-19-Vaccination-Plan.pdf>
  - For Demographic Information:
    - Washington State CHARS Manual: <https://www.doh.wa.gov/Portals/1/Documents/5300/CHARSManual-UB04-5010.pdf>
    - Race Ethnicity Language Data Collection Best Practices: [http://forces4quality.org/af4g/download-document/6011/Resource-validated\\_final\\_rel\\_data\\_collection\\_best\\_practice\\_guidelines\\_updated\\_11-28.pdf](http://forces4quality.org/af4g/download-document/6011/Resource-validated_final_rel_data_collection_best_practice_guidelines_updated_11-28.pdf)
    - Collecting Sexual Orientation and Gender Identity Information: <https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html>

# Association of Washington Business PPE Portal

Tommy Gantz, AWB



# State Money to Hospitals

Chelene Whiteaker, WSHA



## Hospitals Receiving \$38 million!

- **WSHA's advocacy has been a success**
- **\$38 million CARES funding being allocated: minimum \$250k per acute care hospital**
  - Rural
  - Payor mix
  - COVID patients
- **Can be used for expenses, including wages for employees**
- **WSHA will send details once confirmed to CEOs, CFOs, and government affairs**

# Update on Ventilators

Kristin Peterson, DOH



# WA-DOH Ventilators

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- Ventilators available for distribution through DOH
- Approx. 600 ventilators on hand with more inbound
- All brand new from the manufacture
- Models Available:

Philips Trilogy EV 300 (Portable)
BELLAVISTA 1000US
AVEA II / Vyaire
VOCSN
PERCUSSIONAIRE TXP5
Medtronics 985
MDEPHARMA

Work directly with DOH to request at:  
**[doh-medsurge@doh.wa.gov](mailto:doh-medsurge@doh.wa.gov)**

# Thank you for your leadership!

## Questions? Discussion?

