

## Project Firstline Webinars FAQ

### Webinar 1: Tactical, Operational, and Strategic IPC Planning For Mass Vaccination Sites

**Was there a cost associated with registering for and taking the courses and training identified in the environmental scan?**

The majority of trainings identified on CDC TRAIN and other host sites were free of charge. Some, however, were offered at a cost and offered through a membership such as a professional-based membership. These pay-wall trainings were externally linked and explicitly stated registration costs associated with it to the proposed user.

**In a mass vaccination setting, what was the biggest IPC issue seen?**

For the New Orleans mass vaccination site, the safety measures were well introduced to mitigate bioaerosol transmission risks. The large space utilized for this strategy – large volume of air and the ability to separate visitors - was crucial in establishing this safety measure. This was initially the biggest fear and quickly became almost moot. The biggest risk actually became needle sticks. While at the time, there were only a small number, due to other measures being so well-addressed, the needle stick issue remained an area of focus for safety especially considering the mass volume of visitors.

**How are employee exposures being handled in such a mass site versus a traditional setting?**

We were able to maintain the same process since we were closely located to our main campus – the mother ship was close by, so-to-speak, and we deployed daily from it. We know that when we deviate from typical protocols, we face tremendous challenges – trainings, approvals, etc. So, by keeping the same rapid treatment areas and protocols the same on site and being in close proximity to our normal routine, we transitioned well and overcame many potential challenges.

**What was missing from the scan of all the accessible training?**

Just-in-Time training was missing. Many in-person trainings occur onsite at alternate care and vaccine locations to review overarching and site-specific protocols. These trainings were not part of this formal scan and therefore cannot be quantified.

**There seemed to be a label on one of the vials shown on the presentation covering the mass vaccination site in New Orleans. What was on that label?**

The pharmacy team onsite colored-coded the vaccines daily based on the actual vaccine received that day. Initially, the site would not know until the week began which vaccine was going to be available and how much of it. We were administering three different vaccines at the site – Pfizer, Moderna, and Johnson & Johnson. Not only were the vials already labeled with the manufacturer, we chose to color-code these based on the three vaccines, captured the lot number on the label, and the expiration (each vial had a short shelf life). It was simply another step – an easy-to-see step – we introduced at our location to ensure vaccine safety and proper tracking.



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### **Are there specific shortcomings to providing mass vaccinations at alternate, non-traditional locations?**

Accessibility is a concern. Initially, New Orleans focused on access to the site, which was a major factor to selecting the site in New Orleans – it was easily accessible via public and private transportation. As with most urban settings, many utilize public transportation. And hospitals are typically located on transit routes. With the New Orleans location, the Morial Convention Center is enormous and spans a large portion of downtown New Orleans. We ensured as best we could to locate the site in a Hall easily accessible to parking and transit traffic. A large parking lot, free to the public for this site, was located directly across the convention center's street with pedestrian crosswalks connecting the lot with the center. We also coordinated with Uber for ridesharing.

### **Were there any trainings related to UV-based disinfection?**

Trainings were identified covering proper use of personal protective equipment (PPE) to disinfect and clean surfaces. The scan did not discover training strictly focused on UV-based strategies though. What is important to remember is the potential off-gassing associated with continued use of these disinfectants and the increased exposure to them given the increased use throughout the pandemic. Adding to that, what would the UV-based photolytic process do to these chemicals, which are non-traditional in many settings, when introduced? And are those byproducts safe?

At the mass vaccination site, New Orleans did not introduce UV-based strategies. However, at the hospital, especially during the early onset of cases in the pandemic (due to Mardi Gras perhaps, New Orleans experienced high case counts in March and April of 2020), it was used heavily in COVID patient rooms. After approximately 60 minutes of patient removal from a room to allow for all aerosols to settle, our protocol followed typical infection prevention and control measures and also introduced the UV-based equipment to further clean the room for the next patient. It was almost a hindrance due to the time commitment to use it properly. However, it was an absolute reassurance to the staff and practitioners to showcase safety – we are doing all we can to practice safely. Early on, we simply were unsure of route of transmissions – fomites versus bioaerosols, etc. We made the choice to introduce every safety measure possible at the hospital early on.

### **Discuss the thought process behind appointments versus walk-ins at the mass vaccination site.**

Initially, we wanted appointments, as this facilitated a controlled environment and reduced overcrowding and bottlenecks. This decision was due in part to the experiences we encountered conducting community-wide testing, where we determined the main source of bottlenecks and crowding occurred at registration regardless of how many personnel we had facilitating that process. It simply became overburdened quickly and we wanted to prevent that from occurring at the vaccination site initially. We had an easy-to-use online portal to register as well as a call-in number for phone-based registration. After the initial push, we did introduce a walk-up procedure.

## **Webinar 2: Pod-based Planning, Mass Vaccination, and Infection Control**

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### **Who were the people working at your mass vaccination site in Atlanta?**

External partners were crucial. This was a federally support Community Vaccination Site. We had local universities and hospitals assist in staffing these positions for us – Emory, Mercer University School of Pharmacy and Physician Assistant Programs, FEMA Core personnel, DoD personnel, state level emergency management personnel, local Board of Health and emergency management, and absolutely pivotal was our Medical Reserve Corps (MRC).

### **What types of trainings are needed for these personnel at similar facilities? What do we need to do better?**

We have identified gaps in training. Our scan suggests there are trainings for specific aspects of similar settings and operations. However, there seems to be a gap in connecting critical aspects of specific disciplines important to such comprehensive operations. We should look to invest in the development of a more comprehensive training which, for example, merges the science of public health and infection control and prevention with the operational aspects of coordinating and operating a point of distribution/dispensing or mass vaccination site.

### **What are your thoughts on available IPC-based trainings? Are there gaps?**

Our scan highlighted a large number of relevant trainings. And my experience suggests that personnel searching for trainings might become overwhelmed with such a large volume and not be informed enough on which ones to prioritize. We should consider a more focused training effort to combine such trainings in a more digestible format for the future pandemic-based threats, leveraging much of what we continue to learn from SAR-CoV-2 and the COVID-19 pandemic. We should make these an integrated training element for the entire group of stakeholders involved in medical countermeasure distribution planning – from the public health personnel to the emergency management experts to the private sector partners participating in these efforts via closed/occupational PODs, etc.

### **Looking back on recent events, if you had two wishes to improve, what would they be?**

Just-in-Time training on IPC-related aspects. These are not typical trainings outside of a clinical space and these proved to be time-consuming and difficult to produce in short time. Properly trained staff is always a challenge and imparting a sense of dedication to these staff to ensure the mission is accomplished – ensure the staff are more mission oriented versus time-clock oriented during such perilous times in addressing population health.

A stronger infusion of exposure and IPC-based science into the operational training for these types of threats – available for pre-incident training and to be unpacked for JIT Training.

## **Webinar 3: Applying Science Driving Infection Control Operations to Large-Scale Mass Vaccination Sites**

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### **Is there evidence to suggest that area experiencing high rodent populations are at higher risk of COVID-19 cases?**

Thus far, there is not evidence to suggest a connection between COVID-19 cases and rodent infestations and it would be difficult to unpack the socio-economic associations if one even existed. We have not yet seen an indication in lab settings where rodents are effective at transmitting back into humans.

During the peak pandemic, New Orleans for example experienced a reduction in rodent population due to restaurant and hospitality industry being shut down and the food sources there all but eliminated. We have seen that the pandemic and lock-down protocols really transform rodent populations and behavior.

### **Taking a step beyond the traditional IPC field, how can we better prepare for the next pandemic leveraging what we know about the spillover effect?**

Much of the initial spillover occurs via consumption. Behavioral controls apply here as well. Proper handwashing practice and even meat butchering practice. When populations are forced to comply with environmental controls and practice safety in general, then we are more likely to see positive results. Same rules as we discussed with the traditional implementation of the hierarchy of controls, but in a different setting.