TFAH-COVID-19 Vaccine for Homebound Older Adults: Challenges and Solutions

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Remote CART

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>> Megan is the senior developer where she works with the policy development team to advance and modernize accountable public health system. In her role, she oversees the age friendly public health system initiative which partners with state and local health departments to implement a public health framework to improve the health and well-being of older adults. Welcome, Megan.

>> Thank you, Margie and welcome, everyone. I will provide background and context and we will get right to our great panel of speakers today. Next slide. For those of you who are new to us, TFAH is an organization dedicated to ensuring optimal health and well-being for every community and individual. This project, vaccine access project to explore the challenges and solutions to ensure vaccine who are home bound, but since that time significant progress has been made. We have seen multiple news reports about vaccine who are home bound and just this week the Biden-Harris administration and announced allocation of about $100 million to ensure vaccine availability for aging and disability and every U.S. state territory and expand availability for people with disability in older adults and identify people who are unable to independently travel to vaccination sites and provide technical assistance with people with disabilities and older

adults and I will put the link for announcements in just a few minutes. This has been an integrated effort to address the issue and get back seems to be the home bound. This action by the administration is an indication that there's importance of the issue and government leaders are listening and work to go make progress to get vulnerable populations vaccinated. Next slide. This progress is made possible with the John A Hartford Foundation and we are appreciative of the venders whose vision is helping to make the initiative possible. Next slide. Homebound older adults areunderstudied community and most live in the community and not in nursing homes or other elder care facilities. They are often very isolated with little emotional and social support except of that of caregivers and while older adults living in older-care facilities have rightly been prioritized for vaccination, those focusing on today whether they are older adults or individuals with disabilities, leaving their homes to get a COVID vaccine is challenging, if not impossible. Next slide. There's a lot of variation defining the term homebound and identified as individuals. In Colorado I just heard today that they are defining the homebound as those who never or rarely left the home in the past months regardless of the reason. Now this matters because of the numbers but also identifying these people. So the reason I'm showing this slide is to demonstrate the difference in the numbers based on how the population is defined. The figure most often referenced in terms of total number is 2 million completely or mostly homebound adults but if you like at the AARP definition, it could jump to 12 or 15 million. So it is a really vast difference and important differentiation and I know our panelists today are going to address this as well. Next slide. Homebound often live with functional disabilities, multiple medical comorbidities and depression and impairment and the population the vulnerable and decreased quality of life, loss of independent living and morality and yet homebound older adult populations have received minimal attention even as the number of disabled older adults continues to increase and the demand for homecare services continue to grow. Next slide. Our consulting study have been studying, researching and interviewing, we have identified numerous challenges as well as wonderfully innovative solutions to delivering the vaccine to those who need it at home and you're going to hear from some of -- about some of those today. Unfortunately, there are still challenges as I mentioned just a moment ago and in identifying who these individuals are and ensuring the capacity for local authorities to put the lists together to identify them. State and local governments have no clear path to ensure they will be able to find all of them nor how to address the complexities of increasing the numbers of certified vaccinators and accessing and appropriately handling sufficient vaccines for multiple home visits that are geographically dispersed. Vaccinating this population has made even more challenging because of the variation and vaccination policies. Reimbursement difficulties and workforce needs within cross state and vaccinating caregivers is also an issue that is important and yet eligibility of caregivers especially family caregivers varies across states and jurisdictions. Next slide. The topics of this graphic represent the themes that have emerged in our recommendations we search and will help to organize the recommendations that TFAH is developing, we are

committed to ensuring that all of the recommendations be implemented with health equity as a lens and with the policy focus. The next slide. So at this time I'm going to introduce our 3 speakers and then after their presentations, I will come back and briefly share the set of recommendations that we are working on and then after that, we will open up for discussion for your questions and comments as well as those from our speakers. So first today we will hear from Dr. Amanda Cohn and Dr. Cohn has been working to support public health departments with information and guidance on the COVID vaccine. Next we will hear from Dr. Tom Cornwell at village medical at home and has extensive experience delivering home-base care which gives him great insight of delivering vaccine those who are homebound. And then Ingrid Ulrey, where her team has been in the vanguard in developing innovative strategies and policies to ensure vaccine access for those at home. So we can go to the next slide and I will turn the virtual platform over to Dr. Cohn.

>> Thank you, Megan, so much for having me here today. I'm going to help set the stage for the discussion and for you all to hear more about the amazing things that are happening and all that needs to be done to ensure homebound and older adults are vaccinated. Next slide. Next slide. So we know that the risk of severe outcomes from COVID-19 increases with age. And although most civilities are not known to increase the risk of severe disease, approximately one-third of people with disabilities have one or more high-risk medical condition. Many states are vaccinating, most states if not all are vaccinating older adults and adults with high-medical conditions, however, some older adults and persons with disabilities face a number of challenges getting COVID vaccines. Today I'm going to provide some background of considerations for COVID vaccination of older adults including those who are homebound and adults with disabilities. Next slide. The rationale for including older adults in phase 1 vaccination efforts was due to significant risk in severe outcomes with increasing age. For example, relative to 18 to 29-year-olds, older adults 65 to 74 are 5 times more times to be hospitalized and 90 times more likely to die. At 85 years and older, 8 more times to be hospitalized and 630 times more likely to die compared to younger adults. Race and ethnicity are predictors of increase risk among older adults. Among adults age 65 and older, the risk of COVID hospitalization is two or more times higher among non-Hispanic, American Indian, Alaskan native, black or Hispanic or Latino populations 65 and older compared to non-Hispanic Asian or Pacific Islander or white populations 65 and older. I really appreciate Megan's focus in thinking about addressing the needs of homebound adults through a health equity lens as well. Next slide. Interesting COVID-19 vaccination of older adults is relatively high. The likely acceptance of COVID-19 vaccination increases substantially from December compared to September among older adults. Results of surveys reported in February suggests that 66% of adults age 65 years and older were absolutely a very likely and 15 were likely to get vaccinated. Only 18.7% reported that they were not likely. Next slide. And for the most part, Kaiser Foundation found people optimistic about getting the vaccine and however, people are frustrated and confuse about how to get information on vaccination in the community.

Next slide. And next slide again. So with that background and setting stage we actually have really good news in the overall number of older adults who have been vaccinated. As of March 28th, 72.4% or 39, nearly 40 million adults age 65 years elders are received one or more doses of COVID-19 vaccine. This is really a remarkable feat to have vaccinated over 70% of the older adult population in short period of time. The concern is that the additional proportion that -- additional 28, 27% said they need to be vaccinated in the age group potentially have serious barriers or hesitancy about getting vaccinated. Our supply per vaccine is increasing which is also increasing which should help increase vaccine eligibility for older adults. We anticipate all adults will be -- will have vaccine available in their jurisdictions. So what are the challenges to vaccinating older adults who are homebound and Megan described these really well. There are challenges in identifying older adults who are homebound. There's problems reaching those individuals. In fact, paid and unpaid caregivers, and then one really important component of success will be to ensure that promising practices across jurisdictions are shared. And so I know we will be hearing some of the practices today but there are many others that jurisdictions have implemented that we can learn from. Next slide. In addition to challenges getting vaccination information, disabilities are common among older adults. Challenges related to disabilities increase in age with the older adults, the older adults in high rates to reduced capacity to reduce activity of daily living. Older adults are very interested in the vaccination, many have difficulty accessing the vaccine. Next slide. And as adults age, higher percentage need assistance. Next slide. And -- and as Megan just discussed the definition for homebound persons, a person considered is homebound if they need help of another person or medical equipment such as crutches, walker or wheelchair and believes that their health on illness could get worse if they leave their home and it's difficult for them to leave their home and they typically cannot do so. When we began at CDC to think about this population in collaboration with many of our partners, we actually took the largest approach and more expansive definition than the definition of homebound and included many adults who are semi-homebound, for example, may leave the house up to twice a week but still potentially have significant barriers for getting vaccination in a mass have been nation clinic or in other vaccination location. We recently posted new guidance of vaccination homebound persons for healthcare providers who vaccinate person who is are homebound and this clinical guidance helps address some of the technical logistical barriers of actually bringing vaccine into the home efficiently and effectively while maintaining the -- the integrity of the doses. Next slide. People with disabilities need to consider challenges for access in the computer or Internet. Communication should also meet the necessary requirements of the ADA and other disability rights law. Next slide. Providing written materials and other ways to get vaccination information to older adults is particularly important to those without computer or Internet access. Although 95% of people have Internet access, only 76% with Internet access. Next slide. New materials for vaccination of older adults and people with disabilities including vaccination of homebound persons are on the CDC website. In addition, a fact sheet for older adults

that can be printed into one page and has space for organizations assisting with vaccinations to provide their local organization's contact information is in development and based on the language on the third bullet here. Additionally, we have materials that are coming out that are in multiple additional languages, reduced reading level as well as sign language videos and other resources for persons hard of hearing. Next slide. And this is just a final list of additional materials that we have available on our website and on other websites. And as Megan, I believe Megan mentioned previously the funding that ACL is able to provide which -- which they will be providing in the next week or couple of weeks to programs that can help with interpretation services and getting homebound adults and semi-home bound adults appointments or vaccine and two vaccination sites and make sure that they understand the process will be a really important resource that we hope will help support efforts to get that additional piece of older adults who haven't been vaccinated, vaccinated and paying special attention to adults with disabilities and adults who are either homebound or have limited ability to leave their home to get vaccinated. Next slide. So in conclusion, the list of disease with COVID-19 increases with age and older adults should get vaccinated at this time. Older adults are for the most part very interested in getting vaccinated, however, many of them have challenges to accessing the vaccines. New guidance is available to aid in vaccination of persons who are homebound. That concludes my presentation, thank you.

>> Thank you so much, Amanda, I really appreciate the information especially the kind of most up to date information that you have. It's really helpful and we are so appreciative of all the work that you and your team are doing. It's just an invaluable, your invaluable resource and I really appreciate it. Thank you. So next up, Dr. Tom Cornwell, thank you, Tom for being with us today and I will turn the platform over to you. You're speaking and you're still muted.

>> Sorry, I didn't want to have an echo. So I too thank you for being part of this wonderful panel. Next slide. And I want to echo Megan's comments. The CDC just has invaluable information that is, treatment well written, easy to read in terms of patients as well as providers and listed resources and also has tremendous resources on providing vaccines in the home. Next slide. I want to kind of personalize this a little more and kind of bring the homebound into our conversation here in a very personal way. I'm going to talk a little bit about the forces behind the return of the house call and you can see them listed here. The aging and society. Increased home and community-based payments, technology, the value of house calls and finally payment reform. Next slide. I want to start with health care article that was published in 2015 by Dr. Kristin Richie and Bruce and what I liked about it is the title, the invisible homebound because I'm so appreciative of trust for America's health and the Johnny Hartford Foundation, CDC who are really helping to make the invisible homebound visible and I think, Megan, when you started with the great announcement from President Biden, we are making this invisible population visible and one of the invisible homebound was Elsa here, she

was born in Germany in 1921 and came to the United States after World War II. Before my first visit she had been hospitalized which is not on uncommon six times in four months for heart failure, diabetes, you can see from her right foot and left leg amputations, she has vascular disease and she had pressure sores on her bottom because she literally lived and slept on the chair 24 hours a day. The hospital told her she had no choice. She had to go to a nursing home because in their view she was not clearly able to care for herself. When I first met her, she shared part of the reason she lost her legs because of frostbite damage caused by cold Winters in prison camp in Germany during World War II and she said that she had been forced into a prison camp early in life and she just didn't want to be forced into a nursing home at the end of life. What mattered more was staying home. Got heart failure and diabetes under control and home-health that she wasn't able to have earlier because there wasn't provider and we got her hospital bed and her pressure sores healed. Next, we actually got her so much better. Next slide. We were able to pay for her transportation to get new prothesis and helped her life but also dramatically reduced cost and you can see bringing primary care which include immunizations to the patients helps as well as reduces cost. Next. This is just a slide of the cost. The homebound population that has been invisible is generally 5% of the healthcare population that consumes 50% of all the costs and the top 1%, unbelievably consumes 20% of all the costs that over $11,400,000 per patient and we need to provide these patients primary care so they don't drive acute care and immunization is a part of that. Next. And another force, this gets into public policy that we are talking about. Here is a great example of how public policy can so dramatically impact the population we are talking about. Long-term support and services are made up of institutional care and home and community-based services. Back in the 1980□'s□, 1983 specifically 99% of all funding went to nursing home care and over time there's been support for community services and now half goes to supporting nursing home eligible patients to remain in the community but the patients also need to get care in the community along with as we are talking today the immunization when they are homebound and cannot get to vaccinations. This is how public policy can benefit the homebound and support what matters most to them this is often times staying in their home. Next. House calls are mainly high-touch primary care but we do have the high-tech capability to do the highest quality of care in the home. You can see here my Smartphone in second can get an EKG and ultrasound in the palm of your hand and you can use smart screen and X-rays can be done the same day, they are electronic and we can draw any lab we need in the home and send it down in a centrifuge that plugs into the lighter in your car and there's also therapeutic technology such as home, dialysis as well as smart pumps that can do IV antibiotics and IV fluids in the home. I can actually do more technology in the home than the great majority of primary care offices can do. So it was really technology that drove health care into the home because you had to go to the office to get the technology. Now we can because of the technology has become portable, we can bring it to patients in their home. Next. And so the last part before I get to COVID vaccine specifically is I just

want to show you some data. I showed you a wonderful anecdotal story but we also have good data as to the value of this and the first major data came from the veterans administration largest home-based primary care in the country and it came because in the middle of the last decade, Dr. Tom Edes who runs program in the VA was told to cut the program because as you can see here they were spending $11,000 more on care in the home by sending doctors and nurse practitioners and physician assistants and mental health workers and he was told that they just could not afford this and he asked if he could all have the cost data analyzed and he was given approval and was sent to the University of Pennsylvania and I think what they found even surprised Dr. Edes, next, they found an 87%, 87% reduction in nursing home costs for the VA. Sixty-three% reduction in hospital costs and overall $9,000 savings per bet and when you multiply with the program they were saving $103 million and so not only was the program not -- it's now up to 38,000 vets in this program in all 50 states. This data was first presented on the Senate section of the -- of the capital visitor center and really brought home-base primary care to the attention of both CMS as well as Capitol Hill. Next. The last thing that I want to talk about and unfortunately this is a significant aspect as we know of COVID. Is the costliest year of life, not surprisingly is the last year of life. It consumes 25% of Medicare dollars. You can see from the bar graph, while 70 to 80% of Americans say they would like to pass away at home, this is actually increased some to 30% hospital deaths have been 30% and this is in 2017 in nursing home about 20%. The reason why it's so costly, 65% of Americans are in the hospital in the last 90 days of life and 29% are actually in the ICU in the last 30 days and if you know the data, the ICU is not the place that you want to be if you're looking for a peaceful death. And so next slide. And our numbers, so this is the practice that I was with for 23 years on northwestern physician and in you can see our numbers where 75% of our patients, 20 to 25% of the patients die a year. We are dealing with very, very sick people and but 75% have passed away at home and you can see our hospital numbers just so remarkably less. Thirty-seven% being in the hospital, over half of our patients are not even hospitalized in the last year of life and only 5% being in the ICU. Next. And so a topic on hand and, again, I really appreciate how the Johnny Hartford Foundation, CDC are all just getting these patients really on the radar and we have just had some wonderful publicity. This is just all in the last month where the upper-left is Dr. Liz Davis giving a COVID vaccine in inner city Chicago. "The New York Times" article was on Long Island. You can see her carrying and we will get into this a little bit the cooler because you have to maintain the cold change. Making sure that we keep the stability of the vaccines and so we are giving them quality vaccines in the home and then last picture here on ABC news as Ingrid will talk about the different providers that are doing this, this is public health nurse Robin Tanner with the Northern Navajo center giving patient COVID vaccine in New Mexico. So COVID had added to bringing the visibility of the importance of -- of home care, whether it'd be home care, hospice, public health, home-base primary care into the home. Next. And so I'm going to end with just some of the logistics in terms doing vaccines in the home. You know, obviously there are

great efficiencies with doing mass vaccinations versus at home but Dr. Cohn described that there's this population that we are talking about today that literally it is impossible unless you want them to go by an ambulance to a mass vaccination to get them there. And so for doing this, you will hear more from Ingrid but it's home-base primary care, home health and it's difficult for home health because one of the things we will talk about in terms of policy is up to 2 weeks ago the payment was $16 and for the travel time, the observation time it was really a labor of love if they did this. There was no way to possibly cover their costs. CMS just two weeks increased that payment from $16 to $40 which, again, is greatly appreciated but still just does not cover the costs to do one or two immunizations in the home. You have to get to them as well as paramedic that you will hear about from Ingrid. So the chain, I think we will go to the table at the bottom that kind of shows some of the difficulties in terms of logistics and some of the advantages particularly to the J&J Janssen vaccine. One of the things that we have heard about in terms of -- is getting people, you know, vaccine hesitancy is one of the areas that Megan talked about that we have to kind of combat and one of the problems is when the J&J vaccine shows 72% but it is actually 86%. The one that are 95 and 94 are better but there's been no head to head comparisons so you cannot say one is better than the other at this time and there's a huge advantage to J&J because of the travel time and the observation time when you're only dealing with one vaccine at a time or maybe two or three if you're talking about caregivers but the one vaccine gives the J&J just a huge logistic advantage. Another thing that most people don't know about is that there's only 5 doses in the J&J vaccine compared to 10 in Moderna and the Pfizer because you only have 6 hours once you first puncture it and so it's very difficult to get to ten homes. One of the things that we did find out, I will give Steve Lander credit for, home-base leaders in the country, he actually contacted Pfizer and Moderna and did find out that if you did do pre-draw, pre-draw the vaccines, that they have the same stability in a syringe, the 6 hours as if you have them in the vile that was very important for us. So some of the practices are meeting and they can get the doses in the 6-hour period. The last column I will talk about is after puncture. You can see the advantages of the Pfizer and the Moderna, they can be kept at room temperature up to 77 degrees for up to 6 hours where the J&J is only stable for 2 hours at room temperature and so to keep it, to give you the 6 hours to provide all 5 doses, you need to keep it in a cooler and people need to have these data logger, thermometers to assure that you keep it within that time during 6-hour time for that stability that Dr. Cohn talked about. You do need to do 15 minutes of observation on everyone. If they have had severe reactions to the vaccines in the home, severe reactions to the vaccine in the past or if they have had severe allergic reactions, you're supposed to wait a half hour and in mass vaccinations, I was on the call with a public health department yesterday and we are going to J&J vaccines and the logistics of doing it at home are more difficult from a payment stand point and since providers are going into the home actually we at the practice of North western I was with at 24 years consistently had the highest percentage of patients

getting the flu or pneumonia vaccine. Best primary care practice because we so knew the importance of it for our patients, so it is very doable.

You just need to kind of go through some of these hoops in terms of making sure that they are getting stable vaccine in the home. And that is -- that is my time, Megan.

>> All right. Thank you so much, Tom. That was so helpful and so informative. You obviously have a great passion for the work that you do as well and we appreciate all -- all that you're doing to -- to take care of the patients that are in the home to make sure that they can age in place and -- and healthfully. Now we will turn to Ingrid Ulrey from Seattle-king County. Ingrid, the platform is years.

>> Great, thank you, Megan. I'm just so grateful to you and the whole team at TFAH and the partners for focus homebound vaccination. I think just really simply put, if we don't bring vaccines who people who can't leave their homes, they will be left out and they will remain at very high risk of se your illness and death due to COVID-19. So this work is really important, it's also really challenging and we need to learn from each other about how best to go about it. So thank you for the forum. Thank you also for TFAH's work and pioneering the age friendly public health. This is meaningful for me as someone who has spent the bulk of my career in the aging sector with SCIU interpreting the interest of the long-term care workforce and nearly decade as at advocacy director for AARP for the state of Washington. So coming from my own experience, my reflection is that nothing more than the pandemic could have made it more obvious why it's critical that public health and the aging network align and ally. That's not only to fight back against the disease of COVID but also to address broader health threats such as socialization and loneliness that has been exacerbated by COVID. In King County, our close partnership with our area agency on aging and other aging and disability partners which were formed pre-pandemic have really been instrumental in our ability to quickly stand up and affected COVID response. So I'm going to spend the next few minutes describing how we are working together to address the challenges, all of the logistical challenges you heard about from the previous speakers and get shots in arms for people who are homebound and that I'm happy to take questions. So next slide. And next slide. Thank you. So just a quick overview in King County we have a coordinating group which I can support people from public health, from our triple A as I just mentioned, city officials, people who work for the housing authorities, long-term care providers and other advocacy groups. We've been meeting multiple times a week throughout the pandemic. Earlier focusing a lot on COVID testing in long-term facilities and across older adult population and most recently on vaccine delivery and our group frankly struggled for several months on how to solve this challenge of vaccinating the homebound population and surpassed all of the logistical challenge that is have been discussed. Finally, we handed on a strategy which I think is pretty straightforward which I am just giving you a quick overview of the strategy on the slide and there are really just 5 major elements to it. First is just defining what we mean by homebound for the purposes of eligibility of in-home vaccination. The second is working with community

partners to generate demand. In other words, developing a list of who the focus population group is for this service and making sure that people in the community also know about the service. The third is identifying vaccinators and piloting a delivery protocol. The fourth is developing the systems and capacity to screen, appoint, dispatch and report and operationally get the work done and then finally but very importantly is more of the sustainability, it's working with providers to ensure ongoing capacity for routine immunization. Next slide. I think what I've described is actually very pretty straightforward and also replicable in smaller regions than King County. We are not a small community. King County is a large area. Local health jurisdiction is the ninth largest health department in the country. Bigger than many state health departments. The quick facts I put few your on the slide, we have a total population of 2.2 million people. Our goal is to equitably, efficiently and quickly vaccinate a minimum of 70% of all eligible adults and children when they become eligible. And progress to date is just this week, earlier this week, we surpassed 1 million mark for shots in arms. So we are making progress but we have a long way to go. Next slide. I want to underscore the strong commitment in King County as it relates to vaccine delivery and our team, Jenny Durkin in Seattle and other city mayors and Patty Hayes, with their leadership, we developed principles for equitable vaccine delivery which we ask providers to understand and abide by and these principles emphasizes removing barriers and those at highest risk first. So like other areas of the county or the country, sorry, we've been struggling and working intentionally to close the gaps that we do see in vaccination based on race and ethnicity. Dr. Cohn from CDC mentioned earlier, one of the metrics we are all watching around the country is the first group for eligibility, 65 plus, what percent have been vaccinated. So we are a bit ahead of the curve in King County overall. More than 80% of people age 65 plus in King County have received at least their first dose. So we are happy and excited and proud of that. But we want to -- we are concerned about these remaining gaps based on race and ethnicity and working to close them so you can see from this chart that while it's 83, almost 84% for the white population, 65 plus it's significantly lower especially for Hispanic and black or African-American. Since I put the slide together yesterday, we bumped up from 69 to 70% of all black and African-American, older adults in our county vaccinated, vaccine relief. Again, our minimum is everyone across all race and ethnicities and geography above 70%. That's what we are shooting for. So it's really, this focus on equity is the ethical basis for our sense of urgency in reaching the homebound who really qualify as one of the very hardest to reach populations, have the biggest barrier to really accessing any vaccine and any of our other modalities. So next slide. It's really essential to sort of meet people where they are and provide vaccine across multiple modalities. So I'm not going to go through this whole table but you can see the range. In addition to the mass sites which we talked about earlier, we have more than a handful of those in King County. They are delivering thousands of doses per day. We also have many people accessing vaccine through the health system, their community health center. We have a systematic way to set up pop-up or community vaccination events in trusted locations.

People are also increasingly accessing vaccine at pharmacies and notably for this conversation, we have mobile teams who we are dispatching to serve people in adult family homes, in low-income senior housing and now soon as they become eligible the homeless population and homeless shelters. At the very bottom of the list that I've underlined in red is this modality of in-home vaccination. This is -- this is reserved for the people who meet the definition which I will share in a minute and in notably it definitely -- it says in the chart low output capacity, it's really ultra low. It's the lowest group, slowest, most labor intensive way to get people vaccinated. We are finding that our teams of 2 can visit between 5 and 7 sites or homes per day generating 10 to 15 doses per day as they also vaccinate caregivers. Each of these modalities has their own value, so in-home vaccination is not about volume. It's really about serving the hardest to reach population from an equity lens. Next slide. We struggled can how to define homebound for the purposes of eligibility for in-home vaccination. We landed on the definition, I've illustrated on this slide which is adults age 16 and above currently it's 16 and above but that's changing quickly. I put in 16 for now who have not been vaccinated who have an injury, developmental disability or medical condition that makes it difficult to leave the home and for whom it would require considerable and taxing effort to access vaccine outside the home. That is our working definition. We really are striving to find a balance between having it focused enough so that we are ruling out individuals who could otherwise access vaccine through other doors because as I said for the goals of doing this sufficiently and quickly in-home vaccination isn't the answer to that. So if we can get people other doors, we want them to go through other doors and that's why it's focused and also expansive enough so people aren't left out. Next slide. This has been another challenging part of developing the in-home vaccination strategy. It's just getting our arms around the focus population. Generating demand by developing lists of individuals for whom this will be a necessary and important service. We are doing this in phases. So phase 1 is we generated a list which is shy of 1,000 but moving towards there, that was really from our closing partners our aging networks and also providers of meals on wheels and chicken group as well as Alzheimer's organization identifying list with people with dementia and caregivers who meet the definition as well as fire departments who have frequent callers who are homebound. And finally, also people who just call in to the health department requesting this service. That is our go-first strategy of developing that list and serving those individuals. Our next phase we will be curating list of additional potential individuals, both from primary care organizations from managed care organization referrals as well as we've received a very large list of names from our state agency partners and we will be going through there to de-duplicate the list and understand who is eligible. And finally, we haven't yet but we will reach a point where we -- we publicize this service to the community by posting it on our public health website, cross-posting with partners and generally making a public announcement. We are waiting at the point until we are more fully -- have our systems fully tested. More doses slowing into our county and more capacity in place but we are getting there very soon and then the next slide. Identifying vaccinators was

also not easy. We started first with the in-home care providers or primary care home agencies, hospice agencies for many of the reasons that Dr. Cornwell described. They were not ready and prepared to vaccinate so we moved onto other options including volunteer groups, medical, public health reserve Corp, academic, UDOP volunteers, we hit a number of walls and challenges and that wasn't going to work, here is where we landed. Our number one vaccinator group for homebound teams are all fire departments, EMS. We have 3 major departments around the country who are committed to this work. They were already set up and running with mobile teams that I described earlier, serving adult family homes and senior housing and so this work is really an extension of that work. They reduced the team to two. Sometimes they would just spend the day visiting 5 to 7 homes in other situations they would identify people who are homebound and serve them at the end of the day or between visits with larger sites. We are appreciative of our fire department partners. Secondly, is our own in-house public health mobile teams. We have limited capacity. They have also been serving in the same-low income senior housing and will be serving in homeless shelters soon but currently they have taken some geography within the county and we are using own public health nurse and teams to serve individuals who are homebound. We are also currently in the mix of contracting with the pharmacy to cover another portion of our county if which we didn't have a fire department or mobile team assigned and finally, we have discussions with the major health systems and found that one of the major health systems has a large volume of their own established patient who is are designated homebound and they will be serving them themselves. So it's complicated and it hasn't been one approach. It's a variety of vaccinators that we have identified. Next slide. So this is the fourth element is really just operationalizing the whole program. A big part -- well, this was more challenging in the pre-COVID relief package world. It's more feasible now because it takes resources, again, super appreciative of our partnership with the agency on aging and others to share the load. A big part of this is screening, is contacting individuals referred to us as potentially eligible asking them a series of questions to ensure that they meet the definition, they want to be vaccinated, they verbally consent and then arranging for them to be appointed. Because of the digital divide that Dr. Cohn spoke of yesterday, this is all phone base work and we have 3 existing call centers, one through public health and one through the customer service in the county and one through the City of Seattle to handle the load of doing the screening. The screening and the appointing is labor intensive and home-base and through public health is where we are organizing the dispatching across geographies across the different teams and reporting and tracking of how many visits have been completed, how many people yet to be served. In the case slide. I think the final element is what we are thinking more about now that we've piloted and just barely started to launch and really the thing that's made the launch possible, again, is the arrival of the Johnson & Johnson vaccine in King County. Now that we are going, what's going to sustain this for the long haul? We all know that COVID is not going to go away. That this will continue to be a chronic challenge for society and particularly for older adults. So we are asking

questions, like after the emergency response, how would COVID vaccine -- vaccination for homebound be built into routine care, who are the largest in-home care provide nester the county? We started having conversations with them. Some of the hurdles that have been mentioned have been improved including reimbursement rates. So what is their readiness going forward to have access to doses, structure and reimbursement systems in place because we know is this system of doing this first round of mass vaccination through fire departments and public health teams and patching it together is not what will work for the long haul, so how do we build that muscle into the system so this population will continue to be served. Next slowed. That kind of covers the 5 sort of major elements of how we are going about this in King. I just want to point out some of the major lessons that we've learned implementing this locally. The first is that it's important to make vaccine sites in the community as accessible as possible and also to intentionally give people the option of transportation. During these things, will reduce the need for in-home vaccination which, again, is not the preferred modality for people who can go through another door will be able to serve everyone more quickly and efficiently. The second is and Dr. Cornwell, you emphasized this as well, before the arrival of the Janssen J&J vaccine this felt undoable, high-intensity intervention and then have to go back and have a second visit, feels like a very large hurdle. So really the one-dose vaccine makes this feasible and within reach. The third is operational flexibility in ensuring that when we send a team into a home they vaccinate not only the individual who is homebound but also their caregiver or other eligible members of the household and makes a lot of sense for efficiency and to ensure that we are getting as many shots in arms to as many people as possible and recognizing that caregivers face their own hurdle of challenges and difficulty in giving time out from their caregiving to getting vaccinated. Finally is just recruiting vaccinators with pre-pandemic understanding of and relationship with the homebound population. That is one of the beauties of working with the fire department partners. They know a lot of the individuals in their local communities and have sometimes received calls from those homes before and they also know their communities. So that is -- that has worked out beautifully even though we know that the fire departments are not the long-term solution for sustainability. And finally, I can't emphasize enough how critical having before the pandemic, having already set up our partnership with the area agency on aging and the trust that we built between public health and the aging sector and one thing that I did early on in this was actually just recruit and hire the former director of our local triple A to work embedded in our response and she's been an incredible leader in this effort. So those are the major lessons. I have just two more things that I want to share so next slide. Yeah, thank you. Just to put sort of a human point on this. And I -- I appreciate Dr. Cornwell how you did this as well. I'm just going to read this quick testimonial. So my mother is 96. She lives with advanced dementia and accompanying physical decline. She lives at home with round the clock care. I manage her care and visit daily. She has not left the house in 2 years. Our caregivers, alarmed by anti-vaccine propaganda have declined

to get COVID vaccines. My sister, a COVID-19 denier and anti-vaxxer visits regularly. I'm frantic to get my mom vaccinated. Her healthcare provider says the only way that my mother can be vaccinated is to come to the hospital and wait in line. Her advanced dementia and associated physical decline prevent this. Are you aware of any resources available to help fragile homebound elders like my mom to obtain COVID vaccine? Next slide. I think the answer to that question that we all want to say is yes, yes, we can do this which reminds me of this tag line that we are seeing in Seattle right now. It's actually we got this Seattle. But I'm going to broaden it to King County and it's something that every time I see this message really resonates for me because while it's been a brutal year, it's been hard. We really all are in this together and more so really than any other aspect of the vaccine delivery work we are doing, I'm struck about how this focus on homebound really gets to the center of the sense of community connectedness by sending the clear message that you, people who are struggling with COVID in private behind closed doors, you can't get out but you are not invisible. We are going to send someone to you because you belong here and you matter. So we got this king County. Thank you.

>> Wow, Ingrid, thank you so much. That was really powerful, very powerful way to end. Very emotional and we are in this together and I appreciate all of you, Amanda, Tom and Ingrid for your dedication to this issue and to the humane aspect of this issue as well to make sure that, you know, these people are not -- should not be invisible. To really appreciate that. So if we could go to the next slide, please, and I just want to talk briefly about our recommendations, so, again, with support from our funders at the Johnny Hartford foundation, led two national convention and conducted multiple interviews, reviewed countless articles and other literature and facilitating biweekly calls to identify the high-level policy solutions. Excuse me, one second. Each one of the recommendations and building them out and providing examples for many of them and these recommendations are once we think federal, state, territorial, legal and tribal governments should adopt and implement including prioritizing the homebound and caregivers, providing a definition so that, you know, other jurisdictions can -- can optimize the definition for their own jurisdictions. Identifying possible data sources as they've done in king County and initiate data sharing. So if there's a problem, you know, from one stakeholder to another, how can that data be shared? Ensuring all costs are fully covered and equitable access to the -- the vaccine and want to go make sure that the vaccinators reflect their community in terms of developing that trust, providing flexibility and creativity in innovative solutions and making registration and scheduling easy. So those are the overarching very succinct way of describing the recommendations that we are working on, again, it's being drafted and hopefully published within about a month. We can go to the next slide and I know that we have a number of very, very good and potentially challenging questions to -- to -- for our panelists. So we will be sharing those in just a moment, but for those of you who may have joined late, to submit a question at the bottom of your screen, you can look at the -- the circle with the ellipsis in it and you can either use that function or the Q&A button in

that panel, check your question in the Q&A box and select all panelists and just hit enter. If you would, unmute yourself and provide the first question.

>> So the first question is with the definition being quote, unquote, rarely left the home in the past month, how do you separate the truly homebound from those choosing to stay at home due to the pandemic?

>> I think the definition came from Colorado. I offered to the panelists a broader question about different new anticipates in the definitions and how can different jurisdictions, you know, deal with the different nuances.

>> This is Amanda. I think I can address part of that without diminishing, still needing to address the barriers and need of truly homebound. From our perspective, you know, considering a broad definition of individuals who have been in the home regardless of whether or not they are trying to protect themselves or whether or not they're truly -- their limited activities of daily limits them from leaving the home. We want to make sure that all of those individuals have the ability to get vaccinated. I certainly think that's truly homebound individuals that require nursing care and other types of home support and have agencies supporting those individuals, we are able to identify and list a little bit better even though there are still challenges, but I'm not too sure from, you know, I'm not sure from an implementation perspective the goal would be to reach all of this as adults.

>> Ingrid you put it well. Where do you want to air, do you not want to miss anyone or you want to be more specific to make sure that you target resources to the ones that really do have difficulty getting out? Medicare does have a definition and that's actually -- I saw part of the definition in your presentation, Ingrid, and in the medical page, you can go to beauty parlor once a week or church once a week and still be considered homebound. So that's the reason why in Megan's number, 2 million, to 12 million. I use 4 million. It really does depend on what your goal is in terms of not missing anyone or making sure the resources that you use --

>> Ingrid, the way that you ultimately -- the way King County has defined homebound.

>> Thanks, Megan. We were trying to strike a balance. If people can use another modality, they would but expansive enough so no one gets left out. So keeping it pretty general and saying, assuming that you have conditions and make it difficult to leave the home and then this is unique to vaccination in saying and for whom it is required considerable and taxing effort to access vaccine outside the home. One thing that I wanted to mention is that it's really important to have access to drive-thru sites for some individuals with health conditions, a drive-thru site is much more feasible. So as much as we can enable people to access other modalities, all the better. For me the goal, you know, completing this quickly and efficiently, so finding a balance.

>> I think that's really important as well. Thank you all very much. Next question.

>> I'm going to go with a quick question because it's come up twice. This is for you, Ingrid, can you share the questionnaire that is used, the screening tool, are you able to share that with participants?

>> Yes, we can share that post webinar, however that's feasible, Megan. I don't have it right in front of me but we've been working on retyping that but to keep it as brief as possible but to check the right boxes and cover the necessary pre-questioning so that we can make sure that we are not sending a team out to a home for someone who, you know, has not consented or has issues that would in the make it feasible. So happy to share and I can share through TFAH, through Megan after the webinar.

>> We will definitely make sure that goes out with the e-mail and the recording and slide. Thanks, Ingrid.

>> As a caregiver of elderly parent, how can we feel comfortable even after they are vaccinated that they are safe from not contracting COVID? Essentially, when do we decide that taking a parent out is better than -- if they can still contract COVID?

>> Amanda, I think that CDC might have guidance on that. Can you jump in on this question?

>> Sure. Fully vaccinated person, two weeks after an individual is fully vaccinated, CDC now has guidance allowing people who are fully vaccinated to see other people who have fully vaccinate and even be around people in small groups and still in sort of your close-knit family and close friends who have not been vaccinated as long as those individuals are not at high risk. In translation, I have told -- I now let my elderly parents, you know, now I bring my family -- we will soon have data -- we will soon have guidance that even expands those a little bit and it's okay to go to the beauty parlor, it's okay to go to indoor restaurant. We still don't want people going in high-volume or high-traffic places and, of course, we want people to wear a mask and socially distance as much as possible. We have increasing evidence to support vaccination does prevent infection incredibly well but at the same time we -- we also know that the importance of getting older adults to see their loved ones back into their regular routine and the ability to get out is really important. And so with that, we are moving towards allowing or -- giving confidence -- giving people confidence that their loved ones can start to return to some normal activities.

>> Great, thank you. I think it's a matter of risk assessment and I think that the, you know, things are getting definitely much more optimistic that there's a little bit less risk in going on if you've been vaccinated. So I think that's helpful. Do other panelists want to respond to that question?

>> Yeah, I still recommend from my vaccinated seniors to still wear their masks and be careful and part of that, I will be interesting if Dr. Cohn has data, with the flu vaccine we give a high-dose for people age 65 because they tend to not respond to immunizations

because it's not as good and are we seeing data Dr. Cohn that seniors don't have as much of a robust response or has it been just as strong as younger?

>> So at this time we actually don't have evidence likely that says that there's a substantially different robust response. The clinical effectiveness is still really high for older groups. The vaccines are so effective, the antibody response is to high that even if -- it's still clinically very effective. That being said, the duration of protection will be really important to follow in older adults because we may really start to see differences. You know, I still recommend older adults and everyone continue to wear masks and socially distance as much as possible simply because we know that the -- the more we can keep transmission as limited as possible, the further we will get as the communities are vaccinated in fighting off, you know, emerging variants and things like that.

>> Thank you.

>> Thank you. Next question, please.

>> So this is going to be a combination of several questions. It's addressing the contact in the homes. So how do you go around the issues of informed consent and how do you approach someone if they may be nervous opening the door and how do you determine the caregiver should be vaccinated? These are all interactions once you reach the home. How do you determine -- how do you provide consent and how do you engage if they are afraid to open the door?

>> Great, thank you. Any of our panelists?

>> I will just say briefly. We do a verbal consent when we do the screening phone call to arrange in-home vaccination. For caregivers, as much as possible serve more than just the single person in the home. In Washington State I think not different than any other states prioritizations on unpaid family care givers on phase 1A and also included people 50 plus who live in intergenerational household and who require support from family caregiver. So we haven't had any issue. We haven't had to be too concerned about eligibility for the other people in the home that have generally been eligible. So I think 25% so far we are vaccinating not a single person but also a caregiver or a family member along with the individual. And I think -- I think that covered your questions, thank you.

>> Thanks, I grid.

>> Yeah. And I saw one of the questions had to do what if you don't have a guardianship or POA and every state has what they call a surrogate decision-maker law. Just Google the surrogate decision-maker law. You know, most of them are pretty consistent in terms of if you're a spouse, you can make decisions if your loved one can no. If you're a child, they do not general I will say like oh, this child or anything like that. And so the only time that's a problem, even -- I was thinking Ingrid in the quote that you gave, the only problem in her patient there was an anti-vaxxer with a daughter that was

desperate for getting the vaccination and that can cause some problems if when they have equal decision-making ability, what if there's different opinions but that was the last thing in terms of surrogate decision-maker law because the states do make that relatively clear who make decisions if a person cannot.

>> Thank you. I think part of that question also was in terms of, you know, someone who comes to the door of a person who is homebound and they potentially don't know them or don't remember who that person is even if they've seen it before. How do you -- first of all, how important is it that the person who comes to the door is familiar or a trusted party or shares a culture or ethnicity or race or language? Are those issues really important and how do you overcome that?

>> We haven't had any major challenge with that to date. But, again, we are just getting off the ground with this strategy. We have had concern about people in uniform as seeming intimidating particularly to immigrant populations who come from countries where the military may not be a trusted entity. But, however, our fire department teams do we are firefighter uniform and they thus not far have had problem with people being presented at the door. Again, it's prearranged. People know that the team is coming but as you point out, Megan, people do have dementia and memory loss but today it has not been an issue.

>> Another question relating with working with the department level and contact other departments and want to know if they can set up a partnership with the aging sectors specifically the agency and non-aging reach the homebound?

>> So go ahead, Ingrid. I would like to know who asked that question and where are they coming from? Are they from public health? Sounds like a local health public person and Ingrid, I will let you respond to that.

>> And it's basically yes and yes and I would recommend seeking guidance from your state department of health to understand where in your state there's already a strategy set up that you could replicate or to get advice and also to make sure that they're attuned to the need for allocation of Janssen, Johnson & Johnson vaccine and, yes, collaborate with the state department of health and, yes, form a partnership with the area agency on aging and I'm sure Megan that you can provide support about how to bring together aging in public health.

>> Absolutely. Thank you for the plug. We are happy to do that. And Ingrid, kind of piggyback on that question for you. A question for you is, for local health departments that are just getting started in developing strategies and plans for getting vaccines to those who are homebound, what's your advice on first steps and kind of building that infrastructure that's necessary, building capacity?

>> I'd start with a pilot. The first step I would say to go to agency on aging and identify the list of who is receiving home care and narrowing it to indicators that they could be homebound, develop, recruit a team of vaccinators in our county at work. King County

is a little different because we are the coordinating entity for EMS and we have a lot of relationship with our fire departments but I would recommend for any local health jurisdiction to go to their local fire department so find that partnership between your triple A which they exist in every community, fire departments which exist in every community develop an initial list, all the right protocols get allocation of J&J vaccine and get out and test your systems.

>> Great, thank you. Makes very much sense. Next one.

>> There are two questions related to actually transporting the vaccine. The question is do you plan a day of vaccination so there's no leftover doses at the end of the day and getting at the question you can't predict how many caregivers or the family members would need to be vaccinated and transportation of the vaccines.

>> Sure, I can jump in on that one although Ingrid and Tom may have additional input. So this is -- I think this is one of the very early challenges when there was such limited supply and not proposing now that we waste vaccine but I want people to start worry to getting in arms than potentially wasting doses as we have enough supply now even though it doesn't feel like it. We totally understand the unknowns in terms of the caregivers and things like that. What you said at the beginning of the question is plan a day and try to plan out the number of doses that you will be giving is great and for sure the J&J vaccine is the easier one that's planned around because there's fewer doses per vile but I would really -- I'm hoping that especially over the next couple of weeks, the shift about wasting recognizing that what we do know that what we waste, especially if we are reaching those who are the most difficult to reach to get vaccinated.

>> Thank you, Amanda. Other panelists?

>> Right now we are very, very good about knowing who we are going to be vaccinated. We ask the caregivers that want it and need to make sure that we give them two-hour windows as to when we will arrive and -- and just to make sure that everyone is there and it's not been an issue. And one of the things is that the government pays for vaccine. None of us want to waste. That makes me cringe a little, but you're right, when we have enough, you know, it's important to get it in the people's arms and if you have to waste one of five doses, it's not horrible and the other nice thing just right now for us is that the government is paying for the vaccine, so as you're not -- $40 for that shot, you're not losing even more because you're wasting vaccine that you paid for.

>> Great advice. Thank you.

>> I will just add that, you know, our wastage numbers right now are so incredibly low. There's less than 1% which is -- we always anticipated wastage would be 5 to 10% which is what you see internationally and things like that. And so I commend everybody because I know it's much a critical issue and I still cringe a little when I say it too. I think we are moving to sufficient supply to -- to be able to support that.

>> And we heard from a couple of health departments that we've been interviewing that in some states where eligibility is -- is restricted to those, you know, 65 and over or 60 and over that in order not to waste, they were actually going against some of the state policies to make sure that they were using vaccines. And sounds like everyone thinks that's probably a good idea to go ahead and get vaccinated as many as possible and even if it means not completely complying with the -- the regulations and jurisdictions.

>> Yes, absolutely.

>> Thank you for affirming that.

[Laughter]

>> Great. And Ingrid, did you have a response to that as well?

>> No. Just great to hear from you Dr. Cohn about supply. We do hope that we are entering into a different era. Has been 100% of the biggest barrier, the lack of a stable and robust supply. We see it started to change and it's super exciting. We do have a leftover dose policy and it is to avoid waste and to start with highest risk first to try to use the left-over doses and to go outside of phase if necessary to avoid the -- avoid throwing any doses.

>> Great, thank you. I think we have time for one more question.

>> Okay. This is related to the -- people actually delivering the vaccines and challenges that people want to ask about. So one part of the question is, is it true that pharmacies cannot give the vaccine to a third-party administrator and there's some questions about volunteers professionals to go give vaccines and concerns about malpractice insurance and also challenges with home health and administering the vaccine. The questions are all the related to how to address those challenges.

>> You know, I will add to that. One of the applications, this has caused problems to getting vaccine. I think Dr. Cohn it would be good for you to know that some of the applications state in bold letters, vaccine must be shipped to location where they will be administered because they don't want them to be you know, diverted and want them to get to the people that they need to. The problem with that is because of fear of losing vaccine ability for future. They haven't been willing to give them, even if it's an office where one of the patients is homebound, they've not been willing to give us a dose to give the homebound patient for failure of breaking that rule and the reason I bring that up is that would explain why pharmacists would definitely with the vaccines they are giving that, to go to homebound patient if they are under that rule that it has to be given in the office where it was delivered. And then, you know, the cold chain that we talked about, basically the data logger thermometers that are $150 which you get at home, another cost, that we are using to make sure that during the 6 hours we keep it within that time frame of the 36 to 46 degrees and the CDC website has good information on -- on, you know, how to kind of do this.

>> Great. Thank you. I'm afraid we are going to have to stop there. Could we go to the last slide please in the deck. And I just want to thank our three panelists, Dr. Cohn, Dr. Cornwell, Ingrid, thank you all so much for all that you're doing and especially for the time today. It's just been invaluable information and very, very helpful. For those who submitted questions that we didn't get to, we will endeavor to answer those and share those as well when we send out the slides and the recording. Again, our policy brief will be published in early May, this webinar recording will be available on our public health website. You can register for our April biweekly huddle call. The registration was just placed in to the chat on April 2nd. This week we will hear from Donna Walsh, health officer of Seminole County, Florida who has operationalized to getting vaccine to older adults and next week on Wednesday we will hear from Tom Lally from Bloom Health, a healthcare provider who has done innovative work. So thank you all, everyone, for joining us today. We wish you the best. Stay safe and hope that you will join us for our huddle calls and next webinar whenever that may be.

>> Thank you so much.

(Ended 4:30 p.m.)

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