The Arc
Prince George's County
A Caring Community

January 13th COVID Vaccine Discussion and Q&A

The material is for informational purposes only. It does not represent a medical recommendation. You should consult with your physician regarding any medical questions or concerns that you may have and before undergoing any medical procedure or treatment including a vaccine. The Arc Prince George's County does not assume any responsibility for any health outcomes.

Agenda

- **Announcements**
- **Meeting Details**
- **Brief Introductions**
- **Discussion and Q&A**

Lauren Linkenauger, Healthcare Supervisor Walgreens

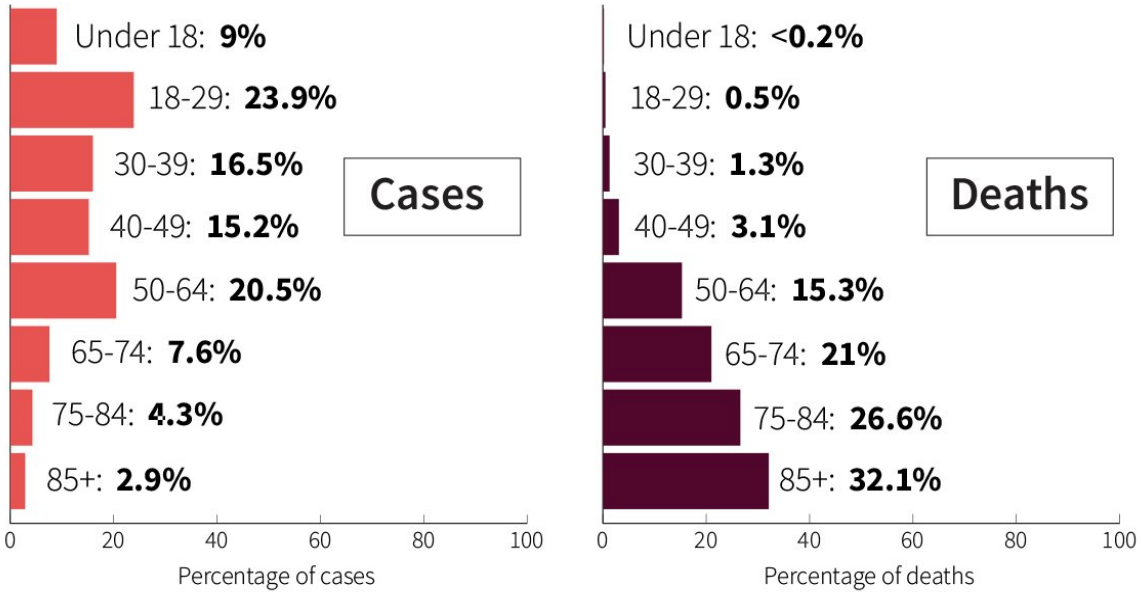
- Dr. Linkenauger's experience brings a broad acumen of the Pharmacy and Healthcare Industry. She started as a Walgreens Pharmacist in 2007.
- In 2015 Lauren transitioned to District Manager for the Roanoke District, overseeing the entire store operations.
- In 2017, Lauren moved back into operations as the Healthcare Supervisor before switching over to support the Rite Aid Integration.
- Lauren is currently supporting operations as a Healthcare Supervisor for parts of Maryland and Virginia.
- Lauren has a strong focus on building leadership capabilities in moments that matter, inspiring others to focus on positive patient healthcare outcomes, and leading the customer experience.
- Lauren holds a Doctor of Pharmacy and Master of Business Administration from Shenandoah University in Winchester, Virginia

A Key Partner

Walgreens

Reasons People with IDD Should Get The Vaccine

1. 90% of deaths have been in people over the age of 50
2. People with IDD have a higher incidence of COVID-19-related deaths than the general population
3. Black and Brown people are at higher risk of death – nearly 3 times
4. The country needs ~80% of the population inoculated



Source: Centers for Disease Control and Prevention, CDC COVID Data Tracker.
Based on available data as of Oct. 29, 2020.

COVID-19 Cases, Hospitalizations, and Deaths, by Race/Ethnicity

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases[1]	1.8x	0.6x	1.4x	1.7x
Hospitalization[2]	4.0x	1.2x	3.7x	4.1x
Death[3]	2.6x	1.1x	2.8x	2.8x

Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., among frontline, essential, and critical infrastructure workers.

How to Slow the Spread of COVID-19

Wear a mask

Stay 6 feet apart

Wash your hands

References on back

cdc.gov/coronavirus

CS319360-A 11/30/2020

People With The Following Top 10 Conditions:

1. Serious heart conditions, such as heart failure, coronary artery disease or cardiomyopathies
2. Cancer
3. Chronic kidney disease
4. Chronic obstructive pulmonary disease (COPD)
5. Obesity (BMI of 30 or greater)
6. Severe obesity (BMI of 40 or greater)
7. Sickle cell disease
8. Smoking
9. Type 2 diabetes
10. Weakened immune system from solid organ transplar

Reasons DSPs Should Get The Vaccine

- DSPs provide **close-contact and intimate care** – in a small congregate setting (for group homes)
- Getting a COVID-19 vaccine **may help keep you from getting seriously ill** even if you do get COVID-19.
- **It may also protect people around you**, particularly people at increased risk for severe illness from COVID-19.
- Getting COVID-19 may offer some natural protection, known as immunity. But experts don't know how long this protection lasts, and the risk of severe illness and death from COVID-19 far outweighs any benefits of natural immunity. COVID-19 vaccination will help protect you by creating an antibody response without having to experience sickness.
- Wearing masks and social distancing help reduce your chance of being exposed to the virus or spreading it to others, but these measures are not enough.


COMMON
QUESTIONS

Common Questions

We Know We Should All Get Advice From Our Physicians…

- What is a mRNA Vaccine (the type of vaccine that is now being distributed)?
- What Are Physicians Likely To Advise If Someone Has Pre-existing Medical Conditions?
- What Adverse Reactions Are People Having?
- How Was This Vaccine Created So Quickly? What Happened?
- Will The Vaccine Really Prevent People From Contracting And Spreading The Virus? What % Level Would We Expect?
- Can People "Wait Until The End Of COVID?" What Would That Look Like? How Do We Get to The End?

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Common Questions

We Know We Should All Get Advice From Our Physicians…

- What is the difference between side-effects and long-term damage? Are There Any Critical Ones with The COVID Vaccine?
- How long does the vaccine immunity last?
- How will the COVID vaccine or/ will the COVID vaccine effect those that have taken the Flu vaccine?
- Are there any side effects of ingredients in the vaccine that should not be mixed in the body if you have taken both the Flue and COVID vaccines?
- How are vaccine's tracked in a way that we know they are not spoiled – meaning they have been kept at the right temperature?
- If you don't get the vaccine during your phase, are you still in the priority for vaccination in whatever current phase we are in?

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Vaccine Distribution and Clinics

What We Know About the Process So Far

- Vaccine Clinics Will Be Arranged With a Provider Like Walgreens
  - Three clinics will be scheduled with your site
  - These clinics will be set up between 21 to 28 days apart, as most vaccines require two doses with at least 21 or 28 days in between doses.
  - After the second dose, it probably takes another two or three weeks to develop the optimal degree of immune protection.
  - A few weeks after the second dose, studies have shown that the vaccine efficacy is approximately 95%.
  - The vaccine has not yet been shown to reduce transmission of the virus

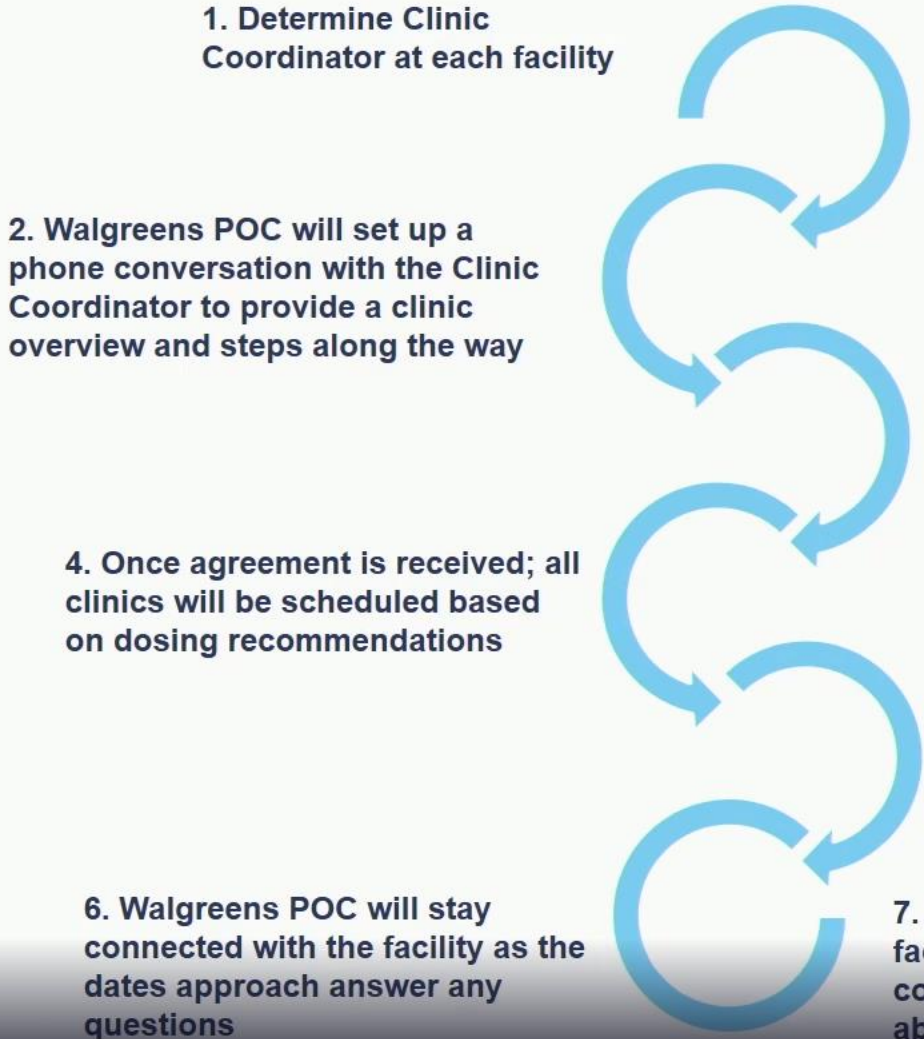
Vaccine Clinics

- Participants should only attend the clinic if they intend on receiving an immunization. Participants will NOT be vaccinated, and SHOULD NOT attend the clinic if:
  - They are feeling sick, have a fever, or are exhibiting any respiratory symptoms.
  - Have been diagnosed with COVID-19 within the last 2 weeks.
- Walgreens clinic team members will assess for signs of illness, which may include asking screening questions (if recipient is able) or taking participant's temperature using the touch-free digital thermometer.
- If able, participants must wear a face mask or face covering
- Participants will need to practice appropriate social distancing guidelines.

Clinic Day (cont'd)

- If possible, participants should wear clothing that allows the immunizer to easily access the shoulder area for a more efficient vaccination process (i.e. t-shirt and/or easy to remove layers).
- The facility will be responsible for providing any additional support for patients requiring special assistance.
- Walgreens clinic team member will fill out a shot card for each recipient of the vaccine, it is critical that your facilities keeps these for each resident. If a resident moves out of your facility, you should ensure you provide them their card.

We will be in touch!



1. Determine Clinic Coordinator at each facility

2. A Walgreens POC will be assigned to be your point of contact

2. Walgreens POC will set up a phone conversation with the Clinic Coordinator to provide a clinic overview and steps along the way

3. Walgreens POC provides the COVID-19 Clinic Agreement and Clinic Preparation Guide

4. Once agreement is received; all clinics will be scheduled based on dosing recommendations

5. Clinic Coordinator provides Walgreen POC a roster of the residents that wish to be immunized

6. Walgreens POC will stay connected with the facility as the dates approach answer any questions

7. A store team member will contact the facility to confirm resident count, consent has been obtained, and inquire about any COVID-19 cases that they know of

We bring disciplined clinic set-up procedures

Workflow set up

- 2 check in stations
- 4 immunization stations
- Dedicated waiting area
- Observer/Flex

Roles & responsibilities

Check In

- Hand out consent forms
- Verify third party billing information
- Record patient temperature on consent form margin
- Direct patients to Immunization station

Immunizer

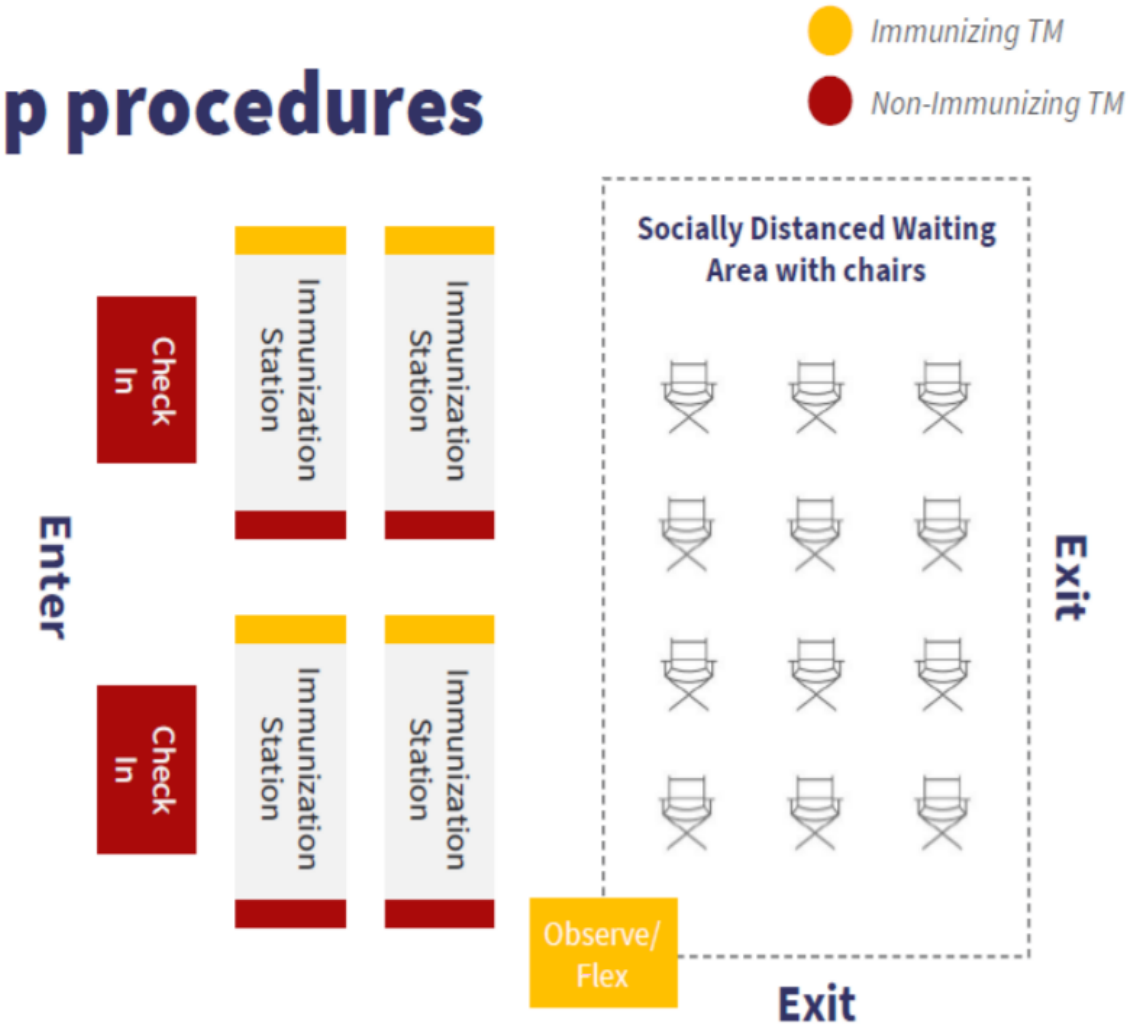
- Review consent form for contraindications
- Administer immunization
- Sign and complete consent form

Immunization Assist

- Prepare vaccination supplies
- Take-away documents
- Lot/Exp recorded on consent form
- Duties as requested by immunizer

Observe / Flex

- Observe patient's post-vaccination
- Flex duties based on need (ex: Re-distribute supplies, flex into role for meal breaks)



Illustrative example of how a central location clinic may be set up

Walgreens

Guide To Filling A LTCF VAR

Fill before clinic

Vaccine Administration Record (VAR)
Informed Consent for Vaccination in Long Term Care Facility (LTCF)

Walgreens

SECTION A-1 Please print clearly.

First name:_____ Last name:_____

Date of birth:_____ Age:_____ Gender: ☐ Female ☐ Male Phone:_____

LTCF Name:_____ Address:_____

City:_____ State:_____ ZIP code:_____ Patient Email address:_____

Fill day of clinic

I want to receive the following vaccination(s): COVID-19 Vaccination

SECTION A-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent to consent. Further, I hereby give my consent to Walgreens or Duane Reade and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s)) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Walgreens will send vaccination information from this visit to the LTCF Medical Director.

Patient/Authorized Person signature:_____ Date:_____

SECTION B-1 **SCREENING QUESTIONS.** The following questions will help us determine your eligibility to be vaccinated today.

1.	Do you feel sick today?	☐ Yes ☐ No ☐ Don't know
2.	Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
3.	Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
4.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes ☐ No ☐ Don't know
5.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	☐ Yes ☐ No ☐ Don't know
6.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know

SECTION B-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Representative:_____ Date:_____

VAR Insurance Information or Medicare Information

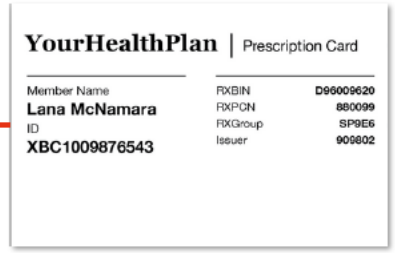
SECTION C — **INSURANCE – PATIENT TO COMPLETE IF APPLICABLE**

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed at Walgreens.

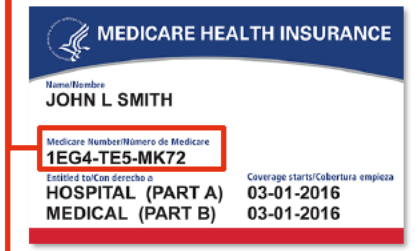
Non-Medicare:	Pharmacy Card	Medical Card
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

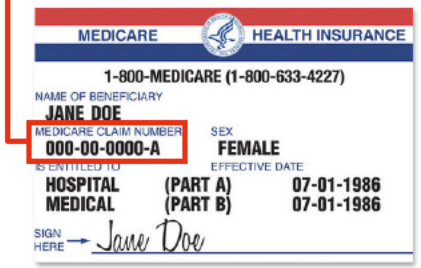
Medicare:	Medicare Part B
Medicare Number*:	

*Medicare Claim Number for cards distributed earlier than 2018



For those covered by an insurance group





For those covered by Medicare Part B

Vaccine Administration Record (VAR)

Informed Consent for Vaccination in Long Term Care Facility (LTCF)

Walgreens

SECTION A-1 Please print clearly.

First name:_____ **Last name:**_____

Date of birth:_____ **Age:**_____ **Gender:** ☐Female ☐Male **Phone:**_____

LTCF Name:_____ **Address:**_____

City:_____ **State:**_____ **ZIP code:**_____ **Patient Email address:**_____

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I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable.

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Print Name: _____ **Patient/Authorized Person signature:**_____ **Date:**_____

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2.	Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
3.	Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
4.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes ☐ No ☐ Don't know
5.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	☐ Yes ☐ No ☐ Don't know
6.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know

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Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed at Walgreens.

Non-Medicare:	Pharmacy Card	Medical Card
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

Medicare:	Medicare Part B
Medicare Number*:	

*Medicare Claim Number for cards distributed earlier than 2018.

Is the patient the cardholder? ☐ Yes ☐ No

If no, please provide cardholders name, date of birth (MM/DD/YYY) and relationship: _____

SECTION D — HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

1. I have reviewed the **Patient Information** and **Screening Questions.** Initial here: _____
2. I have verified that this is the **vaccine requested** by the patient. Initial here: _____
3. This vaccine is appropriate for this patient based on the **Age Guidelines and Other Guidelines** provided by federal and/or state regulations and company policies. Initial here: _____

   3a. Does this patient have a high-risk medical condition? ☐ Yes ☐ No

   If yes, please list medical condition(s): _____
4. The **Vaccine NDC matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (Perform **3-way NDC match.**) Initial here: _____
5. I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below. Initial here: _____

SECTION E — Complete DURING the patient interaction

1. I confirm(ed) the patient's **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form. Initial here: _____
2. I have reviewed the **Screening Questions** and answers. Initial here: _____
3. I provided a **EUA Fact Sheet** to the patient or the LTCF representative. Initial here: _____

SECTION F

Complete AFTER vaccine administration

Vaccine	NDC	Manufacturer	Dosage	☐ Dose 1 ☐ Dose 2	Site of administration	EUA Fact Sheet published date

Clinician's name (print):_____ **Clinician's signature:**_____ **Title:**_____

If applicable, intern/tech name (print):_____ **Administration date:**_____ **Date EUA Fact Sheet given to patient:** _____

COVID-19 VACCINE LOT# _____ **COVID-19 VACCINE EXPIRATION DATE** _____

1. Update the patient's record with any new allergy, health condition or primary care provider information.
2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.

The Arc
COVID Vaccine
Survey Results

The Arc PGC COVID Vaccine Survey

Objectives

- Get a Sense of The Current Thinking and Perspectives Around The Vaccine

Data

- 111 Participants; 57 Provide Direct Support

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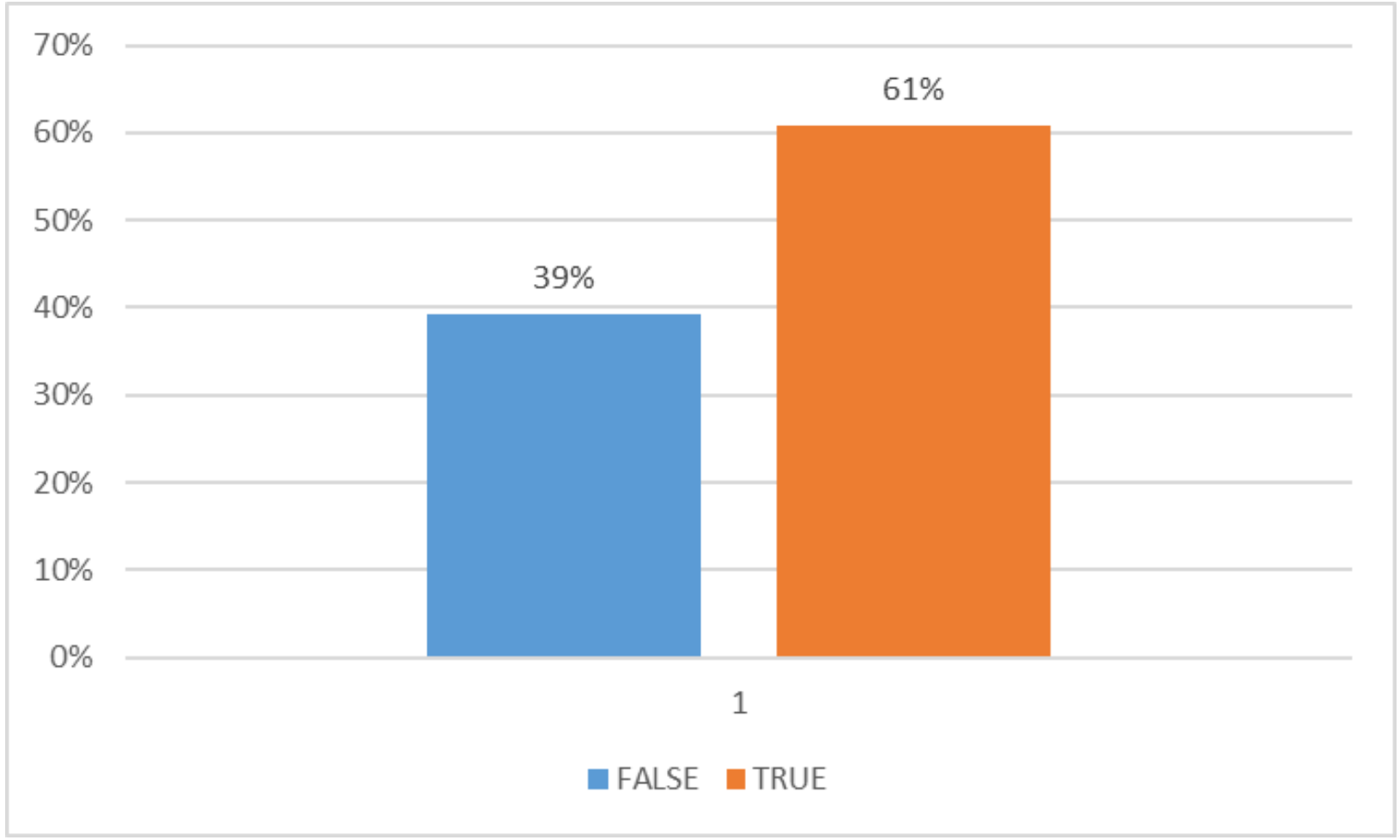
The Vaccine is Safe and Reliable



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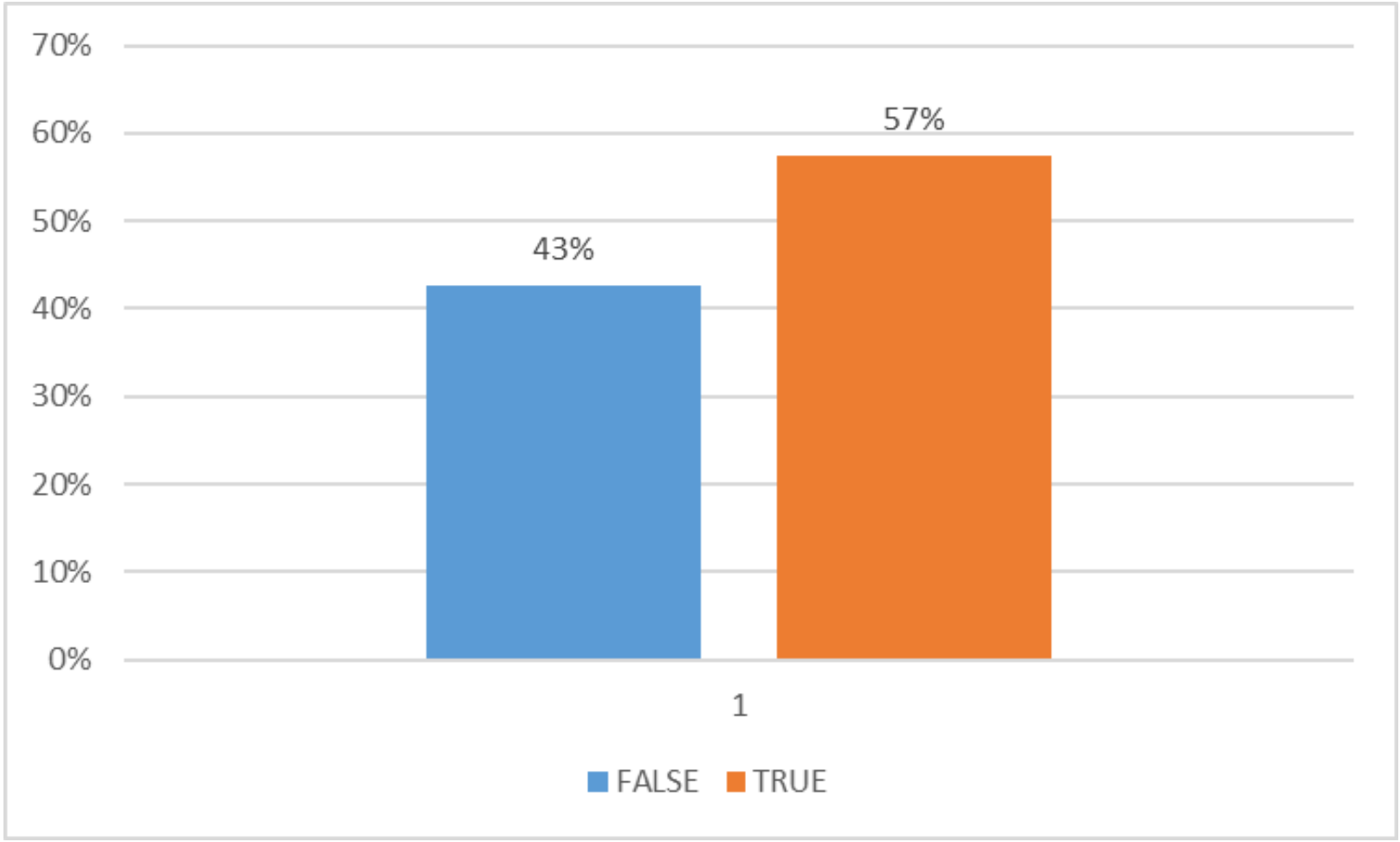
The Vaccine Will Be Effective



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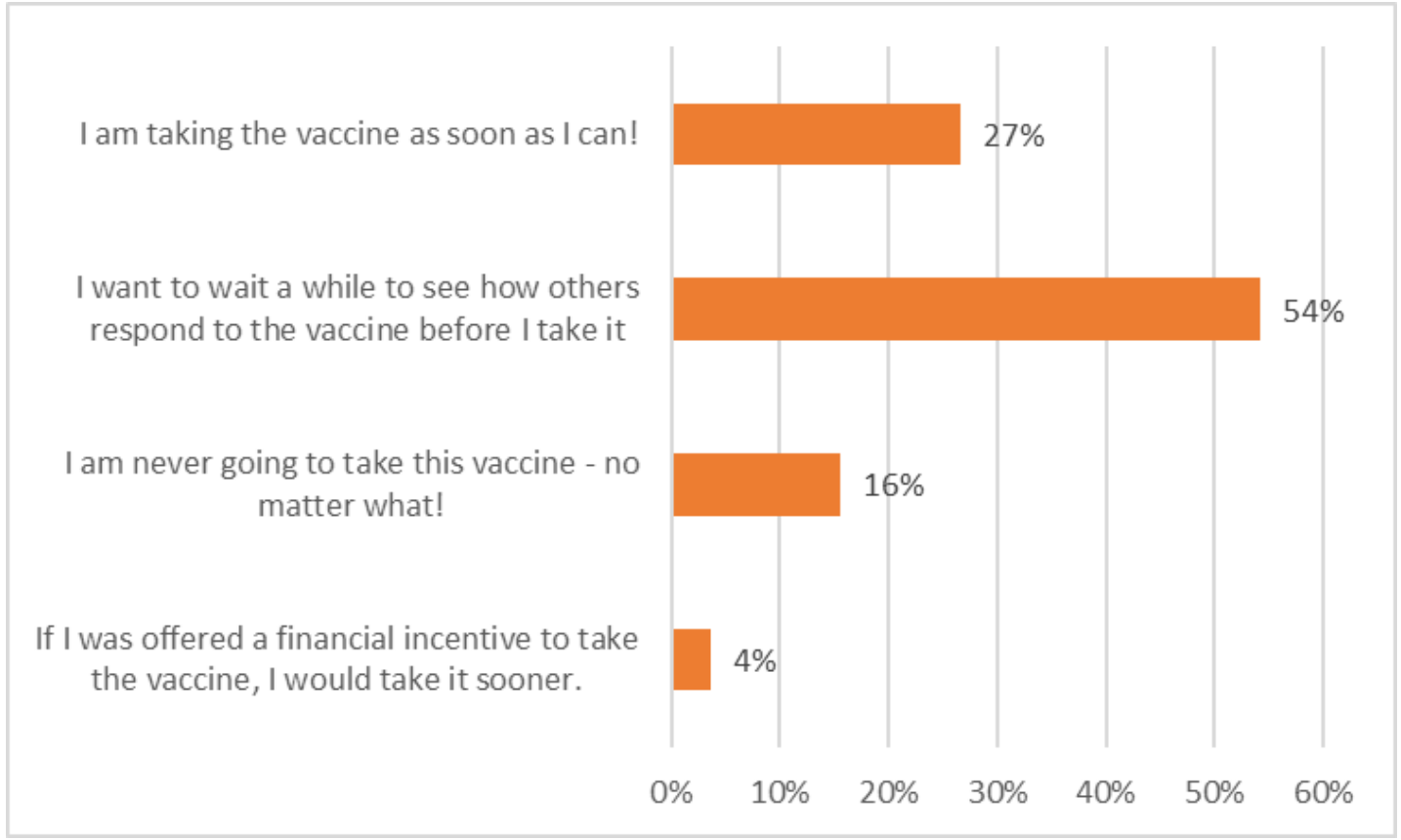
Timing

- When I'd Prefer To Take The Vaccine



Many Would Like To Wait As Long as 6 Months

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What We Are Hearing

For

- I want to **protect family and those around me**
- We have to do something
- If my doctor recommends
- If it is safer, based on my pre-existing conditions

Against

- This was **Rushed**
- I want to wait to see the side-effects

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- Will The Vaccine Really Prevent People From Contracting And Spreading The Virus? What % Level Would We Expect?
- Can People “Wait Until The End Of COVID?” What Would That Look Like? How Do We Get to The End?

Remember to Get Advice From Your Physician

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- How long does the vaccine immunity last?
- How will the COVID vaccine or/ will the COVID vaccine effect those that have taken the Flu vaccine?
- Are there any side effects of ingredients in the vaccine that should not be mixed in the body if you have taken both the Flue and COVID vaccines?
- How are vaccine's tracked in a way that we know they are not spoiled – meaning they have been kept at the right temperature?
- If you don't get the vaccine during your phase, are you still in the priority for vaccination in whatever current phase we are in?

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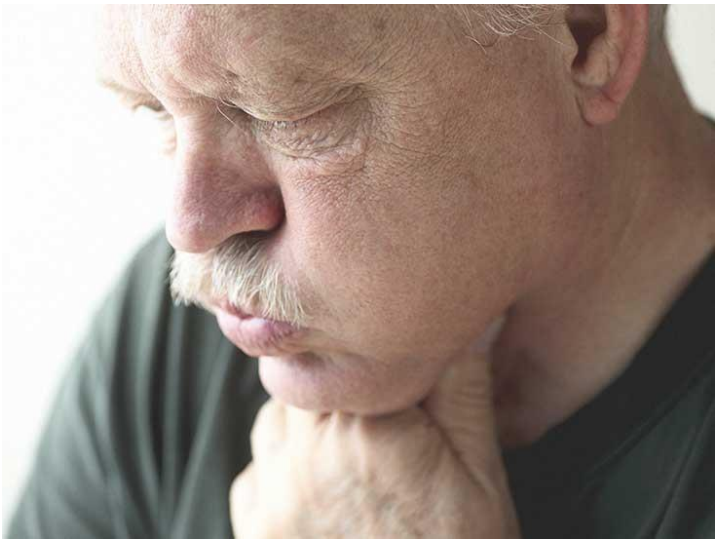
Who Should Avoid Getting The Vaccine?

- Anyone With Severe Allergies To The Ingredients
- People Who Are Not Feeling Well



Vaccine Creation

How Did We Get The Vaccine So Quickly

- Check out the Amazing Work of Dr. Kizzmekia Corbett:
  - https://www.youtube.com/watch?v=a09PhAqw16A
  - https://www.youtube.com/watch?v=881eS5UAlA8 (more detailed presentation)

LA Times…

The scientific evidence is clear regarding the safety and efficacy of the vaccines after trials involving tens of thousands of participants, including elderly people and those with chronic health conditions. The shots are recommended for everyone except those who have had a severe allergic reaction to any of the ingredients.

What We Know About the Process So Far

- Vaccine Clinics Will Be Arranged With a Provider Like Walgreens
  - Three clinics will be scheduled with your site
  - These clinics will be set up between 21 to 28 days apart, as most vaccines require two doses with at least 21 or 28 days in between doses.
  - After the second dose, it probably takes another two or three weeks to develop the optimal degree of immune protection.
  - A few weeks after the second dose, studies have shown that the vaccine efficacy is approximately 95%.
  - The vaccine has not yet been shown to reduce transmission of the virus

- Lauren Linkenauger, Pharm.D. - A Rep From Walgreens - Will Join us For Our **January 13th Call**

- Dr. Ernest Carter, A Rep From The Prince George's Department of Health, Will Join us On **January 20th**