COVID-19 VACCINATION PLAN

Contra Costa County

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COVID-19 Vaccine Implementation for CA Health Jurisdictions

Introduction/Explanation

As is stated in the [CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations](#), immunization with a safe and effective COVID-19 vaccine is a critical component of the strategy to reduce COVID-19-related illnesses, hospitalizations, and deaths and to help restore societal functioning. The goal of the U.S. government is to have enough COVID-19 vaccine for all people in the United States who wish to be vaccinated. Early in the COVID-19 Vaccination Program, there may be a limited supply of COVID-19 vaccine, and vaccination efforts may focus on those critical to the response, providing direct care, and maintaining societal function, as well as those at highest risk for developing severe illness from COVID-19. [California's COVID-19 Vaccination Plan](#), as well as a [summary of CA's efforts to plan for COVID-19 vaccine](#), are both posted at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID-19Vaccine.aspx .

This CDPH document is modeled after the CDC playbook and follows the recommendations for local health jurisdictions that have been presented in weekly webinars with Immunization Coordinators, Emergency Preparedness Planners, Local Health Officers and Health Department Executives.

The intention of this document is to help prepare local health jurisdictions for the phased implementation of COVID-19 vaccine in their communities. Completion of this template is a requirement for the COVID-19 vaccine funding for your jurisdiction. We realize that there are still many unknowns about COVID-19 vaccine. Completion of this template, however, will help to ensure that the foundational planning components for your COVID-19 vaccine response are in place. This is a high-level planning tool that only requires concise responses. This completed template is **due to CDPH by:**

<div style="border:1px solid red; padding:10px;">

5:00 pm December 1, 2020
Please email completed templates to CDPH.LHDCOVIDVAC@cdph.ca.gov

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Box size roughly indicates how much we'd like to hear about your plan for the different sections. Boxes will expand if you need to add more text.

Thank you. We look forward to learning about your strategies and plans as we embark on this new and critical vaccine journey.

Section 1: COVID-19 Vaccination Preparedness Planning

A. Describe the multi-agency Task Force/Entity that has been put together in your jurisdiction to plan for COVID-19 vaccine implementation.

The COVID-19 Vaccine Procurement and Distribution Branch ("Vaccine Branch") of Contra Costa County's Department Operations Center (DOC) was created in August 2020. This branch originally incorporated flu vaccination in addition to COVID vaccine planning. On November 30 2020 the Vaccine Branch and the Testing Branch were merged into the "Testing and Vaccine" branch in order to rapidly scale up and maximize and leverage the operations, logistics and delivery structure already existing in the Testing Branch and expand this to COVID vaccine distribution. The Testing and Vaccine Branch is headed by the county's Chief Nursing Officer with the county's Immunization Coordinator providing technical advice. The branch also includes staff from public health emergency preparedness, data/analytics, clinic services and other programs within Contra Costa Health Services [CCHS - the organization which includes the public health department, acute care hospital (Contra Costa Regional Medical Center, CCRMC) and ambulatory care sites that are part of our immunization delivery system]. The branch contains units for planning/evaluation, operations and logistics with many subunits as indicated in the org chart in section 2A. In addition, we work closely with partners such as CDPH's Immunization Branch and Emergency Planning Office, our Med Health Coalition, Medical Reserve Corps, ABAHO and the Bay Area Mass Prophylaxis Working Group (BAMPWG). Finally, Contra Costa is in the process of establishing an ethical and equitable allocations committee which will involve internal and external stakeholders, including community stakeholders, in order to guide the allocations process.

B. Revisiting institutional memory and after-action reports, what are the major lessons learned from H1N1 in your jurisdiction and how are they being considered for COVID-19 vaccine implementation?

In the aftermath of the 2009 H1N1 Pandemic, health officers and agency directors cited the invaluable contributions made by ABAHO in facilitating regional coordination during the pandemic. Contra Costa Health Services participates in all regional planning for COVID-19 response. Key areas of improvement for regional work included consistent messaging and consistent priority allocation groups. ABAHO will review and ensure priority allocation groups are accepted regionally and provide consistent messaging.

In addition to regional collaboration, CCHS had several specific lessons learned from H1N1 Point of Dispensing (POD) planning, as outlined in after action reports:
- To increase speed of vaccination teams, provide a floater vaccinator to reconstitute and fill the vaccine syringes for the injector;
- Develop messaging for two separate vaccines and importance of second dosage matches first dose received;
- Arrange for programs within CCHS that have nurses to commit personnel to the PODs/clinics

process;
- Bring in Critical Incident Stress Debriefing team for those who worked POD activation;
- Complete POD set ups one day in advance; and
- Test new tracking and inventory management systems prior to use.

These lessons learned are integral to our planning for the receipt and distribution of COVID-19 vaccine in Contra Costa County.

C. What lessons have been learned thus far from influenza vaccine activities in your jurisdiction that can be applied to COVID-19 vaccine distribution and administration?

This flu season has been a great test run for distribution of COVID-19 vaccine as Enhanced Flu funding from CDPH and the creation of the Vaccine Branch in our DOC allowed us scale up flu vaccine distribution in our county considerably, and to practice doing so with similar social distancing requirements as may be in place as COVID-19 vaccine rolls out. Through these activities, we strengthened partnerships with Community Based Organizations (CBOs), congregate care facilities, and workplaces, including sites we can repurpose for COVID vaccine distribution as open or closed PODs. We also fine-tuned our strategies for efficiently vaccinating large groups of people in a short amount of time. Key lessons learned include:
- Our weekend clinics and/or drive-through clinics were most successful in attracting large amounts of people;
- Distribution of flu vaccine at established testing sites via model of offering flu vaccine with COVID test. This allowed for daily distribution options of flu vaccine to our population.
- Creating a workflow at our COVID testing sites which allowed for multiple vaccine types to be distributed. The workflows allowed staff to triage and assess for proper distribution. This included development of protocols, safety checks and other documents.
- Having an ample amount of interpreters was important for reaching our non-English speaking population as well as to increase clinic throughput;
- Planning for the possibilities of smoke, heat, and other inclement weather are important as we plan clinics throughout the seasons; and
- Having a strong Public Information Office partnership to promote and message around vaccination is crucial to ensuring a high turnout and preparing patients for what to expect at the PODs.

In addition to the above, the systems in which we receive and distribute state general fund (SGF), federal 317, and Vaccines for Children (VFC) flu vaccine throughout Contra Costa County has many parallels with the plans for future distribution of COVID-19 vaccine. Because staff in the Vaccine Branch has experienced flu vaccine distribution together, we feel we are well-prepared for distribution of COVID-19 vaccine when it arrives, as we have many systems and relationships in place that are transferrable.

Section 2: COVID-19 Organizational Structure and Partner Involvement

A. Please share your local organizational (org) chart that is guiding COVID-19 vaccine planning by pasting it into the space below or add it as an Appendix at the end of this document.
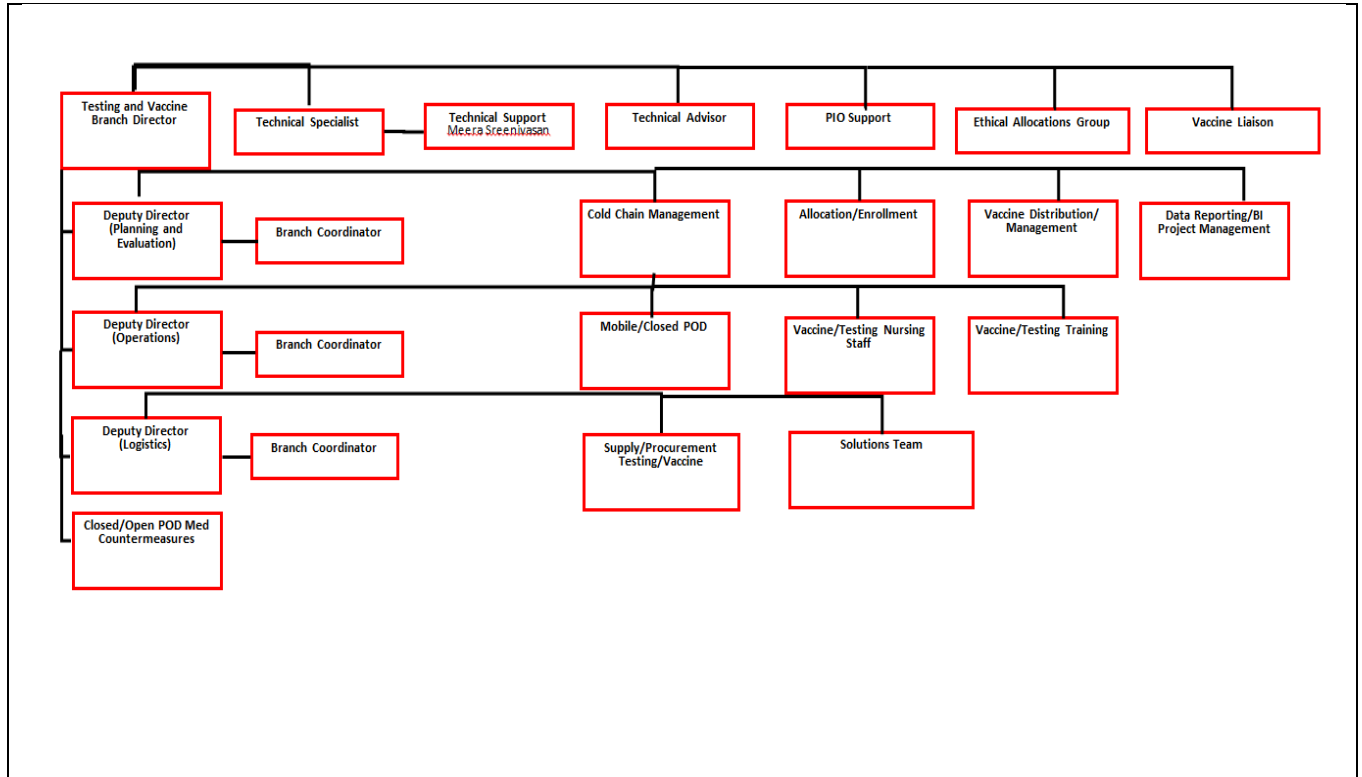
B. How are you engaging external partners in your planning process? Who are your primary external (outside of your local health department) planning partners?

Our primary planning partners are CDPH Immunization Branch, Emergency Planning Office, ABAHO, BAMPWG, our Med Health Coalition, as well as the numerous community partners we work with during our public health emergency planning processes, such as law enforcement, fire agencies, school districts, and large essential businesses. As mentioned above, we are also establishing an ethical and equitable allocations committee which will involve internal and external stakeholders (including representatives from other health systems and community stakeholders) to help guide the allocations process.

Section 3: Phased Approach to COVID-19 Vaccination

A. Have you incorporated a phased roll out of COVID-19 vaccine into your overall COVID-19 Response Plan? ☒ yes   ☐no

B. Have you established any point of dispensing (POD) agreements to potentially vaccinate Phase 1a populations? List entities with whom you have agreements and who they've agreed to vaccinate.

CCHS will use several POD modalities including but not limited to: 1) open/closed POD sites using existing systems in place (e.g. COVID testing sites), 2) closed POD agreements with agencies that are able to vaccinate their own personnel, 3) closed POD sites that will need vaccinators, 4) strike teams for populations unable to travel to POD locations, and 5) open POD mass vaccination events. POD agreements will be continually updated to match the ACIP priority populations and our local vaccine allocations.

Phase 1a:
- Hospitals will receive direct shipment of vaccine to their facilities via establishing provider accounts in COVIDReadi, and are responsible for vaccinating their phase 1a high-risk healthcare workers. If a hospital is unable to receive direct shipment from the state, CCHS will facilitate redistribution of vaccine for the facility to vaccinate its phase 1a high-risk healthcare workers. Sites receiving direct shipments of COVID-19 vaccine in our jurisdiction include:
    - Kaiser Richmond
    - Kaiser Walnut Creek
    - Kaiser Antioch
    - John Muir Concord
    - John Muir Walnut Creek
    - Sutter Delta Antioch
    - San Ramon Regional Medical Center (Tenet Health)

- Contra Costa Regional Medical Center (CCRMC) is an acute care hospital within Contra Costa Health Services; therefore vaccine will be supplied via CCHS' provider account and administered via CCHS staff, along with other CCHS's staff identified as priority Phase 1a populations.

- Congregate Care Settings: CCHS has encouraged congregate care and living centers such as Skilled Nursing Facilities, Long Term Care Facilities, Board and Cares, Residential Care Facilities, and group homes to enroll in the CDC Long Term Care Facility (LCTF)-Pharmacy Partnership Program to receive vaccine. To date 215 facilities in Contra Costa, including 30 SNFs, have enrolled in the LTCF-Pharmacy partnership. Any facilities that did not meet the requirement will require CCHS for assistance in vaccine allocation and administration via

strike team or closed POD planning. We plan to elicit the agencies that need our assistance through use of our Med Health Coalition and internal contact lists.

- Federal Entities within LHD: Military Ocean Terminal of Concord (MOTCO) and the Veterans Affairs (VA) have a unique Memorandum of Agreement with CCHS to provide vaccinator assistance. VA will receive direct allocation of their vaccine, but MOTCO will not. VA will assist in vaccinating MOTCO personnel with CCHS-allocated doses once priority phase is identified.

- First Responders – Law and Fire: CCHS will work with EMS and Fire Agencies to develop MOAs for their agencies to vaccinate their own personnel under the LEMSA agreement for paramedics to vaccinate. Fire will assist in vaccinating their local law enforcement agencies. The following fire districts have MOAs in place:
    - Contra Costa County Fire Protection District (ConFire)
    - Rodeo Hercules Fire Protection District

Additional references include:

Graphic on page 11 of CDC COVID-19 Vaccination Program Interim Playbook and

A phased approach to Vaccine Allocation for COVID-19 from National Academies of Sciences Engineering Medicine

Section 4: Critical Populations

A. Describe your efforts to identify the health care workforce, critical infrastructure workforce and vulnerable populations in your jurisdiction including reviewing the data from CDPH.

Using the data provided from CDPH, CCHS reviewed categories of health care workers, critical infrastructure workers, and vulnerable populations, and created a categorization of risk system taking into consideration type of worker, location of work, and personal risk factors for the individual worker. These efforts were done in preparation for final guidance on priority populations. Census tracts in the county that fall into the lowest quartile have been mapped, and flu mass vaccination sites were held to target the most vulnerable populations. Once general population vaccination begins, a similar approach will be used for COVID-19 vaccine. Our ethical and equitable allocations committee will review data sources and recommendations for gaps and assist in efforts to reach critical populations. We plan to send surveys to facilities in our jurisdiction for input as necessary to collect more information to guide this process.

B. Describe your plan for communicating with acute care facilities about their readiness to vaccinate during Phase 1a. (Are they ready to hit the ground running?)

Contra Costa Regional Medical Center (CCRMC) is part of Contra Costa Health Services, therefore the county's COVID-19 response efforts will include vaccination of that acute care hospital's phase 1a workforce, as well as other phase 1a populations (e.g. first responders) identified that work for the county. Other acute care facilities have enrolled, or are in the process of enrolling, in COVIDReadi and will be assessed for readiness via that system. CCHS is in regular communication with these facilities and CDPH about the progress of their enrollment. We will reach out via email and/or survey to those who have not successfully enrolled in COVIDReadi or the LCTF-pharmacy partnership to assess the reason. If gaps are identified the county will assist these facilities by setting up closed pods or providing vaccine for the facility from our supply via redistribution agreements.

C. With an eye on equitable distribution, how do you plan on reaching other populations that will need vaccinations in subsequent phases?

In collaboration with our PIO, we will develop a vaccination communications plan. We will use various methods for outreach (e.g. email, phone trees, distribution of door hangers, social media) to partners that serve these populations, such as residential facilities, food banks, schools, and other CBOs in order to promote vaccination and provide resources for obtaining vaccination. We will schedule closed and open PODs as appropriate for the site, and advertise these via a public information campaign using our Public Information Office, which will include press releases, interviews, website/social media presence, and flyers. Throughout this process we will engage our ethical and equitable allocations committee, our trusted community partners, and the county's Community Engagement and Outreach program, which has established workgroups for Historically Marginalized Communities, Latinos, older adults and others.

Additional references include populations listed on page 14 of CDC COVID-19 Vaccination Program Interim Playbook

Section 5: COVID-19 Provider Recruitment and Enrollment

CDPH is identifying large health systems and other multi-county entities (MCEs) that will receive vaccine allocation directly from CDPH. Some MCE criteria are that the entity has facilities in three or more counties; is able to set policy for its facilities, can plan centrally and support implementation of a COVID vaccination program at all of its facilities in California; and that the entity can order, store and administer vaccine to its employees or arrange with an outside provider (other than the local health department) to do so. It is not necessary for local health departments (LHDs) to invite these entities to enroll as COVID vaccine providers. LHDs should review the list of MCEs for their jurisdiction and be familiar with the MCEs' vaccination plans.

A. What are you doing to identify non-MCE providers to invite to participate in Phase 1a? *(e.g. acute care hospital providers not affiliated with an MCE, staff of long-term care facilities, ambulatory care settings providers).*

We will check enrollment in COVIDReadi and the LTCF-Pharmacy partnership and reach out to those who have not enrolled using CDPH-provided datasets, our contact lists, subject matter experts (such as our congregate care team, which worked with these facilities in other phases of COVID response to provide mobile testing and flu vaccine), and our Med Health Coalition to identify potential facilities who have been missed. Facilities will be sent a survey via email to assess readiness and current needs, and the LHD will follow up to provide PODs or strike teams to these sites.

B. How will you continue to recruit new providers to register and vaccinate during subsequent phases when there is more vaccine?

We will implement our Vaccine Communications Plan. We will send targeted emails and letters, using CDPH-provided template language, to providers with information about how to sign up to be a provider via COVIDReadi or forthcoming enrollment sites. We will also provide links and instructions on our website, https://www.coronavirus.cchealth.org/, where the COVID-19 vaccine section (currently under development) will reside.

C. Who will be reviewing your local provider enrollment data to ensure that pharmacies and providers are enrolled?

Our Hospital Preparedness Program and Med Health Coalition partners are assisting in this process by reviewing CDPH-supplied data on enrollment in the LTCF-Pharmacy partnership and providing the Vaccine Branch with contacts for outreach. Vaccine Branch staff and subject matter experts, such as members of our ethical and equitable allocations committee, will

review additional provider datasets for potential enrollees, and we will reach out accordingly to provide assistance as appropriate for that facility's barriers, whether that be technical assistance with the enrollment process, arranging a closed POD at that facility, providing vaccine via redistribution agreements with CCHS, or directing staff and/or patients to a county-run POD.

Section 6: Vaccine Administration Capacity

A. Looking at your previous dispensing and vaccination clinic activities, what elements have resulted in greater throughput results?

Good advertising and support from our Public Information Office via social media, our website, and media interviews helped ensure higher turnout. Drive through models also yielded higher throughput as many family members visited in the same car and our local Community Emergency Response Team (CERT) assisted with traffic control to ensure organized flow. In both drive-though and walk-through models we streamlined our processes and stations to ensure bottlenecks were addressed. At our COVID testing sites, we were able to develop traffic workflows and separate lanes to facilitate the distribution of the vaccines while ensuring that there was appropriate social distancing and room for traffic flow of vehicles. The COVID testing sites also leveraged our appointment systems to aid in high throughput of patients via appointments to the various COVID Testing which distributed flu vaccine. The Vaccine team also will be able to use data from adminstration of flu vaccine to calculate how many doses can be given in a day by a nurse and the time it takes to administer. This ratio will be use to scale up to increase throughput at the vaccination clinics.

B. What mapping information do you have access to that will help your recruitment efforts and POD plans? (e.g. disease hot spots, vulnerable communities, testing sites, POD sites etc.)

This flu season we mapped our mass flu vaccine distribution sites overlaid with the Healthy Places Index bottom quartile in order to ensure we were accessible to the most vulnerable communities in our county (map: https://arcg.is/1KzezS0). For COVID vaccine, we plan to use disease hot spots and Healthy Places index to plan POD sites, in addition to reusing POD sites we established during flu season, as well as continue to distribute vaccine (as we did with flu) via our established COVID testing sites throughout the county.

C. How will data be entered into CAIR/SDIR/RIDE from your POD sites?

    a. ☒ PrepMod (primary method for phase 1a)
    b. ☒ Mass Vax module (backup method for all phases)
    c. ☒ Other – CCRMC, CCHS ambulatory sites and other POD sites using electronic health records (EHR) with functional bidirectional exchange with CAIR may enter doses directly

into the EHR. We anticipate this being the primary modality for these sites during phases 2 and beyond of vaccine distribution.

D. Please describe the staffing strategies you are planning for mass vaccination PODs. (e.g. mass vaccinator contract, Medical Reserve Corps, volunteers etc.) Also, in this section, please add any anticipated support you think you will need from the State for the different phases.

> For open PODs we will use county-employed vaccinators, paramedics, Medical Reserve Corps, and state mass vaccinator contracts as needed. For closed PODs we will use any/all of the above if the facility does not have their own vaccinators. If the facility has vaccinators of their own, we will verify they have received the appropriate training to be a COVID vaccinator in advance.
>
> Support needed from state is reliable vaccinators via mass vaccinator contracts (i.e. Maxim or similar) for individual vaccinators in all phases.

E. Describe your plan for identifying where PODs will be conducted in the community and for which populations.

> Initially we will create closed PODs based on phase 1a priority populations for vaccine. This will be determined by analyzing datasets to identify where these priority populations live or work, in close collaboration with our ethical and equitable allocations committee and Community Engagement and Outreach program partners. In most cases Phase 1a PODs will be held at the facility where the priority population works or lives. As more vaccine becomes available and we move into phase 1b and beyond, we will use sites that have already MOAs with us as closed POD sites, reuse open POD sites that we used for mass flu vaccination clinics, repurpose existing county COVID testing sites as PODs, as well as partner with agencies to enroll new open/closed POD sites for all phases as appropriate for the priority population in question and our local allocations. As we did during H1N1, we also plan to hold large mass vaccination event/open PODs at outdoor venues (e.g. Sleep Train Pavilion, Hilltop Mall) once COVID-19 vaccine is available to the general public, in order to efficiently administer large quantities of doses as well as provide a vaccination option to those without a medical provider.

F. How will you assess provider throughput for LHDs PODs and for the broader provider community? *(Consider your current experience running socially distanced flu clinics to help answer this question.)*

We will review AARs from H1N1 vaccine PODs for lessons learned as well as use our efforts this season distributing flu vaccine to estimate throughput while incorporating other key variables (the 15 minute monitoring period post-vaccine, traffic and flow considerations, and social distancing requirements). In addition we plan to train vaccinators in COVID vaccine administration requirements and use this core group of vaccinators as much as possible in order to increase efficiency and reduce the need for retraining, which can slow down throughput.

Section 7: COVID-19 Vaccine Allocation, Ordering, Distribution and Inventory Management

A. Who will be responsible for submitting allocations to State for conversion to orders? *(title/role of individual(s))*

Kristin Burnett (Immunization Coordinator, CCHS COVID Vaccine Coordinator) and/or Melissa Hermerding-Lim (Vaccine Distribution Manager, CCHS COVID Vaccine Backup Coordinator) or other staff as assigned.

B. How will you use storage capacity information in the registration system to allocate doses?

We will evaluate storage capacity information provided to determine appropriate vaccine product that can be stored in the unit, as well as the amount that can safely be stored based on cubic footage of the unit, referencing guidance provided by CDC, CDPH, and vaccine manufacturers.

C. Describe your process to follow up with providers who may not be meeting ordering, storage, inventory or IIS requirements.

Similar to our processes for state general fund and Vaccines for Children, we will email and call providers as necessary to offer technical assistance. We will distribute job aids and refer providers to training as appropriate. If providers continue to have issues after multiple attempts to assist we will seek guidance from CDPH.

Section 8: COVID-19 Vaccine Storage and Handling

A. Describe your plan to assess cold storage capacity for LHDs and providers (including ultra-cold storage capacity)

Similar to our current VFC and state general fund vaccine processes, we will check the make and model numbers of the storage units to ensure they meet criteria for storage and handling, collecting photos as necessary. We will also ask for 72 hour digital data logger temperature readings as proof of stable temperatures.

B. Describe your plan to ensure that you have access to dry ice if needed.

Because we have 30 cubic feet of ULT storage we do not anticipate needing dry ice. If we do, we will obtain through the federal government's distribution, and we have a back-up plan for obtaining dry ice from a research organization in our jurisdiction, Diablo Clinical Research, which has agreed to supply us dry ice and additional ULT storage if needed.

Section 9: COVID-19 Vaccine Administration Documentation and Reporting

A. How will you handle questions from local providers about vaccine administration reporting and have you identified the staff responsible?

> Our COVID-19 response's Vaccine Branch includes a technical advisor who is a doctor familiar with vaccine reporting, as well as a deputy director overseeing provider enrollment and guidance. In addition, we will post a comprehensive "Frequently Asked Questions" document specific to COVID vaccines on our website, https://www.coronavirus.cchealth.org/, which will provide answers to common provider questions. This document will be updated as needed by our Public Information Office staff in consultation with medical and subject matter experts on the Vaccine Branch team and/or within CCHS. In addition, our established CCHS Immunization Task Force will provide guidance to CCHS providers during monthly meetings, via Tip Sheets, and nursing education modalities.

B. On a high level, what kind of data analysis are you planning to do regarding COVID-19 vaccine administration for your jurisdiction? For reference, see pages 45and 46 of California's COVID-19 Vaccination Plan.

> CCHS will take a multi-pronged approach to data tracking and analysis. Dashboards or reports will be created to track 1) general administration of vaccine and completeness of data elements required for entry into CAIR, as compared to CDC Required Data Elements 2) discrepancies between vaccine allocation and uptake, 3) populations at risk and uptake among them, and 4) rates of COVID-19 vaccinations in comparison to populations receiving vaccine.

Section 10: Vaccination Second Dose Reminders

A. How will you inform vaccinees at your PODs of second doses of COVID-19 vaccine and remind them when to come back?

> We will inform vaccinees in several ways: 1) scheduling of next appointment at the time of the 1st dose. 2) reminder cards which come as part of the vaccine ancillary supply kit will be handed to vaccinees at time of receipt of first dose, 3) reminder emails generated by EHR, CAIR, PrepMod, 4) second dose reports generated by CAIR will be used to text/email/call patients due for second doses, and 5) we will co-opt other reminder systems in use by our testing team, Contra Costa Health Plan, or other CCHS programs as deemed useful.

B. How will ensure that patients coming for their second doses receive the appropriate product?

> We will verify patient records in CAIR or PrepMod (and in later stages, electronic health records) to match the product they received for their first dose.

C. How will you communicate with/monitor other providers about second doses for their patients?

> We will use CAIR to generate reports on who is due/overdue for second doses, and reach out to administering providers as needed to provide technical assistance if they have not had success bringing patients in for second doses in a timely manner. Depending on the situation and abilities of the provider, we may employ county disease investigation staff to follow up and ensure that high risk patients receive a second dose of the vaccine.

Section 11: COVID-19 Vaccine Requirements for IISs or Other External Systems

A. What are your strategies for directing providers to the CDPH Provider Enrollment and Management page/system for all phases?

We plan to send emails to providers identified via our data sets, our allocations committee and Med Health coalition to invite them to enroll. We will also provide enrollment information on https://www.coronavirus.cchealth.org/ once our vaccine page is developed. In addition, we will train call center staff on how to provide this information. As the provider enrollment system shifts from COVIDReadi to forthcoming enrollment systems, we will keep all of the above updated on any changes to the process.

Section 12: COVID-19 Vaccine Program Communication

A. On a high level, what is your COVID-19 vaccine communication plan? Please consider the following:
   a. Communicating with external providers
   b. Communicating with transparency to the general public
   c. Using multiple communication channels to ensure information is accessible to all populations
   d. Ensuring updated information on your website
   e. Establishing methods to hear (or learn about) and respond to public concerns and address potential vaccine hesitancy

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Our broad messaging framework will be:
- Describing the role of Contra Costa Health Services in the distribution and management of COVID-19 vaccines
- Educating providers and the public about when the vaccine will be available to different populations during a phased rollout
- Amplifying our state and federal partners' messaging about vaccine safety and efficacy
- Working with the PIO to implement our Vaccine Communications Plan

We will continue to use many of the same methods and channels we've been using since the start of the pandemic: Direct outreach to providers and stakeholders, our COVID website (which gets about 300K page views each month), press releases, social media and possibly our COVID-19 call center. We will also continue to answer questions from the news media, the public and local elected officials. Community partners such as 211 may also play a role in addressing questions about vaccine resources.

B. Describe how you will identify and work with trusted messengers to communicate with vulnerable and diverse communities.

Our Community Engagement Outreach Program will work with representatives of historically marginalized communities to ascertain and address issues of concern in those communities. We will use email outreach to partners that serve these populations, such as residential facilities, food banks, schools, and other CBOs in order to promote vaccination and provide resources for obtaining vaccination. We will translate collateral materials into multiple languages.

C. Describe how you will communicate with employers, community-based organizations, faith-based organizations, and other stakeholders.

For employers, we will push out relevant information to contact lists developed by our Environmental Health Division and Contact Tracing Branch, as well as through other public-facing channels such as social media and our COVID website. We will work with our elected representatives, Public Information Office and Community Engagement team to deliver information to CBOs, faith-based organizations and other stakeholders.

Section 13: Regulatory Considerations for COVID-19 Vaccination

A. Have you designated where on your local website you will post the Emergency Use Authorization (EUA) Fact Sheets for COVID-19 vaccine? Please include the links to those pages.

We will post this information on https://www.coronavirus.cchealth.org/. The information will be on our vaccination page, which is under development.

B. How will you communicate about EUA fact sheets to other providers and vaccinators in your jurisdiction? How will you ensure that all health department clinics use the proper EUA fact sheets?

In addition to posting to our website, https://www.coronavirus.cchealth.org/, we will educate COVID call center staff on how to direct callers with questions to the fact sheets. Similar to Vaccine Information Statements (VIS), we will have copies of the fact sheets in multiple languages at all our POD sites in order to distribute these to vaccinees. If there is the ability to add these to PrepMod, we will include fact sheets in that system so patients can view when registering for an appointment. As much as is feasible, we will link to the original source website (CDC/FDA) to ensure any updates to documents carry over.

Section 14: COVID-19 Vaccine Safety Monitoring

A. How will you communicate with providers in your jurisdiction about reporting of potential adverse events (via VAERS) and reporting of potential vaccine errors (via VERP)? Have you identified where on your local website you will post links to VAERS and VERP? If yes, please provide links to those pages below.

> We will post this information on https://www.coronavirus.cchealth.org/ under "information for providers." We will also post this information on our COVID-19 vaccination page, which is under development. In addition we will educate COVID call center and Communicable Disease program staff who might receive questions about how to guide providers to the proper reporting procedures.

Section 15: COVID-19 Vaccination Program Monitoring

A. What key metrics will you monitor regarding your overall COVID-19 vaccine plan in your jurisdiction?

Below is a preliminary list of metrics that CCHS will monitor to support oversight of logistics, equity and improvement efforts. These metrics will be continually refined by a team of Data Scientists and Epidemiologists based on evolving operational needs.

Provider/Staff Recruitment and Enrollment
- % of eligible providers in the county that have registered
- Adequacy and availability of provider administration sites at zip code level compared to County population

Vaccine Administration
- % of eligible population per phase that have been vaccinated stratified by age, HCP, LTCF resident/staff, Jail resident/staff, homeless, etc.
- Equity:
  - Vaccination rate by race, ethnicity, language, city, etc. compared to corresponding % of County population
  - Vaccination rates in census tracts with higher cases per 100K compared to County average
- Cycle times:
  - Average days from receipt of dose to administration
  - Average number of minutes from patient registration to appointment completion (Phase 2 onwards)
- Third Next Available appointment for vaccination (Phase 2 onwards)

Vaccine Logistics
- Daily Inventory turnover rate: Vaccine administered vs available inventory
- Days to depletion: Number of days before depletion of inventory based on previous 7-day average of doses administered
- Daily Fill rate:
  - Total number of doses delivered to provider sites vs number of doses requested
  - Total number of doses received by CCHS vs number of doses requested
- Cycle Time: Number of days to receive doses compared to requested date
- Inventory Stock: Comparison of physical inventory vs data systems
- Number of unused

Vaccine Communication

- Number of public awareness campaigns
- Number of automated reminder/recall messages sent
- Efficacy of communication campaigns

Vaccine Safety
- % of patients with adverse events compared to State and National averages

Vaccine Program monitoring
- % of patients with completed race, ethnicity, language and city reported to CAIR
- Incidents of new infection by sub-population to ascertain the impact of vaccine

B. How will you monitor the above metrics?

CCHS has a robust centralized team of Data Scientists, Epidemiologist, Business Intelligence Developers and Data Warehousing experts. This team will be responsible for building automated solution to aggregate data from various sources, including CAIR, PrepMod, CalREDIE, electronic health records, pharmacies and other partners in its data warehouse. Automated reports, dashboards and alerts will be developed like the ones CCHS has developed as part of the COVID response. The management team will be reviewing these metrics individually ad in its meetings to provide oversight, make plans, improvement and be responding to automated alerts. The team of Data Scientist and Epidemiologist will be running advanced analysis, risk stratification and use machine learning techniques to draw and share additional insights.