LTC Vaccination & Infection Prevention Best Practices Webinar

Division of Public Health, Communicable Disease Branch

December 10, 2020
Logistics for today’s COVID-19 Forum

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com
<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter/Facilitator</th>
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</thead>
</table>
| Opening Remarks               | Hugh Tilson  
Director, NC AHEC  
Susan Kansagra  
NC Division of Public Health |
| LTC Vaccination Strategy      | Carrie Brown  
CMO for Behavioral Health & IDD, NC DHHS |
| Infection Prevention Best Practices | Jennifer MacFarquhar  
Epidemiologist, CDC & Prevention  
NC Division of Public Health  
- Emily Berns  
- Teresa Fisher  
- Amy Braden  
Lindsay Clontz  
Covenant Village  
Michael Wynant  
Compass Healthcare & Rehab  
Hawfields |
| Q & A                         | Amanda Fuller More  
NC Division of Public Health |
|                               | IP Best Practices Speakers |
Vaccination Strategy for Long-term Care Facilities

Division of Public Health, Communicable Disease Branch

December 10, 2020
Status of Vaccine Development

NC Vaccine Response Principles

Priority Groups

Overview of Plan

Provider Enrollment

Communications

Questions
The COVID-19 Vaccine Development Process

Developing, Manufacturing and Distributing a COVID-19 Vaccine

Multiple COVID-19 vaccines are being developed. Thousands of people have volunteered as part of research trials to see if a vaccine prevents COVID illness and to learn more about its safety in these overlapping steps. Promising vaccines are being manufactured at the same time they are being tested, so there will be an initial supply ready to go right away when the science shows which vaccines are found to be safe and effective. Once we have a vaccine or vaccines, it will still be some time before it is widely available to everyone. States will receive limited supplies at the start. North Carolina is drawing upon the experience and expertise of leaders from historically marginalized communities to develop and implement its vaccine distribution plan.

PHASE 1 & 2: Safety & Dosing
10s-100s of healthy volunteers
• Are there any side effects? How many volunteers experience side effects?
• What is the best vaccine dose to create an immune response with the fewest tolerable side effects?

PHASE 2 & 3: Safety & Efficacy
>30,000 of volunteers
• Does the vaccine prevent COVID-19 infection?
• What are the most common side effects?
• Do the benefits of the vaccine outweigh the risks?

Approval & Distribution
• FDA reviews the safety and efficacy data to determine if benefits are greater than risks
• An independent, non-FDA scientific committee reviews findings
• Vaccine is authorized and recommended for use (may only be for certain populations)
• Vaccine is labeled for use, benefits, side effects

Large-Scale Manufacturing: Making millions of vaccine doses for nationwide distribution, continued quality-control testing of vaccine batches and manufacturing facilities, FDA and CDC continually monitor vaccinated patients for safety

Availability: Limited availability in the beginning. More widely available over time.

https://files.nc.gov/covid/documents/Vaccine-Timeline.pdf
Two Leading COVID-19 Vaccine Candidates

<table>
<thead>
<tr>
<th><strong>Preliminary Efficacy Data</strong></th>
<th><strong>Pfizer Vaccine</strong></th>
<th><strong>Moderna Vaccine</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nov 18 Press Release data analysis reported 95% effectiveness in preventing illness.</strong></td>
<td>• 162/170 cases were in placebo group</td>
<td>• November 30 Press Release data analysis 94.1% effectiveness in preventing illness.</td>
</tr>
<tr>
<td>9/10 severe cases were in placebo group</td>
<td>• Phase 3 trial included over 43,000 participants, 42% with diverse backgrounds.</td>
<td>• 185/196 cases were in placebo group</td>
</tr>
<tr>
<td>Phase 3 trial included over 43,000 participants, 42% with diverse backgrounds.</td>
<td>• 9/10 severe cases were in placebo group</td>
<td>• 30/30 severe cases were in placebo group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Timing of EUA</strong></th>
<th><strong>Pfizer Vaccine</strong></th>
<th><strong>Moderna Vaccine</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applied for EUA 11/20/20</strong></td>
<td></td>
<td><strong>Applied for EUA 11/30</strong></td>
</tr>
<tr>
<td><strong>FDA Review Dec 8-10</strong></td>
<td></td>
<td><strong>FDA Review Dec 17th</strong></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Temperature and Storage</strong></th>
<th><strong>Pfizer Vaccine</strong></th>
<th><strong>Moderna Vaccine</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requires ultra-cold storage (-75 degrees Celsius).</strong></td>
<td></td>
<td><strong>Requires storage at -20 degrees Celsius (similar to the chickenpox vaccine).</strong></td>
</tr>
<tr>
<td><strong>Lasts up to 5 days at refrigerated temperatures.</strong></td>
<td></td>
<td><strong>Lasts up to 30 days at refrigerated temperatures.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dosing</strong></th>
<th><strong>Pfizer Vaccine</strong></th>
<th><strong>Moderna Vaccine</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2-dose schedule; 21 days apart</strong></td>
<td></td>
<td><strong>2-dose schedule</strong></td>
</tr>
<tr>
<td><strong>Protection after 10 days of 1st dose, 52% after first dose</strong></td>
<td></td>
<td><strong>Administered 28 days apart.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Type of Vaccine</strong></th>
<th><strong>Pfizer Vaccine</strong></th>
<th><strong>Moderna Vaccine</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Both vaccines use mRNA technology from the coronavirus’s own genes to have people's cells make viral proteins to trigger immune system to produce antibodies against the COVID virus. mRNA vaccines can be made faster than older vaccines and require frozen storage to remain stable</strong></td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Safety</strong></th>
<th><strong>Pfizer Vaccine</strong></th>
<th><strong>Moderna Vaccine</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No reports of serious safety concerns in either vaccine in either the clinical trials. Temporary reactions (e.g., fever, soreness at site of injection, fatigue) noted 24-48 hours after vaccination</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Updates on Remaining Operation Warp Speed Candidates

<table>
<thead>
<tr>
<th>Type</th>
<th>AstraZeneca</th>
<th>Johnson &amp; Johnson</th>
<th>Sanofi</th>
<th>GSK</th>
<th>Novavax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protein Subunit</td>
<td>![AstraZeneca Logo]</td>
<td>![Johnson &amp; Johnson Logo]</td>
<td>![Sanofi Logo]</td>
<td>![GSK Logo]</td>
<td>![Novavax Logo]</td>
</tr>
<tr>
<td>Protein Subunit</td>
<td>![AstraZeneca Logo]</td>
<td>![Johnson &amp; Johnson Logo]</td>
<td>![Sanofi Logo]</td>
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<td>![Novavax Logo]</td>
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<thead>
<tr>
<th>Phase</th>
<th>AstraZeneca</th>
<th>Johnson &amp; Johnson</th>
<th>Sanofi</th>
<th>GSK</th>
<th>Novavax</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Estimated Availability</th>
<th>AstraZeneca</th>
<th>Johnson &amp; Johnson</th>
<th>Sanofi</th>
<th>GSK</th>
<th>Novavax</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Doses Required</th>
<th>AstraZeneca</th>
<th>Johnson &amp; Johnson</th>
<th>Sanofi</th>
<th>GSK</th>
<th>Novavax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doses: 2 (testing half-dose: full-dose regimen v. two full doses) First interim analysis 90% effective with first half-dose</td>
<td>![AstraZeneca Logo]</td>
<td>![Johnson &amp; Johnson Logo]</td>
<td>![Sanofi Logo]</td>
<td>![GSK Logo]</td>
<td>![Novavax Logo]</td>
</tr>
<tr>
<td>Doses: 1 or 2 (testing both)</td>
<td>![AstraZeneca Logo]</td>
<td>![Johnson &amp; Johnson Logo]</td>
<td>![Sanofi Logo]</td>
<td>![GSK Logo]</td>
<td>![Novavax Logo]</td>
</tr>
<tr>
<td>Doses: 1 or 2 (testing both)</td>
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<td>![GSK Logo]</td>
<td>![Novavax Logo]</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Transport Temp</th>
<th>AstraZeneca</th>
<th>Johnson &amp; Johnson</th>
<th>Sanofi</th>
<th>GSK</th>
<th>Novavax</th>
</tr>
</thead>
</table>

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<tr>
<th>Storage Temp</th>
<th>AstraZeneca</th>
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<th>Novavax</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Target Supply</th>
<th>AstraZeneca</th>
<th>Johnson &amp; Johnson</th>
<th>Sanofi</th>
<th>GSK</th>
<th>Novavax</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B by mid 2021</td>
<td>![AstraZeneca Logo]</td>
<td>![Johnson &amp; Johnson Logo]</td>
<td>![Sanofi Logo]</td>
<td>![GSK Logo]</td>
<td>![Novavax Logo]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At Risk US Government Purchase</th>
<th>AstraZeneca</th>
<th>Johnson &amp; Johnson</th>
<th>Sanofi</th>
<th>GSK</th>
<th>Novavax</th>
</tr>
</thead>
<tbody>
<tr>
<td>100M</td>
<td>![AstraZeneca Logo]</td>
<td>![Johnson &amp; Johnson Logo]</td>
<td>![Sanofi Logo]</td>
<td>![GSK Logo]</td>
<td>![Novavax Logo]</td>
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<td>100M</td>
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<tr>
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<td>![GSK Logo]</td>
<td>![Novavax Logo]</td>
</tr>
</tbody>
</table>

_Sources: BioPharma Dive, NIH, ClinicalTrials.gov, Johnson & Johnson News, Sanofi News_
Provider agreement language updated to reflect that the vaccine must be provided at no cost to recipient; Vaccine cost covered by federal government; administrative costs covered by Medicare, Medicaid, and commercial insurance; HRSA will reimburse providers for COVID-19 vaccines administered to uninsured individuals.

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Medicare</th>
<th>Uninsured</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>As long as a state is claiming enhanced Medicaid match as part of the Public Health Emergency, the state must cover, without cost sharing, “any testing services and treatments for COVID-19, including vaccines;” this extends to vaccines authorized via EUA.</td>
<td>The CARES Act mandated that Medicare Part B cover a COVID-19 vaccine without any cost sharing in cases where “such vaccine is licensed under section 351 of the Public Health Service Act”; a vaccine authorized by an EUA would not meet this standard. To address this gap, CMS announced a new rule on October 28th guaranteeing Medicare coverage for a vaccine approved via EUA; this guarantee applies to beneficiaries enrolled in both traditional Medicare and Medicare Advantage.</td>
<td>HRSA will reimburse providers for COVID-19 vaccines administered to uninsured individuals, once a COVID-19 vaccine receives either an EUA or full licensure from the FDA. Provider Relief Fund (<a href="https://www.hrsa.gov/CovidUninsuredClaim">https://www.hrsa.gov/CovidUninsuredClaim</a>) Consistent with HRSA’s prior guidance regarding treatment services, an individual with public or private health coverage will be deemed “uninsured” for purposes of the HRSA Program if the individual has a form of health coverage that excludes vaccines (e.g., individuals enrolled in a limited Medicaid family planning program).</td>
<td>Current law and regulations require vaccines recommended by ACIP to be covered as an Essential Health Benefit without cost sharing.</td>
</tr>
</tbody>
</table>
NC COVID-19 Vaccination Plan: Vision of Success

GOAL
Immunize every person living in North Carolina who is eligible and wants to receive a COVID-19 vaccine

GUIDING PRINCIPLES

- All North Carolinians have equitable access to vaccines
- Vaccine planning and distribution is inclusive; actively engages state and local government, public and private partners; and draws upon the experience and expertise of leaders from historically marginalized populations
- Transparent, accurate, and frequent public communications is essential to building trust
- Data is used to promote equity, track progress and guide decision-making
- Appropriate stewardship of resources and continuous evaluation and improvement drive successful implementation
Advisors

• COVID-19 Vaccine Advisory Committee
  • **Purpose:** Provide updates from industry and stakeholders to ensure alignment
  • Group of >60 stakeholders

• Historically Marginalized Populations Advisory Group
  • **Purpose:** Identify and address issues related to HMP in the COVID pandemic response
  • Vaccine team presents regularly to HMP Advisory Group for input and partnership opportunities
  • Group of >80 internal and external stakeholders

• COVID-19 Vaccine Communications Advisory Group
  • **Purpose:** Enhance the development of North Carolina’s COVID-19 Vaccine Communications Plan and to serve as dissemination partners to extend the reach of the communications efforts, especially to prioritized, critical, and historically marginalized populations
COVID-19 Vaccinations: Those most at risk get it first.

A tested, safe and effective vaccine will be available to all who want it, but supplies will be limited at first. Independent state and federal public health advisory committees have determined that the best way to fight COVID-19 is to start first with vaccinations for those most at risk, reaching more people as the vaccine supply increases from January to June. Keep practicing the 3W’s—wear a mask, wait six feet apart, wash your hands—until everyone has a chance to vaccinate.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Health care workers fighting COVID-19 &amp; Long-Term Care</td>
</tr>
<tr>
<td>1b</td>
<td>Adults at highest risk of severe illness and those at highest risk for exposure</td>
</tr>
<tr>
<td>2</td>
<td>Adults at high risk for exposure and at increased risk of severe illness</td>
</tr>
<tr>
<td>3</td>
<td>Students and critical industry workers</td>
</tr>
<tr>
<td>4</td>
<td>Everyone who wants a safe and effective COVID-19 vaccination</td>
</tr>
</tbody>
</table>

Every health care worker at high risk for exposure to COVID-19—doctors, nurses, and all who interact and care for patients with COVID-19, including those who clean areas used by patients, and those giving vaccines to these workers.

Long-Term Care staff and residents—people in skilled nursing facilities and in adult, family and group homes.

Adults with two or more chronic conditions that put them at risk of severe illness as defined by the CDC, including conditions like cancer, COPD, serious heart conditions, sickle cell disease and Type 2 diabetes, among others.

Adults at high risk of exposure including essential frontline workers (police, food processing, teachers), health care workers, and those living in prisons, homeless shelters, migrant and fishery housing with 2+ chronic conditions.

Those working in prisons, jails and homeless shelters (no chronic conditions requirement).

Essential frontline workers, health care workers, and those living in prisons, homeless shelters or migrant and fishery housing.

Adults 65+

Adults under 65 with one chronic condition that puts them at risk of severe illness as defined by the CDC.

College and university students.

K-12 students when there is an approved vaccine for children.

Those employed in jobs that are critical to society and at lower risk of exposure.

DECEMBER 8, 2020
VACCINE DISTRIBUTION PRIORITIZATION FRAMEWORK

Risk-based prioritization based on National Academy of Medicine Framework for Equitable Allocation of COVID-19 and CDC Advisory Committee Immunization Practice. Refined by input by North Carolina Institute of Medicine Vaccine Advisory Committee. May be revised based on Phase III clinical trial safety and efficacy data and further federal guidance.

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
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</thead>
<tbody>
<tr>
<td><strong>Phase 1a:</strong></td>
<td><strong>Phase 2</strong></td>
<td><strong>Phase 3</strong></td>
<td><strong>Phase 4</strong></td>
</tr>
<tr>
<td>• <strong>Health care workers at high risk</strong> for COVID-19 exposure based on work duties or vital to the initial COVID vaccine response</td>
<td>• Migrant Farm/fishery workers in congregate living without 2+ Chronic Conditions</td>
<td>• Workers in industries critical to the functioning of society and at increased risk of exposure who are not included in Phase 1 or Phase 2</td>
<td>• Remaining population</td>
</tr>
<tr>
<td>o High risk of exposure is defined as those caring for COVID-19 patients, cleaning areas where COVID-19 patients are admitted, performing procedures at high risk of aerosolization (e.g., intubation, bronchoscopy, suctioning, invasive dental procedures, invasive specimen collection, CPR), handling decedents with COVID, administering vaccine in initial closed or targeted vaccination clinics.</td>
<td>• Incarcerated individuals without 2+ Chronic Conditions</td>
<td>• K-12 students (if data from clinical trials), college students</td>
<td></td>
</tr>
<tr>
<td>o Population includes: nurses, physicians, respiratory techs, dentists, hygienists, nursing assistants, environmental services staff, EMT/paramedics, home health workers, personal care aides, community health workers, health care trainees (e.g., medical students, pharmacy students, nursing students, etc.), morticians/funeral home staff, pharmacists, public health nurses, public health and emergency preparedness workers who meet the above definition of “high risk of exposure.”</td>
<td>• Homeless shelter residents without 2+ Chronic Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Long Term Care staff and Residents</strong> (e.g., Skilled Nursing Facilities, adult care homes, family care homes, and group homes; individuals with intellectual and developmental disabilities who receive home and community-based services and the workers directly providing those services)</td>
<td>• Frontline workers at high or moderate risk of exposure without 2+ Chronic Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 1b:</strong></td>
<td><strong>Phase 2</strong></td>
<td><strong>Phase 3</strong></td>
<td><strong>Phase 4</strong></td>
</tr>
<tr>
<td>• <strong>Adults with high risk of complications</strong> per CDC and staff of congregate living settings</td>
<td>• Migrant farm/fishery workers in congregate living without 2+ Chronic Conditions* or ≥ age 65</td>
<td>• Homeless shelter residents without 2+ Chronic Conditions*</td>
<td>• Remaining population</td>
</tr>
<tr>
<td><strong>Operationally prioritize settings based on risk of exposure</strong></td>
<td>• Incarcerated individuals without 2+ Chronic Conditions* or ≥ age 65 and jail and prison staff</td>
<td>• Frontline workers at high or moderate risk of exposure without 2+ Chronic Conditions*</td>
<td></td>
</tr>
<tr>
<td>• Migrant farm and fisheries workers in congregate housing with 2+ Chronic Conditions* or ≥ age 65</td>
<td>• Homeless shelter residents without 2+ Chronic Conditions</td>
<td>• All other Health Care Workers not included in Phase 1A or 1B</td>
<td></td>
</tr>
<tr>
<td>• Incarcerated individuals with 2+ Chronic Conditions* or ≥ age 65</td>
<td>• Frontline workers at high or moderate risk of exposure without 2+ Chronic Conditions</td>
<td>• Education staff (Child Care, K-12, IHE) without 2+ Chronic Conditions</td>
<td></td>
</tr>
<tr>
<td>• Homeless shelter residents with 2+ Chronic Conditions* or ≥ 65 and homeless shelter staff</td>
<td>• Other adults age 18-64 with one chronic condition*</td>
<td>• Other adults age 18-64 without 2+ Chronic Conditions</td>
<td></td>
</tr>
<tr>
<td>• Health care workers not included in Phase 1A with 2+ Chronic Conditions</td>
<td>• 65+ year olds with one or no chronic conditions*</td>
<td>• Workers in industries critical to the functioning of society and at increased risk of exposure who are not included in Phase 1 or Phase 2</td>
<td></td>
</tr>
<tr>
<td>• Frontline workers with 2+ Chronic Conditions at high risk of exposure (e.g., firefighters, police, workers in meat packing plants, seafood and poultry not in congregate housing, food processing, preparation workers and servers, manufacturing, construction, funeral attendants and undertakers not included in Phase 1A, transportation workers, retail workers (including grocery store workers), membership associations/org staff (e.g., religious orgs), education staff (e.g., child care, K-12 or IHE) and workers in government, public health, emergency management and public safety whose functioning is imperative to the COVID-19 response)</td>
<td></td>
<td>• Workers in industries critical to the functioning of society and at increased risk of exposure who are not included in Phase 1 or Phase 2</td>
<td></td>
</tr>
<tr>
<td>• <strong>Other Adults</strong> with 2+ Chronic Conditions*:</td>
<td></td>
<td>• K-12 students (if data from clinical trials), college students</td>
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</tbody>
</table>

* Defined by CDC as increased risk for COVID

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13
## NC COVID-19 Vaccine Operational Plan: Overview

<table>
<thead>
<tr>
<th>Planning</th>
<th>Implementation</th>
<th>Adjustment</th>
<th>Transition</th>
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</thead>
</table>
| **Populations**
  * Establish priority groups | • Phase 1 populations
  • Stabilize health care delivery system and protect individuals at highest risk | • Continue to move through phased populations as vaccine supply allows | • Offer vaccination to all populations through Phases 3 and 4 |
| **Vaccination Channels**
  * N/A | • Through local health departments and on-site vaccination clinics (in closed settings) | • Require more points of access, mass vaccination clinics, and broad vaccination sites | • Vaccination in established channels
  • Fewer mass, mobile, or community-based clinics |
| **Enrollment/Ordering/Allotment**
  • Identify/enroll providers
  • Expect CDC centralized distribution to providers | • Continue to enroll providers
  • Allocations to state, allotted to enrolled providers | • Transition to provider ordering vaccines based on need for population and local demand | • Ordering similar to annual seasonal flu vaccine campaign |
| **Shipment**
  • None shipped
  • Expect vaccine and ancillary supplies procured and distributed by fed gov't | • Shipment in increments of 1,000 for some
  • May require ultra-cold storage & 2-dose series | • Shipment minimum of 100 for most vaccines | • Move to high supply/lower demand |
| **Data**
  • Confirm capability for required functionality, data collection, and reporting | • Data systems for ordering, scheduling, dose tracking, inventory, data collection and reporting requirements | • Data systems for ordering, scheduling, dose tracking, inventory, data collection and reporting requirements | • Data systems for ordering, scheduling, dose tracking, inventory, data collection and reporting requirements |

**Before vaccine is available**

**Begins when first vaccine doses are allocated to states**
Vaccine Journey

1. CDC/ Operation Warp Speed (OWS) provide pro-rata vaccine allotment to the state.
2. CDC/ OWS places orders with manufacturer/distributor for vaccines and ancillary kits/supplies.
3. NC DHHS transmits orders to CDC/ OWS.
4. Upon receipt, providers store the COVID-19 vaccines in accordance with storage requirements.
5. Vaccines are transported by the manufacturer and/or McKesson to enrolled sites as indicated by the orders. McKesson distributes ancillary kits/supplies.
6. Provider administers the first vaccine dose and logs administration in CVMS. Appointments for second doses should be scheduled.
7. Providers will organize vaccination clinics. Patients can register on CVMS (COVID-19 Vaccine Management System) and schedule an appointment or schedule with their provider to receive COVID-19 vaccine.
8. Provider administers the second vaccine dose and logs administration in CVMS. Continues adverse event monitoring.
9. Provider monitors and reports adverse events using V-SAFE or VAERS in accordance with Emergency Use Authorization (EUA).
10. State divides allocation of COVID-19 vaccines across providers based on prioritization, populations served, geography.
11. Patient receives a second dose reminder and schedules appointment if not already set up.

Federal Responsibility
State Responsibility
Provider Level
Vaccine: Provider enrollment

NC’s provider enrollment strategy is based upon the prioritization strategy

**Phase 1A providers:** Hospitals and Local Health Departments (LHDs)

**Phase 1B providers:** FQHC’s, Rural Health Centers and Free and Charitable Clinics

Federal enrollment of pharmacies (Walgreens and CVS) for long term care settings

**Coming Soon**

Remaining provider enrollment is expected to begin in mid- late December (e.g. primary care, urgent care)

Federal enrollment of more pharmacies

**Enrollment Complete**

115 Hospitals (100%)

**Currently Enrolling**

130 FQHC / RHC / Free & Charitable Clinics (32%)

**Next to Enroll**

100 LHDs (100%)
Vaccine: Federal long-term care pharmacy program

LTC ENROLLMENT DASHBOARD

| ~498 Adult Care Homes (84%) | 427 Skilled Nursing Facilities (100%) |

KEY PROGRAM DATES

- 12/7: Notification of Fed Government to turn on program
- 12/21: Start pulling vaccines from Moderna allocation banks
- 12/28: Start administering vaccines

The federal government – in coordination with the CDC – has created the Pharmacy Partnership for Long-term Care (LTC) Program in partnership with CVS and Walgreens to vaccinate those in LTC settings.

Program Details

As part of this program, pharmacies will:
- Schedule and coordinate clinic dates with each facility
- Order vaccines and associated supplies
- Ensure cold chain management for vaccine
- Provide on-site administration of vaccine including patient information and consents as needed
- Report required vaccination data to local, state/territorial, and federal jurisdictions within 72 hours of administration

Allocation will come from state allocation starting with NC’s week 2 allocation.
Vaccine: First allocations

**Week of Dec 13-19**

85,800 doses (88 increments of 975)

Initial shipment will go to **53 hospitals:**
- 11 early ship sites – Ultra-cold storage
- 42 others distributed according to **bed capacity, health care workers, and county population**

Future allocations will factor in **administration data and on-hand inventory**

**Week of Dec 20-26**

**Doses TBD**

175,900 doses (increments of 100)

**Pfizer** shipments will focus on more hospitals & health systems

**Moderna** shipments will focus initially on Long Term Care and then health departments and community providers

**Initial allocation:**
- **Hospitals:**
  - 85,800 doses
  - 88 increments of 975
  - 53 hospitals
  - 11 early ship sites – Ultra-cold storage
  - 42 others distributed according to bed capacity, health care workers, and county population

**Future allocations:**
- Factor in administration data and on-hand inventory
- Will adjust based on hospitals & health systems needs
- Will be distributed based on Long Term Care / Local Health Departments
### What is CVMS?

CVMS is a secure, cloud-based vaccine management solution for COVID-19 that enables vaccine management and data sharing across providers, hospitals, agencies, and local, state, and federal governments on one common platform.

When the CVMS is launched on 12/10, providers will be able to:

- **Enroll** in the COVID-19 Vaccine Program
- **Employees** can register for vaccination
- **Manage** vaccine inventory
- **Track** vaccine administration data

### Who will use CVMS?

- State officials will enroll providers and verify provider eligibility along with verifying site readiness
- Providers will verify patient eligibility, log dosage administration, and track frequency and timing of additional dosages
- **Training** for Phase 1 providers started week of 11/30
- CVMS will be available to select providers for a soft launch on 12/8 and the remaining providers will have access to the system on 12/10

### Who won’t use CVMS?

- **Pharmacies**, such as CVS and Walgreens, will not use CVMS to administer and manage vaccines
- Pharmacies will to use their **current systems**
- Building capability to ingest vaccine data files from pharmacies into CVMS

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<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/23</td>
<td>CVMS Provider Enrollment Soft Launch</td>
</tr>
<tr>
<td>11/30</td>
<td>CVMS Priority Access Preview</td>
</tr>
<tr>
<td>12/8</td>
<td>CVMS MVP Soft Launch for subset of Phase 1a providers</td>
</tr>
<tr>
<td>12/10</td>
<td>CVMS MVP Go-Live And available to Phase 1a and Phase 1b providers</td>
</tr>
<tr>
<td>12/17</td>
<td>CVMS MVP R2 Go-Live Additional features released</td>
</tr>
<tr>
<td>TBD</td>
<td>CVMS R3+ Go-Live Future features and enhancements available within CVMS</td>
</tr>
</tbody>
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**For Official Use Only | Not for Distribution**
COVID Vaccine Communications: North Carolina’s Commitment

Provide early, transparent, consistent, and frequent communications so that North Carolinians:

- **Trust the information** that they receive from NC DHHS and local health departments about COVID-19 vaccinations
- **Understand the benefits and risks** of COVID-19 vaccinations
- **Make informed decisions** about COVID-19 vaccinations
- **Know how and where** to get a COVID-19 vaccination
Communications Strategy Informed by Research

One in three North Carolinians say they will definitely get a COVID 19 vaccine once approved by the FDA and offered for free. Another one in four say they will probably get the vaccine.

Less likely to say they will get vaccine
- Blacks/African Americans
- Females
- High school or some college only
- Lower income groups
- Under age 35

More likely to say they will get vaccine
- Hispanic, Latinx
- Asians
- White Non-Hispanics
- Males
- College or higher educated
- Higher income residents
- Ages 65 and older

Most common reasons for vaccine avoidance:
- Concerned about side-effects
- Feel it hasn't been tested enough
- Don’t want to be first to take the vaccine
Core COVID-19 Vaccine Messages

Great care has been taken to make sure COVID-19 vaccines are safe and effective.

- **Scientists had a head start.** Although the vaccines were developed quickly, they were built upon years of work in developing vaccines for similar viruses. Development time was cut without cutting corners.
- **Testing was thorough and successful.** More than 70,000 people participated in clinical trials for two leading vaccines to see if they are safe and effective. To date, the vaccines are nearly 95% effective in preventing COVID-19 with no safety concerns.

A tested, safe and effective vaccine will be available to all who want it, but supplies will be limited at first. The best way to fight COVID-19 is to start first with vaccinations for those most at risk, then reach more people as the vaccine supply increases throughout 2021.

North Carolina is drawing upon the experience and expertise of leaders from historically marginalized communities to develop and implement its vaccine plan.

Communication Tools - [https://covid19.ncdhhs.gov/vaccines](https://covid19.ncdhhs.gov/vaccines)
Materials to Inform the Press & Long-Term Care Workers

Vaccine Talking Points:
Updating weekly
Focus on setting expectations

• NC DHHS COVID Vaccine Website
  • Revamping

• Vaccine 101 Deck
  • Updating

• Pressers: Vaccine comments in Governor & Secretary remarks
  • Identifying trusted messenger champions for participation

• Vaccine Message Framework and Toolkits
  • Available mid-late December

• Initial PSA’s & videos in development:
  • From Secretary Cohen to LTC workers & families
  • From Deputy Money to LTC workers
  • With LTC nurses, med techs and staff in multiple locations (Raleigh, Winston-Salem and Greensboro)

https://covid19.ncdhhs.gov/vaccines
COVID-19 Communication Tools

[Image of COVID-19 Communication Tools]

https://covid19.ncdhhs.gov/vaccines
What materials do you need most urgently?
Best Practices for Infection Prevention in Long-term Care Facilities

Division of Public Health, Communicable Disease Branch

December 10, 2020
Best Practices for IP in LTCFs

NC DHHS would like to thank the following facilities for participating in our discussion and sharing their excellent infection prevention practices with us:

- Brian Center Health & Rehabilitation Wallace, Duplin County
- Compass Healthcare & Rehab, Alamance County
- Covenant Village, Gaston County
- Galloway Ridge at Fearrington, Chatham County
- Gardens of Taylor Glen Retirement Community, Cabarrus County
- Lexington Health Care Center, Davidson County
- Lumberton Health & Rehabilitation Center, Robeson County
- Stewart Health Center at The Cypress of Charlotte, Mecklenburg County
- Trinity Oaks, Forsyth County
Covenant Village

Lindsay Clontz, RN-BSN
Nurse Educator/Infection Preventionist

December 10, 2020
Covenant Village
Changes to Daily Activity

• Everyone who enters our campus must come past the Welcome Center. The guard at the gate checks everyone’s temperature and conducts a screening for symptoms or exposure.

• Staff will also have their temperatures checked halfway through their shift.

• We conduct symptom checks on all of our residents daily. We take their temperatures once a shift (three times daily).
Specific Infection Control Techniques

• Rearranging break rooms to ensure social distancing
• PPE Storage Rooms to prevent the spread of germs
Education

- Weekly or Bi-Weekly Covid-Specific Staff Education
- Frequent Status Updates for Staff, Residents, and Families
- “Covenant Conversations”
Best Practices for IP in LTCFs

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- Stewart Health Center at The Cypress of Charlotte, Mecklenburg County
- Trinity Oaks, Forsyth County
Best Practices for IP in LTCFs

1. Prioritize infection prevention activities.
   - Dedicate a full-time staff position to IP and education.
   - Infection prevention requires a significant time commitment.
   - Ensure that sufficient time and resources are dedicated to IP.
   - Use the IP Staffing Worksheet to ensure that all key duties have been assigned.

2. Engage all staff, residents, and families in IP activities.
   - Collaborate with all staff, residents, and families.
   - Make sure everyone knows what the facility is doing to protect them AND what they are expected to do to protect themselves and others.
   - Empower everyone to gently correct IP issues if they notice them.
   - Everyone in the facility should help each other stay accountable.
   - Have candid conversations with staff about:
     - How their behavior impacts the health of their own families, residents and coworkers.
     - The importance of following public health recommendations outside of work, such as avoiding large gatherings.
3. Incorporate IP education into your facility’s regular routine.

- IP education should be frequent, consistent, and supportive instead of punitive.
- Use existing practices like facility-wide meetings or staff testing to provide education to everyone at the facility, including residents and non-clinical staff.
- Teach concepts repeatedly and in different ways to ensure that everyone understands and implements IP practices.
- Check learning after education sessions using quizzes, return demonstrations, or other methods.
- Audit IP practices among staff frequently to ensure that these key practices are being followed.
  - Infection prevention staff should round on units frequently to offer timely correction, personalized reinforcement, and individual education.
- Share new information across all staff levels through methods such as call systems, email message systems, and daily huddles.
- Set up education stations at a central location or throughout the facility so staff can easily review guidance and ensure they are using appropriate precautions.
Best Practices for IP in LTCFs

4. Have consistent staff working at the facility.

- Communicate with staff about their needs and concerns to help provide a healthy and safe working environment.
- If temporary staff are needed, try to hire the same temporary staff each time so they can become familiar with your facility.
- LTCF staff should ideally work at only one facility.
  - If a staff member has multiple jobs, work with them to determine how they can work at your facility full time.

5. Create an environment of safe, open communication for everyone in the facility.

- Keep residents and families informed about the COVID-19 situation in the local community and the actions the facility is taking to protect them.
- Identify someone who residents should go to in order to answer questions, address concerns, and advocate for the resident. Having this type of contact in place can reassure both residents and their family.
- Consider having a weekly newsletter or call to provide updated information to all staff, residents, and families.
6. Follow [CDC guidance](https://www.cdc.gov) for appropriate selection and use of personal protective equipment (PPE), including when extended use/limited re-use is appropriate.

   - Careful adherence to hand hygiene is **critical** before putting on and after removing PPE.
   - Generally, gowns should not be removed and put back on.
   - If eye protection is removed, it should be disinfected before it is worn again.
   - Limit use of N95 respirators to a single shift if possible.
     - If respirators must be used for more than one shift, store them in a paper bag labeled with the staff member’s name between shifts.

7. **Modify facility layouts and procedures to support social distancing.**

   - Safely modify facility layout as needed so the easiest choice is also the safest choice.
   - If the residents’ dining room is still closed, consider using this space as a staff break room to allow more space for social distancing.
Questions?