

COVID-19 Vaccination Plan

STATE OF CALIFORNIA

Interim Draft

California Department of Public Health
10/16/2020 | VERSION 1.0

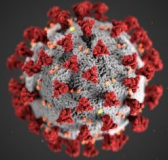
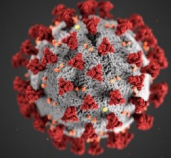


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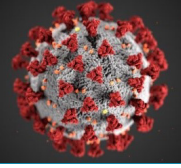
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Record of Changes

Date of original version: October 16, 2020

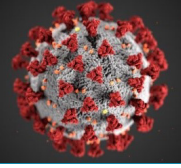
Date Reviewed	Change Number	Date of Change	Description of Change	Name of Author
10/16/2020	1.0	10/16/2020	Initial Release - Interim Draft	California Department of Public Health



Instructions for Jurisdictions

The COVID-19 Vaccination Plan template is to assist with development of a jurisdiction's COVID-19 vaccination plan. Jurisdictions should use this template when submitting their COVID-19 vaccination plans to CDC.

The template is divided into 15 main planning sections, with brief instructions to assist with content development. While these instructions may help guide plan development, they are not comprehensive, and jurisdictions are reminded to carefully review the CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations as well as other CDC guidance and resources when developing their plans. Jurisdictions are encouraged to routinely monitor local and federal COVID-19 vaccination updates for any changes in guidance, including any updates to the CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations.



Section 1: COVID-19 Vaccination Preparedness Planning

Instructions:

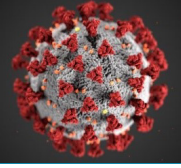
- A. Describe your early COVID-19 vaccination program planning activities, including lessons learned and improvements made from the 2009 H1N1 vaccination campaign, seasonal influenza campaigns, and other responses to identify gaps in preparedness.*

California's early COVID-19 vaccination program planning efforts began in April 2020 with the establishment of a COVID-19 Vaccine Steering Committee within the California Department of Public Health (CDPH) comprised of immunization and subject matter experts. Many members of the Steering Committee as well as several people in key leadership positions in CDPH successfully led the State's H1N1 response efforts in 2009. These experts are taking on many leadership and consulting roles within the COVID-19 response to ensure that the overall effort is guided by the principles of safety, efficacy, efficiency, and equity. Early work within CDPH has focused on assembling key lines of effort with specific deliverables and extensive outreach to local health jurisdictions to plan and prepare. In late summer, CDPH expanded capacity and scope of the planning efforts to ultimately form the California Governor's COVID-19 Vaccine Task Force comprised of members from multiple state departments. The expanded team helps to ensure California is coordinating operational planning, financial support, clear chain of command, highly functional information management, and real-time coordination with key State government stakeholders.

California has an extensive infrastructure and history in mass vaccinations, both urgent and routine. We believe that one of the first steps in creating and implementing a plan to safely and efficiently implement a COVID-19 vaccination program involves a review of lessons learned. To that end, the Task Force conducted a review of lessons learned from H1N1 to inform the development of planning documents for the COVID-19 vaccination program.

Some improvements made in response to the H1N1 lessons learned have been in place for years. For instance, in response to data that indicated gaps in staffing levels and inventory management during H1N1, in 2013 CDPH adopted and trained staff on the Center for Disease Control's Inventory Management and Tracking System (IMATS). This system has worked well throughout the COVID-19 response. A major lesson learned was that the State did not have adequate cold chain capacity. Additional lessons learned are provided later in this section.

We are currently working on improving our preparedness for cold chain management, as this area has proved problematic in the past. In 2019 CDPH developed an expanded cold chain management plan, and we have already been testing this plan throughout the COVID-19 response through the receipt, storage, and distribution of viral transport media (VTM) requiring refrigerated storage and transport. CDPH staff have become adept in the use of refrigerated

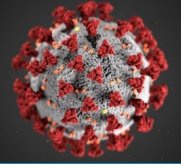


and frozen containers, trailers, and box trucks as well as passive cold chain shipping containers. A draft proposal is under review to establish a regional ultra-low temperature (ULT) network by positioning ULT freezers in locations around the State. We are currently updating our cold chain management to include frozen and ultra-low temperature procedures. Additionally, we are preparing a cold chain management plan template for use by local health departments.

Local health departments have been working to improve and standardize their mass vaccination planning since the H1N1 response. Many have leveraged technology to allow clients to prescreen online prior to arrival and one regional planning group has developed a mobile application that allows clients to identify the Point of Dispensing (POD) nearest to them and then prescreen. Several health departments are in discussions with non-medical businesses who desire to vaccinate their employees. This fall's seasonal influenza clinics have permitted the evaluation of COVID-19 safety measures, e.g., social distancing, COVID-19 screening, and the continual cleaning of public surfaces, to measure the effects on throughput and design. A Vaccination Administration Field Operations Guide incorporating those lessons is nearing completion.

Other lessons learned from H1N1 include:

- Working with our local partners to ensure clinic plans are flexible. In H1N1, the quantities and timelines of vaccine delivery were fluid, so it is important to build contingencies into plans.
- The ancillary kits did not always arrive timely with the vaccine. California has already begun purchasing some ancillary supplies and will utilize its mutual aid system to ensure administration sites have the supplies they need.
- Ensuring a robust data system to track local inventories and doses administered.
- Developing clear, consistent guidance for our local health jurisdictions to equitably allocate vaccine, storage and handling requirements, and re-distribution for the ordering process.
- Developing back-up plans at the state to support local staffing needs, cold chain management, and other critical needs.
- Ensuring guidance, messaging, and materials are developed in multiple languages.
- California needs to augment and tailor messaging and a media campaign specific to the diverse populations in our state.
- The media campaign will evolve throughout the phases of the vaccine distribution from prioritization for vulnerable populations when vaccine supply is low, to a broader outreach when vaccine supply is increased.



We have also gathered important lessons learned based on seasonal influenza vaccination campaigns. California's local health departments conduct seasonal influenza campaigns yearly. Lessons learned include:

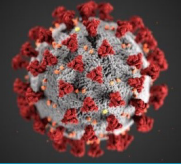
- Local health departments identified the need for a more robust system for real-time data entry into California's Immunization Information System (IIS).
- Patient registration at vaccination sites has continued to be one of the most time-consuming aspects of mass vaccination events. While paperless or pre-registration via technology solutions helps expedite the registration progress, there are challenges associated with these solutions as well. Low literacy rates, lack of access to technology, or limited English-speaking abilities may diminish patients' ability to use in these technologies.
- A strong public information campaign will maximize public participation and can encourage the use of pre-screening or online screening.
- Seasonal influenza clinics have provided local health departments with experience handling large quantities of refrigerated vaccine. However, local health departments have little experience with frozen and no experience with ultra-low temperature vaccines.

In summary, many lines of effort are underway, incorporating the lessons learned from past mass vaccination campaigns and seasonal influenza efforts to prepare and plan for the receipt and distribution of COVID-19 vaccine and its implementation across the state. We will continue to address improvement opportunities as they are identified, and we will continue to coordinate with our established local health department contacts, immunization programs, and emergency preparedness programs to address solutions to the issues identified above and any others that evolve.

B. Include the number/dates of and qualitative information on planned workshops or tabletop, functional, or full-scale exercises that will be held prior to COVID-19 vaccine availability. Explain how continuous quality improvement occurs/will occur during the exercises and implementation of the COVID-19 Vaccination Program.

There are numerous efforts underway to plan scenarios, exercises, and workshops prior to COVID-19 vaccine availability, which are listed below. California Governor's COVID-19 Vaccine Task Force will meet weekly to discuss strengths and gaps and determine corrective actions throughout the course of the COVID-19 vaccination campaign. Additionally, we will seek recommendations from local health departments to improve response activities. The Task Force will regularly update the state plans and procedures with the identified corrective actions.

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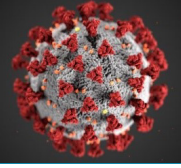


- CDPH will conduct workshops beginning in October to assess the capability and develop plans for the following state agencies to receive, store, and administer COVID-19 vaccines:
 - California Department of Corrections and Rehabilitation
 - California Department of State Hospitals
 - California Department of Developmental Services
 - California Department of Veterans Affairs
- After the Federal Executive Boards and our counties with the largest number of federal offices (such as Los Angeles and San Francisco) provide a list of potential federal partners to California we will conduct workshops with the identified federal partners to assess our collective capabilities and develop plans to receive, store, and administer COVID-19 vaccines.
- CDPH is awaiting final guidance from the Federal government clarifying who is responsible for vaccinating federal entities in California.

In addition to these workshops, the past seven months of COVID-19 response activities have provided significant training building blocks for the upcoming vaccination campaign. State, local, and private partners have honed their skills in resource requesting, receipt, storage, and distribution of medical supplies and on using the equipment required to maintain cold chain management. Recent and upcoming training events include:

- **September:** California's local health departments began conducting multiple seasonal influenza clinics to train additional staff and test the foundation of their mass vaccination plans. The clinics began in September.
- **September:** CDPH staff received training on new cold chain storage and transport containers coming under contract in late September.
- **Fall (exact date TBD):** CDPH will conduct a training webinar for local health departments on COVID-19 vaccine cold chain management once the CDC releases the COVID-19 addendum to its Vaccine Storage and Handling Tool Kit.
- **Fall (exact date TBD):** CDPH will conduct a training webinar for local health departments receiving ultra-low temperature freezers once the models and final site selection is made.

Finally, California anticipates conducting Tabletop Exercises in October through December to identify any gaps in planning and to ensure refinements are underway prior to receiving vaccine. In addition, continuous review of the flu vaccination campaign will guide the COVID-19 vaccine plan.



Section 2: COVID-19 Organizational Structure and Partner Involvement

Instructions:

A. Describe your organizational structure.

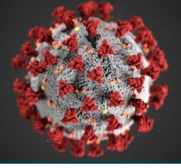
California's COVID-19 response requires complex coordination and partnerships across agencies, departments, local officials, and external partners. The relationship between these key entities and organizations is described below at a high level.

The Governor of the State of California is the state's chief executive and commander-in-chief of California's Military Department. The California Health and Human Services Agency (CHHS) is the cabinet-level agency that oversees departments and offices that provide a wide range of services in the areas of health care, public health, mental health, alcohol and drug treatment, income assistance, social services, and assistance to people with disabilities. Within CHHS, the California Department of Public Health is leading much of the state's COVID-19 responses activities.

The Director of the California Governor's Office of Emergency Services (Cal OES) is the State Emergency Manager. Cal OES leads the state's overall emergency management coordination. The State of California Emergency Plan establishes the California Emergency Support Functions (CA-ESF). The CA-ESFs are 18 primary disciplines or activities essential to addressing the emergency management needs of communities in all phases of emergency management. The CA-ESFs are designed to bring together discipline-specific stakeholders at all levels of government to collectively mitigate, prepare for, cohesively respond to, and effectively recover from emergencies.

CHHS serves as the lead administrative agency for two emergency support functions: Public Health and Medical and Mass Care and Shelter. CDPH and Emergency Medical Services Authority (EMSA) share responsibility for the implementation of these functions.

The Standardized Emergency Management System (SEMS) is the cornerstone of California's emergency response system and the fundamental structure for the response phase of emergency management. Required by the California Emergency Services Act, SEMS is a framework for managing multiagency and multi-jurisdictional responses to emergencies in California. The system unifies all elements of California's emergency management community into a single, integrated system and standardizes key elements. State agencies are required to use SEMS, and local government entities must use SEMS in order to be eligible for any reimbursement of response-related costs under the State's disaster assistance programs.



Each of California's 58 counties and 3 cities¹ (comprising California's 61 local health jurisdictions) have Public Health Departments that serve the residents within their jurisdictions. The local organizational structure mirrors that of state government, in which public health departments are typically under a larger local Health and Human Services Agency. CDPH works closely with local health departments to coordinate and provide technical assistance for all of the different aspects of provider enrollment, data elements, and outreach, etc. At the local levels, jurisdictions have local immunization and pandemic flu coordinators that already have strong connections to local healthcare vaccine providers.

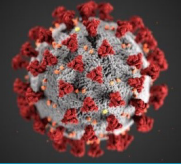
This COVID-19 Vaccination Plan is under the umbrella of California's overall COVID-19 response. **Appendix A** provides the statewide COVID-19 California Governor's COVID-19 Vaccine Task Force Organizational Chart. **Appendix B** provides the COVID-19 Vaccine Task Force Working Group Organizational Chart.

B. Describe how your jurisdiction will plan for, develop, and assemble an internal COVID-19 Vaccination Program planning and coordination team that includes persons with a wide array of expertise as well as backup representatives to ensure coverage.

California has assembled a multi-disciplinary internal team within CDPH and also a multi-agency COVID-19 Vaccine Task Force Working Group. This team is responsible for planning and coordinating COVID-19 response activities, with CHHS input. CDPH has numerous branches, including an Immunization Branch and Emergency Preparedness Office, and these branches are represented on the internal team. Since April 2020, the team within the CDPH has been meeting regularly to prepare for the arrival of the vaccine. Many subject matter experts within the Immunization Branch and Emergency Preparedness Office led the State's H1N1 response efforts in 2009. These experts are taking on many leadership and consulting roles within the COVID-19 response to ensure that the overall effort is guided by safety, efficacy, efficiency, and equity. In addition, leadership at the CDPH were instrumental in executing the H1N1 response as well as several other efforts since then (e.g., the Hepatitis A outbreak). CDPH has also recruited and retained several local experts in immunization and mass prophylaxis to lead and develop the COVID-19 plan. CDPH is continuously adding capacity and subject matter experts to serve as back up to help ensure deliverables are met.

C. Describe how your jurisdiction will plan for, develop, and assemble a broader committee of key internal leaders and external partners to assist with implementing the program, reaching critical populations, and developing crisis and risk communication messaging.

¹ Berkeley, Pasadena, and Long Beach



California established the California Governor’s COVID-19 Vaccine Task Force consisting of subject matter experts and representatives from multiple departments, agencies, and disciplines with the overall goal of planning for and implementing a strategy for vaccine distribution throughout the state. This Task Force meets on a regular basis and is co-led by CDPH and Cal OES.

The effort is comprised of ten workstreams. Workstreams are led by subject matter experts from CDPH, including representatives from the Center for Health and Statistics Informatics, CDPH’s Emergency Preparedness Office, CDPH’s Immunization Branch, and others. The workstreams regularly report to the California Governor’s COVID-19 Vaccine Task Force for input, discussion, and guidance. In addition to this Task Force, California has established two guiding workgroups and will establish an advisory committee as follows:

- 1) Drafting Guidelines Workgroup
- 2) Scientific Safety Review Workgroup
- 3) Community Vaccine Advisory Committee

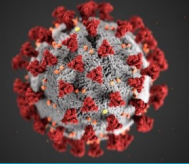
The Drafting Guidelines Workgroup is comprised of immunization, public health, ethicists, healthcare, and academic experts and is charged with developing California specific guidance for the prioritization and allocation of vaccine when supplies are limited. The guidance will be based on several national frameworks from the National Academies of Sciences, Engineering, and Medicine, the Advisory Committee on Immunization Practices, and the Centers for Disease Control & Prevention.

The Scientific Safety Review Workgroup is comprised of immunization, public health, academic, and other subject matter experts and is charged with staying abreast of vaccine candidate(s) trials, evidence of safety and efficacy, and other information to independently provide recommendations to California leadership and vaccine planning efforts as well as ensure public confidence in vaccine safety, efficacy, and implementation efforts.

California will also establish a Community Vaccine Advisory Committee to provide input, feedback, and guidance to the planning efforts and solve barriers of equitable vaccine implementation and decision-making.

To support distribution of the vaccine, the California Governor’s COVID-19 Vaccine Task Force is coordinating with the Cal OES’ Logistics Task Force on planning efforts that include warehouses, cold storage, and logistical and commodity movement. CDPH is also working with the Critical Infrastructure & Transportation Task Force to help identify key points of contact and workforce populations - including state agencies, departments, private-nonprofit, and commercial partners responsible for food and agriculture, energy (power & fuels), water, sewer, solid and

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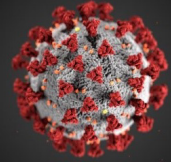
hazardous waste, multi-modal transportation systems (land, sea, and air), as well as the California Highway Patrol and California Department of Motor Vehicles.

In addition, CDPH is working closely with officials at local health departments across the state, as well as established associations and networks such as the California Conference of Local Health Officers (CCLHO), the County Health Executives Association of California (CHEAC) and multiple hospital, health care, and community health networks, many are also represented in the aforementioned workgroups and committees. CDPH’s Immunization Branch and Emergency Preparedness Office serve as the liaisons for the planning and implementation at the local level and are in frequent, close contact with local officials to ensure a cohesive implementation and response; avoid duplication of effort; augment work at the local level; and centralize efforts. For information on California’s crisis and risk communications planning, see Section 12.

D. Identify and list members and relevant expertise of the internal team and the internal/external committee.

Branch/Office/Division	Description/Role
CDPH Center for Environmental Health	The Center for Environmental Health administers programs that protect and manage food, drug, medical device, and radiation sources; regulate the generation, handling, and disposal of medical waste; oversee the disposal of low-level radioactive waste; provide laboratory support that ensures the public's safety from unsafe drinking water, food outbreaks, and recalls; and will soon license manufacturers of medical cannabis.
CDPH Center for Health Care Quality	The Center for Health Care Quality monitors infection rates in hospitals, assists with strategies to reduce or eliminate outbreaks, and is responsible for the regulatory oversight of licensed health care facilities and health care professionals.
CDPH Center for Health Statistics and Informatics	The Center for Health Statistics and Informatics is responsible for registration of birth, death, and marriage certificates, vital records data, and statistical reports.
CDPH Center for Infectious Disease	The Center for Infectious Diseases protects the people in California from the threat of preventable infectious diseases and assists those living with an infectious disease in securing prompt and appropriate access to healthcare, medications, and associated support services.
CDPH Director’s Office	The Director’s Office is responsible for public health policies and programs for the State of California.

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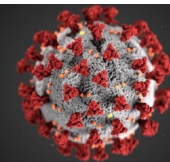


Branch/Office/Division	Description/Role
CDPH Division of Communicable Disease Control	The Division of Communicable Disease Control works to promptly identify, prevent, and control infectious diseases that pose a threat to public health, including emerging and re-emerging infectious diseases, vaccine-preventable agents, bacterial toxins, bioterrorism, and pandemics.
CDPH Emergency Preparedness Office	The Emergency Preparedness Office coordinates overall emergency planning and preparedness efforts for emerging public health threats, including overseeing statewide public health disaster planning, distributing and overseeing funding to local health departments for disaster planning, and other tasks.
CDPH Immunization Branch	The Immunization Branch provides leadership and support to public and private sector efforts to protect the population against vaccine-preventable diseases.
CDPH Office of Public Affairs	The Office of Public Affairs coordinates CDPH's communications activities. Its main responsibilities include media relations, risk communications, web services, social media and internal communications.

The California Governor's COVID-19 Vaccine Task Force (**Appendix A**) is comprised of representatives and subject matter experts from the following entities:

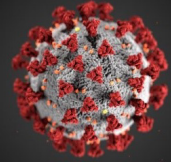
Agency Acronym	Agency Name	Expertise
CalGovOps	California Government Operations Agency	Management and accountability of government programs, increase programmatic effectiveness, and coordinated operational decisions.
Cal Guard	California Military Department	Includes the Office of the Adjutant General, the California National Guard, the California State Guard, the California Cadet Corps, and the California Naval Militia.
Cal OES	California Governor's Office of Emergency Services	Emergency preparedness, response, recovery, and homeland security activities within the State of California.
CalSTA	California State Transportation Agency	Develops and coordinates the policies and programs of the state's transportation entities to achieve the state's mobility, safety, and air quality objectives from its transportation system.
CalVet	California Department of Veterans Affairs	Serves California veterans by connecting them and their families with their benefits through education, advocacy, and direct services.

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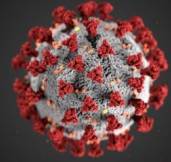
Agency Acronym	Agency Name	Expertise
Cal/OSHA	Department of Industrial Relations, California Division of Occupational Safety and Health	Protects and improves the health and safety of working men and women in California; setting and enforcing standards; providing outreach, education, and assistance. Housed within the Department of Industrial Relations.
CDCR	California Department of Corrections and Rehabilitation	Responsible for the operation of the California state prison and parole systems. Enhances public safety and promotes successful community reintegration through education, treatment, and active participation in rehabilitative and restorative justice programs.
CDPH	California Department of Public Health	Protects the public's health and helps shape positive health outcomes for individuals, families, and communities. Collaborates with local health departments along with state, federal, and private partners.
CDSS	California Department of Social Services	Serves, aids, and protects needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence.
CDFA	California Department of Food and Agriculture	Serves the citizens of California by promoting and protecting a safe, healthy food supply, and enhancing local and global agricultural trade, through efficient management, innovation, and sound science, with a commitment to environmental stewardship.
CDT	California Department of Technology	Guards public data and has broad responsibility and authority over all aspects of technology in California state government, including: policy formation, inter-agency coordination, IT project oversight, information security, technology service delivery, and advocacy.
CHHS	California Health and Human Services	Oversees the State's departments and offices that provide a wide range of services in health care, mental health, public health, alcohol and drug treatment, income assistance, social services, and assistance to people with disabilities.

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Agency Acronym	Agency Name	Expertise
DCA	California Department of Consumer Affairs	Administers more than 3.9 million licenses in more than 280 license types including certificates, registrations and permits, from architects to accountants, dentists to veterinarians.
DDS	California Department of Developmental Services	Oversees the coordination and delivery of services to more than 330,000 individuals who have cerebral palsy, intellectual disabilities, Down syndrome, autism, epilepsy, and related conditions through a network of 21 regional centers and state-operated facilities.
DHCS	California Department of Health Care Services	Provides Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care.
DMHC	California Department of Managed Health Care	The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.
DOA	California Department of Aging	Administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State.
DOF	California Department of Finance	The Governor's chief fiscal policy advisor and promotes long-term economic sustainability and responsible resource allocation.
DOT	California Department of Transportation (Caltrans)	Manages more than 50,000 miles of California's highway and freeway lanes, provides inter-city rail services, permits more than 400 public-use airports and special-use hospital heliports, and works with local agencies.
DSH	California Department of State Hospitals	Manages the California state hospital system, which provides mental health services to patients admitted into DSH facilities, and oversees five State hospitals.

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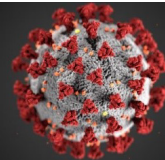


Agency Acronym	Agency Name	Expertise
EMSA	Emergency Medical Services Authority	Provides leadership in developing and implementing EMS systems throughout California and setting standards for the training and scope of practice of EMS personnel. Promotes disaster medical preparedness and coordinates and supports the state's medical response to major disasters.
Go Biz	California Governor's Office of Business and Economic Development	Serves as the State's leader for job growth, economic development, and business assistance efforts.

E. Describe how your jurisdiction will coordinate efforts between state, local, and territorial authorities.

California will leverage its well-established existing framework and emergency response infrastructure to coordinate efforts between state, local, and territorial authorities. There are currently over 4,000 medical providers enrolled in California's Vaccines for Children (VFC) Program and 500 Federally Qualified Health Centers (FQHCs) enrolled in our Vaccines for Adults (VFA) Program. These programs are both supported by a broad communications network (see www.eziz.org) and diverse staff (central and field staff) for support of providers and issues surrounding vaccine distribution and use. CDPH communicates directly with licensed health care facilities via an established "all facilities" network and also has the ability to communicate with medical providers via close partnerships with statewide associations and collaboratives such as California Medical Association (CMA), California Hospital Association (CHA), California Primary Care Association (CPCA), California Association of Health Facilities (CAHF), the California Immunization Coalition (CIC), the California Conference of Local Health Officers (CCLHO) and many others. CDPH conducts monthly conference calls/webinars with local health jurisdictions and has an online clearinghouse for posting relevant information and sharing best practices for local immunization and emergency preparedness leaders. With the ramped-up planning for COVID-19 vaccine, the calls have become more frequent and audiences have expanded beyond the local immunization experts to also include health officers, logistics experts, and mass prophylaxis planners.

In coordination with Cal OES, the California Public Health and Medical Emergency Operations Manual (EOM) establishes a coordinated system to provide public health and medical resources including medical equipment and supplies, medical transportation, or healthcare personnel from both the private and public sectors to requesting local jurisdictions impacted by the disaster.



In addition to EMSA and CDPH, this coordination system includes the Regional Disaster Medical and Health Coordination (RDMHC) Program within each of California's six mutual aid regions, the Medical Health Operational Area Coordination (MHOAC) Program within the Operational Area, and partners at the local level. Partners at the local level include local health departments, local environmental health departments, and local emergency medical services agencies. Incidents with public health and medical impact often require the coordinated involvement of public health, environmental health, health care providers, and emergency medical services.

The Medical and Health Coordination Center (MHCC) serves as the Emergency Operations Center (EOC) for three departments, including CDPH, EMSA, and the Department of Health Care Services (DHCS). The MHCC is also the Coordination Center for state level Public Health and Medical (CA-ESF 8) activities involving other departments within the California Health and Human Services Agency (CHHS) and any other CA-ESF 8 stakeholders with an incident-specific public health and medical role.

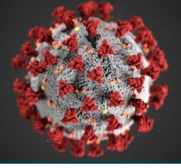
The Receiving, Storing, and Staging Mobilization Center (RSS-MC) is the State's logistical operation center. When activated the RSS-MC can:

- Receive approved resource requests from the MHCC for local health jurisdictions;
- Receive Medical Countermeasures (MCM) from CDC and other approved sources;
- Store and Stage MCM;
- Coordinate and Distribute MCM to local health jurisdictions;
- Maintain the status of MCM stored at the CDPH warehouse.

Cal OES will also work with CDPH to distribute the COVID-19 vaccine if needed, as well as support local jurisdictions with establishing administration sites and any additional security needs if requested. Cal OES oversees an efficient and robust distribution system developed through lessons learned and best practices in responding to recent catastrophic disasters in California. Cal OES is prepared to adapt its existing system to coordinate distribution of the vaccine. With the exceptions of cold vaccine storage, medical supplies can be stored and distributed from their warehouses, as needed.

F. Describe how your jurisdiction will engage and coordinate efforts with leadership from tribal communities, tribal health organizations, and urban Indian organizations.

The Cal OES Office of Tribal Coordination is responsible for coordination and communication with Native American Tribes in California. In addition to the overall tribal coordination provided by Cal OES, many Native American tribal health organizations throughout the state have also built strong relationships with their Medical and Health Operational Area Coordination Programs within the public health and medical system for their respective areas.



There are 109 federally recognized American Indian tribes in California. In addition to developing emergency response capabilities, tribal governments are encouraged to work with adjacent local governments and jurisdictions to plan and prepare for emergencies, including the development of agreements to provide disaster assistance and support. Tribal health clinics will work with local health departments to ensure integration and coordination of emergency public health and environmental health services during an emergency.

CDPH is currently meeting with representatives and liaisons from the Indian Health Services, California Rural Indian Health Board, Cal OES Tribal Liaison, California Consortium for Urban Indian Health, and tribal health programs to coordinate and plan for the COVID-19 vaccine implementation. CHHS has appointed the Associate Secretary of External Affairs and Tribal Liaison as a coordinator to ensure tribal concerns are addressed.

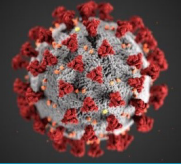
G. List key partners for critical populations that you plan to engage and briefly describe how you plan to engage them, including but not limited to:

- *Pharmacies*
- *Correctional facilities/vendors*
- *Homeless shelters*
- *Community-based organizations*

Specific and targeted engagement is or will be underway in California's planning efforts for many critical populations, including but not limited to:

- Pharmacies
- Skilled nursing & long-term care facilities
- Convalescent homes
- Medical clinics
- K-12 school districts
- Colleges and universities
- Faith-based organizations
- Public and private hospitals and clinics
- Correctional facilities/vendors
- Homeless shelters
- Community-based organizations

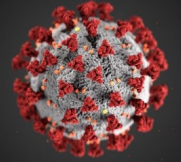
The Community Vaccine Advisory Committee will provide input and feedback to CDPH on the State's COVID-19 planning program, including gaps and concerns in reaching critical populations that need to be addressed. One of the primary efforts of the Community Vaccine Advisory Committee will be to help ensure vaccine planning supports all Californians, but particularly for individuals in communities that are disproportionately impacted, including Latinos, African



Americans, Native Hawaiians, Pacific Islanders, and other Asians including Filipinos. The Community Vaccine Advisory Committee will engage with key stakeholders early on to establish communication channels with a focus on equity and transparency supported by data. Members will be selected to balance the expertise and viewpoints that are necessary to effectively address the issues and challenges of implementing a vaccine effort across California.

CDPH formed a Pharmacy Task Force as described in further detail in Section 5H. CDPH is also currently engaging in efforts with the California Department of Corrections and Rehabilitation to review and develop plans for the staff and inmates of state correctional facilities.

Additionally, CDPH is establishing a Long-term Care Workgroup to specifically focus on the vaccine implementation for this vulnerable population. The workgroup is comprised of state licensing agencies, infection preventionists, associations representing long term care, assisted living, small residential facilities, large chain skilled nursing facilities and pharmacies.



Section 3: Phased Approach to COVID-19 Vaccination

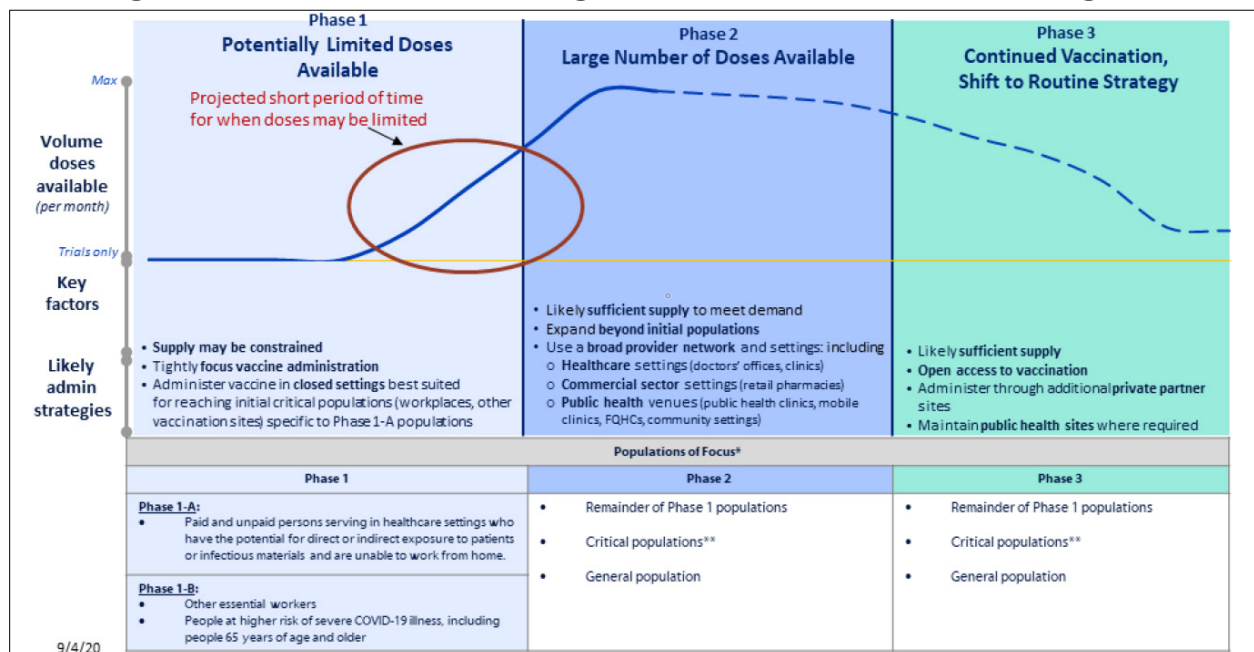
Instructions:

A. Describe how your jurisdiction will structure the COVID-19 Vaccination Program around the three phases of vaccine administration:

- Phase 1: Potentially Limited Doses Available
- Phase 2: Large Number of Doses Available, Supply Likely to Meet Demand
- Phase 3: Likely Sufficient Supply, Slowing Demand

Figure 3.1 provides a summary of the CDC’s three-phase planning approach that California is adopting.

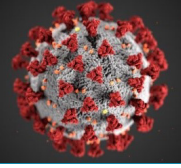
Figure 3.1: Three Phase Planning – CDC COVID-19 Vaccination Program



SOURCE: CDC COVID-19 VACCINATION PROGRAM INTERIM PLAYBOOK FOR JURISDICTION OPERATIONS V1.0, SEPTEMBER 16, 2020.

Phase 1 – Potentially limited supply of COVID-19 vaccine doses available. Since vaccine supply will likely be limited at the beginning of the program, California is creating a scalable foundation to rapidly expand capacity as more vaccine becomes available. California will focus its efforts on first vaccinating its critical populations in two subphases (Phase 1-A and Phase 1-B), including:

- Healthcare personnel likely treating patients with COVID-19 (Phase 1-A)
- Healthcare personnel likely to be exposed to COVID-19 (Phase 1-A)
- People at increased risk for severe illness or death from COVID-19 (Phase 1-B)
- Other essential workers (Phase 1-B)



We have formed two subgroups within the COVID-19 Vaccine Task Force Working Group to further delineate how we will best equitably distribute the vaccine through Target Populations Analysis and Scarcity Analysis:

Target Populations Analysis – Research scientists and data analysts are defining and enumerating California’s health care personnel, essential workers, and critical infrastructure populations, as well as the people in California who are at increased risk for severe illness and death due to underlying medical conditions or other risk factors.

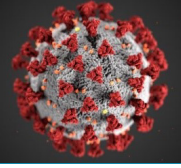
Scarcity Analysis – Communicable disease experts, physicians, epidemiologists, ethicists, and equity specialists are advising on California’s most effective use of the initially scarce vaccine.

The two teams are working together to assess the impact, benefits, and effects from the different planning scenarios. Much of this analysis will depend on the initial available supply in Phase 1, dose(s) needed, and the vaccine’s cold chain requirements. In addition, we are planning for multiple vaccines to be available, each with different dosages and refrigeration needs.

In coordination with a recent survey of local preparedness programs, we will also conduct surveys of our health care sectors (such as hospitals and health systems, skilled nursing facility networks) and our local health departments to better understand their capacity to quickly distribute and administer the vaccine(s). We are also taking direction from the CDC Advisory Committee on Immunization Practices (ACIP) and communicating with other states to share best practices and lessons learned from across the country.

We are currently identifying and estimating the critical populations in the Phase 1 categories with as much granularity as possible including at the county, census tract, or even facility level when feasible. For healthcare personnel, we are creating subsets in the event that the Phase 1-A target population needs to be further delineated. When available, we will use ACIP guidance to identify the Phase 1 critical sub-populations. Vaccine allocations to the jurisdictions will be in alignment with ACIP guidelines and with recommendations from the Drafting Guidelines Workgroup, which is part of the Governor’s COVID-19 Vaccine Task Force. We will be fully transparent in all of these activities and share as much information as possible with local jurisdictions as well.

Vaccine inventory, distribution, and dose administration during Phase 1 will be closely monitored and documented. Smooth enrollment of vaccination providers and distribution of vaccine for Phase 1 is based on our existing close working relationships and partnerships. We have been working collaboratively with the California Conference of Local Health Officers (CCLHO), California Health Executives Association of California, and local health departments to

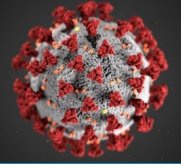


best identify the appropriate audiences within their jurisdictions for Phase 1 vaccine distribution. Additionally, we have been communicating closely with our inpatient/acute care hospital networks and skilled nursing networks to prepare for what vaccine distribution will look like. We are also collecting information from them about their occupational health capacity to vaccinate their own staff and to determine if they can vaccinate eligible groups from outside of their organization. Lastly, we are working closely with local health department emergency and mass prophylaxis planners to review their closed POD plans and determine their capacity to vaccinate critical infrastructure populations who may not be able to receive vaccines in their workplace setting.

In summary, during Phase 1 we will establish and equip the initial vaccination locations to best reach the target populations, determine any cold chain requirements, and initiate the reporting requirements for vaccine supply and uptake. We will also provide statewide guidance on how to determine and confirm eligibility if an individual meets the Phase 1 vaccination eligibility requirements.

Phase 2 – Large number of vaccine doses available. During this phase CDPH will work with all partners and collaborators to ensure vaccine access to all members of Phase 1 critical populations who were not yet vaccinated and also expand our communication efforts to broaden vaccination access to other groups of essential workers and groups at increased risk of COVID-19. We will substantially expand the provider network, enrolling primary care and outpatient sites, community health care sites, school-based clinics, and alternative vaccination venues. California envisions several potential subphases within Phase 2 (Phase 2-A, Phase 2-B, and possibly Phase 2-C) to prioritize vaccinations for essential workers and vulnerable populations before expanding to non-essential workers and the general public.

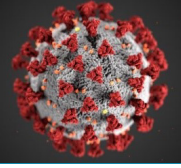
The progression through the phases and sub-phases will be guided by California’s Drafting Guidelines Workgroup (subject matter experts, ethicists, and academics agreeing upon prioritized populations and subpopulations in each phase of vaccine program implementation), which is under the Allocation Framework line of effort of the Governor’s COVID-19 Vaccine Task Force. As we progress through Phase 2, another goal of our efforts will be to improve health equity by focusing on protecting workers at highest risk because they are in jobs that pose inherent challenges to controlling exposure to the virus. Improving health equity will also occur by examining the demographic and social factors that contribute to the overall health disparities in California such as racism, income, ageism, English proficiency, lack of access to healthcare, crowded housing, precarious employment, and discrimination related to disabilities, sexual orientation, gender identity, ethnicity, and immigration status. Our health equity metric is further described in Section 4.



At any given point in time, it is our goal to provide clear guidance regarding how the vaccine will be used and in which populations. This guidance is crucial for local health jurisdictions, vaccinators, and the general public. In this phase we will also maintain our close monitoring of vaccine inventory, distribution, and dose administration so that we can adjust quickly to changing circumstances. It is possible that regional surges in demand can occur in Phase 2 or, alternatively, a drop in demand. It is our goal to be able to adjust as necessary to minimize vaccine waste.

Phase 3 – Continued vaccination/Shift to routine strategy. During this phase, our priority will shift to equitable vaccinations access across the entire population using our traditional routes for vaccine administration. We will actively monitor vaccine uptake and coverage as we reassess our approach to increase uptake in communities and populations with low coverage with the ultimate goal of high coverage rates for California’s 40 million people.

In Phase 3, when there is enough vaccine for the entire population, there will be broad enrollment from health care providers and broad marketing of the benefits of the vaccine so that all indicated recipients can be protected. While California will have a large emphasis on transparency and equity throughout each phase, during Phase 3 we will be able to reach more communities to ensure equal access to vaccination services associated with large amounts of vaccine availability. We will maximize the utility of our systems and previous immunization tracking to see which communities in California might have lower coverage rates for targeted outreach, education (both for patients and to possibly increase provider enrollment), and administration. With increased supply comes increased opportunities for creativity and innovation toward protecting individuals from COVID-19.



Section 4: Critical Populations

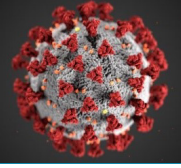
Instructions:

A. Describe how your jurisdiction plans to: 1) identify, 2) estimate numbers of, and 3) locate (e.g., via mapping) critical populations. Critical population groups may include:

- *Healthcare personnel*
- *Other essential workers*
- *Long-term care facility residents (e.g., nursing home and assisted living facility residents)*
- *People with underlying medical conditions that are risk factors for severe COVID-19 illness*
- *People 65 years of age and older*
- *People from racial and ethnic minority groups*
- *People from tribal communities*
- *People who are incarcerated/detained in correctional facilities*
- *People experiencing homelessness/living in shelters*
- *People attending colleges/universities*
- *People living and working in other congregate settings*
- *People living in rural communities*
- *People with disabilities*
- *People who are under- or uninsured*

One of California's key policy goals is to determine critical populations for vaccination, including identifying groups to receive the first available doses when supply is expected to be limited. To that end, California has established an Allocation Data Team specifically for the purpose of identifying, estimating and locating the critical populations in California listed above. The Allocation Data Team is conducting target population analysis as described earlier and is comprised of research scientists, data analysts, and other healthcare professionals from many departments. The team is working cross-departmentally to identify, estimate, and locate critical populations. The guiding principles of the group are to:

- Be as accurate and granular as possible.
- Use defensible strategies and methodologies for combining data sets. An important part of this effort includes evaluating data sets and then consolidating the most representative data to obtain a comprehensive picture of critical populations.
- Present and enumerate data so that it can be used to identify, estimate, and locate critical populations for California.

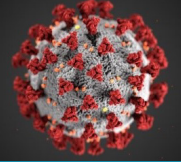


The Allocation Data Team is accessing dozens of data sets (some public and some protected) from various state, federal and non-profit sources including California Department of Social Services, California Department of Aging, Census Area, California Rural Indian Health Board, CDPH Center for Health Care Quality, CDPH Licensing and Certification, California Department of Corrections, California Department of Developmental Services, California Employment Development Department, California Department of Labor, California's Essential Critical Infrastructure Workers, Cybersecurity and Infrastructure Security Agency, FEMA, and many more to provide pictures of different critical infrastructure populations that are comprehensive and useful. For each comprehensive dataset produced to assist with COVID-19 vaccine implementation in California, summary sheets are also being produced that outline the sources of the data and the methods of production. These summary sheets will accompany the individual datasets that are shared with local health jurisdictions as well and maps are being produced to give visual representations of where different workforces and populations are located.

In addition to identifying critical infrastructure populations, California is also focused on identifying disadvantaged populations and communities that have been disproportionately impacted by COVID-19 in terms of higher rates of infection, hospitalization, and deaths. Our daily statistics are located here: [California COVID-19: Cases](#). These disparities have been clearly documented and they create a public health imperative to address exposure in all communities, including especially those disproportionately impacted. In an effort to combat these disparities, California has developed a [health equity metric](#), which helps guide California's counties in their continuing efforts to more effectively fight COVID-19. The equity metric is part of the [Blueprint for a Safer Economy](#) to reduce COVID-19 in the State with revised criteria for loosening and tightening restrictions on activities.

To support a data-driven approach to protecting public health and eliminating COVID-19 disparities, the State is committed to partnering with counties to improve the collection of race and ethnicity data associated with testing and cases. To date, approximately a third of cases and up to half of test results reported to the State do not have required race/ethnicity data. The State will partner with counties to determine milestones in improving the collection of this data. The State will provide county-level data on the completeness of race/ethnicity for COVID-19 tests and cases and will continue to track and publicly post county level data on testing, case rates, and deaths by race and ethnicity.

CDPH has assembled a Health Equity Technical Assistance Team that will partner with key regional collaboratives and advocacy groups to develop a menu and playbook of best practices, resources, and vendors with an equity focus to share and provide resources to counties. A kickoff meeting between this Health Equity Technical Assistance Team and representatives of the COVID-19 vaccine implementation team occurred in early October to begin including equity



indicators from our playbook that will be directly applied to COVID-19 vaccine implementation and access within the community. This is another proactive collaboration to make sure equity is part of the planning criteria from the beginning of COVID-19 vaccine administration.

B. Describe how your jurisdiction will define and estimate numbers of persons in the critical infrastructure workforce, which will vary by jurisdiction.

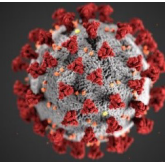
Leveraging the Federal Cybersecurity & Infrastructure Security Agency (CISA) guidance as a key resource, we have identified essential services and workforce that must remain operational; this ultimately framed what remained operational during the statewide stay at home order. To date, the Allocation Data Team has obtained a wide variety of data, including data sets on licensures and certification, labor, health care facility types, correctional facilities, and others. These data sets have been loaded into statistical analysis software and are currently being analyzed. The goal of this effort is to synthesize diverse data sets into a single location that can serve as a comprehensive source on California's critical infrastructure populations. Some of the information has been challenging to collect (for instance, distinguishing clinicians from non-clinicians in the hospital workforce), but through its data analysis work, the team is developing definitions of such populations.

The Allocation Data Team's products will also include visual population maps that will help California's 61 health jurisdictions with their important vaccination provider outreach efforts. We intend to estimate the number of persons in the critical infrastructure workplace down to the county level.

C. Describe how your jurisdiction will determine additional subset groups of critical populations if there is insufficient vaccine supply.

Special attention is being paid to identifying and describing initial populations of focus, including persons in Phase 1-A and Phase 1-B, since Phase 1 populations will be the first to receive available doses of the vaccine. If there is insufficient vaccine supply, we intend to have the data ready to further delineate these groups into additional subsets. In its analyses, the Allocation Data Team is striving to be as granular as possible when collecting data and is operating under the premise that it is easier to "roll up than down." See Section 3A for additional information.

Within healthcare personnel populations, for example, we are distinguishing personnel who work primarily in acute inpatient settings and congregate residential settings such as skilled nursing facilities from those who work in outpatient care. Among the personnel who provide inpatient care, we are further trying to segment this population into those who work in direct



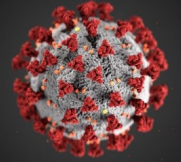
patient care areas and those who do not. Additionally, our goal is to stratify this data down to an individual hospital level.

Armed with this granular detail, along with our state epidemiology trends on where we have the highest burden of disease when we receive vaccines, we will be able to respond quickly to changing circumstances in the early vaccination phases and to identify and segment new subsets of populations in the response as needed. Lastly, we are monitoring several in-progress efforts, including ACIP allocation strategies and the forthcoming CDC mapping dashboard, and will incorporate them into our analyses as appropriate.

D. Describe how your jurisdiction will establish points of contact (POCs) and communication methods for organizations, employers, or communities (as appropriate) within the critical population groups.

With over 4,000 medical providers participating in California's Vaccines for Children program and over 500 federally qualified health centers in our Vaccines for Adults program, a solid communication infrastructure exists for getting information and program updates to participating providers (program updates are sent electronically and also posted at <https://eziz.org/>). The CDPH Immunization Branch also employs field staff in five regions to serve as liaisons between provider offices and local health departments. These mechanisms, combined with the knowledge and relationships between local health care providers, pharmacies, and local health departments, have already established points of contacts and methods of communication. Additionally, local emergency preparedness programs have established close communication channels with first responder organizations, groups serving vulnerable populations and large employers throughout our state's diverse counties. Local health departments have also been keeping close track on communities most adversely affected by COVID-19 and many have bolstered their responses to include specific outreach, education and mitigation efforts in those communities, establishing good relationships along that way that are paving the way for COVID-19 vaccine.

We have also been working with the California Conference of Local Health Officers and the County Health Executives Association of California to define and establish contacts for Multi County Entities (MCEs). An MCE is a health system that has facilities in more than two California counties to centrally support local implementation in all of its locations, set policy for all of its facilities, order and store vaccine, has a centralized pharmacy, and has a demonstrated track record in immunizing all of their staff. Northern and Southern California Kaiser Health Systems are the two largest MCEs defined to date. Conversations are continuing to delineate more MCEs and processes are being created and refined for how these entities will be registered in our provider enrollment systems for vaccine ordering, allocation, tracking and reporting. MCEs will become critical partners to immunizing in their communities and will be brought fully into

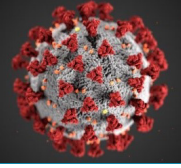


all communication networks and monitoring infrastructures. We will augment these well-established networks with any additional input from our Community Vaccine Advisory Committee.

Successful communication regarding critical population groups will start with clear guidance at the state level. The state will communicate to local health jurisdictions and MCEs about which and when specific critical populations should be receiving the vaccine. The state, in turn, will rely heavily on these local jurisdictions and multi-county entities to communicate directly with the providers for whom they will be approving allocations. The points of contact for these providers will be established through the provider registration process, which is discussed in further detail in Section 5.

Additionally, we will employ various communication methods to reach critical population groups. To communicate out to the groups that will be eligible for vaccination, we will send messages both from the local and state level about which categories of people should be vaccinated and, when. At the local level, emergency operations centers remain activated and will utilize well-established networks for reaching emergency responders and health care personnel. These well-established networks include Public Health and Medical emergency response partners, such as the Regional Disaster Medical Health Coordination and Medical and Health Operational Area Coordination programs. We will rely heavily on these networks as well as on statewide health care associations such as the California Hospital Association, the California Primary Care Association, the California Medical Association, local health care coalitions, and others. We will also rely on the California Immunization Coalition, our CCLHO and CHEAC organizations, EMS organizations (such as the Emergency Medical Services Administrators' Association of California [EMSAAC] and the EMS Medical Directors Association of California [EMDA]), and many other professional associations. Emphasizing transparency and equity every step of the way, we will engage our Office of Health Equity, Governor's COVID-19 Vaccine Task Force, Community Vaccine Advisory Committee members and other stakeholders to ensure that our communications are inclusive and that our strategies are in alignment with the best use of the vaccine at any given point in time.

For additional information on our communication plan, see Section 12.



Section 5: COVID-19 Provider Recruitment and Enrollment

Instructions:

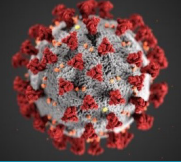
- A. Describe how your jurisdiction is currently recruiting or will recruit and enroll COVID-19 vaccination providers and the types of settings to be utilized in the COVID-19 Vaccination Program for each of the previously described phases of vaccine availability, including the process to verify that providers are credentialed with active, valid licenses to possess and administer vaccine.*

The recruitment and enrollment of COVID-19 vaccine providers are critical processes and will require extensive collaboration between CDPH, local health departments, immunization coalitions and statewide organizations and associations such as California Hospital Association, California Medical Association, California Pharmacist Association, and the California Primary Care Association. CDPH is working closely with local health departments and various organizations (specifically, the California Conference of Local Health Officers and the County Health Executives Association of California) on provider recruitment and enrollment efforts in a series of prior and ongoing meetings.

Vaccine provider recruitment and enrollment will primarily be undertaken by each local health jurisdiction given their local knowledge of the provider community, existing relationships, and established partnerships. Local health departments will pre-screen potential providers according to criteria and guidance provided by CDPH and CDC. A select number of providers will then be invited to register and enroll in the state's new distinct technology system, the COVID-19 Provider Enrollment and Ordering Management System ("provider system"), which is currently under development.

During provider enrollment, providers will be required to sign and agree to the terms and conditions in the CDC COVID-19 Vaccination Program Provider Agreement. Additionally, as part of the enrollment process, the provider system will automatically match enrollment information against current state licensing board data. Providers who do not possess active, valid licenses will be flagged by the system and will not be allowed by the system to move forward in the enrollment process.

In order to support local health departments in their provider recruitment efforts, CDPH will provide specific guidance on the types of organizations and providers to be prioritized for enrollment during Phase 1 and subsequent phases. Provided guidance will also include how specifically to handle sites identified as multi-county entities, state sites, and federal sites for which the federal government will not be providing vaccine. We are currently conducting conversations with representatives of these different types of entities (federal, state, and tribal) to ensure that it is clear who will be accountable in all situations and so that there are no



surprises. Additionally, CDPH will be standing up a state-wide COVID-19 Provider Customer Service Call Center in order to support local provider enrollment efforts during both phases of COVID-19 provider enrollment, and later support vaccine ordering, shipment inquiries and vaccine management efforts.

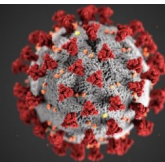
Phase 1

In this early phase, given limited supply and potentially challenging storage and handling requirements for vaccines, jurisdictions will be encouraged to:

- Prioritize recruitment efforts focusing on engaging vaccination providers and settings where critical populations identified in this phase can be rapidly immunized as soon as a vaccine is available; and
- Plan outreach efforts ensuring full geographic coverage and monitoring enrollment of providers in areas where critical populations have been identified.

Vaccination settings during Phase 1 will be dependent upon available vaccine supply, with each product guiding the settings and providers to receive vaccine supply. Settings include public health, occupational health settings, temporary/off site vaccination clinics, mobile clinics reaching critical populations, and closed POD clinics, commercial pharmacies partners reaching people at higher risk of severe COVID-19 illness such as long-term care facilities, and hospital clinics. Criteria for Phase 1 provider outreach will include organizations that:

- Service critical populations groups.
- May immunize critical populations in rural and remote areas where immunization services may be limited or not easily accessible.
- Have the storage capacity and the ability to adhere to storage and handling requirements.
- Have vaccine administration capacity including: 1) the capacity to organize and coordinate vaccination efforts to deliver 2 doses of COVID-19 vaccine within established intervals (21-28 days); 2) existing capacity based on delivery of immunizations during high demand periods or efforts (e.g., influenza vaccination, outbreak vaccination efforts, etc.); 3) follow infection control measures and social distancing guidelines; 4) staffing levels supporting vaccination efforts; and 5) readily able to begin vaccination efforts shortly after vaccine receipt.
- Have the capacity to report vaccine administration within 24 hours of vaccine administration.



- Can conduct closed POD clinics, allowing for mass immunization clinics focusing on critical populations which may otherwise not have access to the vaccine within place of employment, AND are able to implement social distancing and infection control guidelines.

CDPH has been helping local health departments to plan for closed point of dispensing sites for emergency responders and critical infrastructure personnel who may not be able to be vaccinated through their occupational health programs of their employer.

While we anticipate that local health departments will handle the majority of provider recruitment and enrollment activities, the state will work directly with organizations that have multi-jurisdictional locations, such as large health systems. These organizations will be required to meet the same criteria as single-jurisdictional health providers (they will ensure that they can immunize critical infrastructure, meet storage and handling requirements, and report doses administered within 24 hour), as well as additional criteria (currently in development) in order for CDPH to handle the recruitment, enrollment, and direct vaccine allocation of these multi-jurisdictional entities.

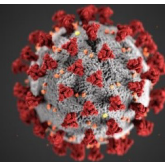
Phase 2 and Beyond

Additional COVID-19 vaccine doses available during this phase will allow an expansion of provider enrollment and recruitment efforts of vaccination settings and organizations targeted during Phase 1, plus initiation of expanded Phase 2 and Phase 3 provider networks, including:

- Commercial and private sector partners (pharmacies, doctors' offices, clinics)
- Public health sites (mobile clinics, Federally Qualified Health Centers, RHCs, public health clinics, temporary/off-site clinics)
- Traditional and non-traditional immunization partners, such as
 - Large settings such as hospitals open PODs
 - Colleges and universities
 - Occupational health settings
 - Correctional facilities

B. Describe how your jurisdiction will determine the provider types and settings that will administer the first available COVID-19 vaccine doses to the critical population groups listed in Section 4.

It is critical that the state guidance be as transparent as possible regarding who is eligible to receive a vaccine, and when they are eligible, based on vaccine supply and available products within each phase of the COVID-19 vaccination program. CDPH has already been communicating with key statewide stakeholders such as health care and medical associations,



local health departments, and community health networks about the different vaccination phases.

However, communications with local health departments will be specifically important to ensure that plans are in place to accommodate vaccine allocations following the differing vaccine availability scenarios of Phase 1. Depending on initial vaccine supplies, guidance will be provided to local jurisdictions (who will be completing vaccine allocations directly to providers) on how to allocate the vaccine depending on the phase and provider type and setting:

Phase 1, Scenario 1, Vaccine A becomes available (Ultra Cold storage required): In this scenario, settings include large sites including public health, occupational health settings, and temporary/off site vaccination clinics, mobile clinics reaching critical populations, and closed POD clinics.

Phase 1, Scenario 2, Vaccine B becomes available (Frozen -20°C): In this scenario, settings include healthcare clinics, public health offices, occupational health settings, temporary/off site vaccination clinics, mobile clinics reaching critical populations, and closed POD clinics. Additionally, settings will include locations such as long-term care facilities and hospital clinics where commercial pharmacies partners can reach people at higher risk of severe COVID-19 illness.

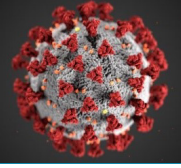
Phase 1, Scenario 3, Vaccine A and B become available: In this scenario, settings include all those listed in Scenarios 1 and 2.

As discussed in Section 4, the CDPH Allocation Data Team is working to create lists and maps of different provider types on a county level. This data will be shared with counties and local health departments to help them identify and recruit the providers that would qualify for the first shipments of vaccine. Using this state-provided data, local health departments will be equipped to recruit and enroll those providers who meet the criteria discussed in Section 5.A.

C. Describe how provider enrollment data will be collected and compiled to be reported electronically to CDC twice weekly, using a CDC-provided Comma Separated Values (CSV) or JavaScript (JSON) template via a SAMS-authenticated mechanism.

California currently has online enrollment systems and processes in place that will be leveraged to meet federal data reporting requirements. Specifically, our existing programs (Vaccines for Children and Vaccines for Adults) will provide the foundation for our COVID-19 vaccine provider enrollment process, which will be accomplished through the new provider system.

The provider system will collect provider enrollment data, including all data elements in the CDC COVID-19 Vaccination Program Provider Agreement and provider profile. Provider acknowledgment of the terms of the agreement will also be captured via this system. This



enrollment data will be exported for upload into the federal Vaccine Tracking System (VTrckS) according to CDC's file specification guidelines, following the existing processes that are in place for current vaccine programs.

D. Describe the process your jurisdiction will use to verify that providers are credentialed with active, valid licenses to possess and administer vaccine.

As discussed in Section 5A, the new provider system will automatically verify and match provider credentials against state licensing board records as part of the enrollment process. This functionality already exists for other state vaccination programs and will be adapted to the new system. If the provider information cannot be verified or matched, the system will issue a flag during the enrollment process and will not allow the provider to move forward with enrollment.

E. Describe how your jurisdiction will provide and track training for enrolled providers and list training topics.

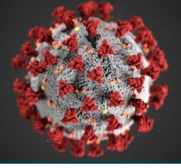
We understand that training of vaccination providers is vital to ensure COVID-19 Vaccination Program success. We will leverage the educational resources provided by the CDC in addition to developing or using state-specific materials, as needed. California already has well established training processes in place for our existing vaccination programs, and we will leverage these processes for this new effort.

Training will be delivered by the new provider system during the provider enrollment process. As part of the enrollment process, each provider will be required to have completed a set of educational requirements covering critical elements for the successful participation in the COVID-19 vaccination program.

Key training elements will include:

- COVID-19 Vaccination Program participation requirements
- Vaccine ordering and receipt
- Vaccine storage, handling, and temperature monitoring requirements
- Vaccine administration (including VIS, EUA, documentation, and Dose 2 efforts)
- Vaccine reporting requirements (including related to vaccine wastage/spoilage)
- Vaccine inventory management and reporting
- IIS participation and reporting
- Reporting of adverse events to VAERS

Additionally, once vaccine supply is known, clinical guidance (e.g., ACIP recommendations, administration information, dosage and indications, or other topics) related to any available



COVID-19 vaccine to be distributed will be emailed to all enrolled providers prior to vaccine receipt.

Training completion will be tracked in the new provider system. Every provider enrolling via the new provider system will be required to acknowledge in the system that they have completed training. This may take the form of an acknowledgement screen, uploading a proof of completion certification, or other method. Training completion will be tracked in the new provider system. Every provider enrolling via the new provider system will be required to acknowledge in the system that they have completed training. Providers will not be allowed to complete the enrollment process by the system if they fail to acknowledge that they have completed training.

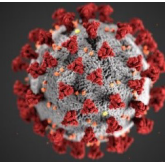
F. Describe how your jurisdiction will approve planned redistribution of COVID-19 vaccine (e.g., health systems or commercial partners with depots, smaller vaccination providers needing less than the minimum order requirement).

Within California, we anticipate that planned redistributions of COVID-19 vaccine will apply to either: 1) health systems or multi-jurisdictional organizations with depots incorporated into their infrastructure; or 2) smaller providers needing less than the minimum order requirements.

All planned redistribution requests will be handled directly by the CDPH Immunization Branch and not by local health departments. In order for redistribution requests to be approved, entities must sign and adhere to the terms of the CDC COVID-19 Vaccine Redistribution Agreement. Additional criteria for approval include:

- Redistribution will typically be allowed only for refrigerated vaccines. We are evaluating the redistribution possibilities and parameters for ultra-cold vaccine.
- The entity must submit detailed policies and procedures related to redistribution.
- Vaccines may only be transported by motor vehicle.
- There may only be one level of re-distribution (e.g., once a vaccine is redistributed from the primary shipping local, it may not be redistributed again).

CDPH conducts the redistribution process annually with the flu vaccine. The process and criteria for approving redistribution requests specifically for COVID-19 vaccine are still being refined and will be shared when finalized. Only a limited number of organizations will be allowed to redistribute vaccines upon approval from the State. Therefore, the review, documentation, and approval process for these sites will be tracked separately from the provider enrollment interface. Approved Redistribution sites will be identified. Regardless of redistribution approval, sites will still be required to report all required elements (administration, inventory, etc.) for each site receiving vaccines.



G. Describe how your jurisdiction will ensure there is equitable access to COVID-19 vaccination services throughout all areas within your jurisdiction.

While local health departments will be responsible for enrolling providers and allocating vaccination doses, CDPH will be responsible for developing and providing an allocation framework, guiding principles and policies (following federal guidance) to guide provider allocations at the local level. We are evaluating how to develop criteria to identify unacceptable allocation strategies. CDPH will also closely follow provider allocations reflected in the orders. During this process, CDPH will retrospectively review the provider allocations (completed by local jurisdictions) after ordering the vaccines for fulfillment from CDC. CDPH will use visual data software to map provider enrollment and allocation information. The team will focus its review on ensuring vaccine access and delivery across all areas of the jurisdiction, especially in any area where critical populations have been identified for each phase. Moreover, the team will review this data for any gaps in coverage within geographical locations and provider types.

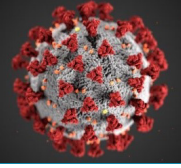
Lastly, vaccine allocations will also be reviewed by the CDPH ordering team for any general inconsistencies or irregularities. CDPH will follow up with the local jurisdiction, MCE, or relevant State or Federal entity to gather additional information where needed, or to confirm data prior to converting the local allocations into vaccine orders. Once the confirmation process is complete, the CDPH team will submit the vaccine orders to VTrckS for upload and transmission to CDC.

H. Describe how your jurisdiction plans to recruit and enroll pharmacies not served directly by CDC and their role in your COVID-19 Vaccination Program plans.

In collaboration with the California Immunization Coalition, the CDPH Immunization Branch is convening a Pharmacy Task Force devoted to recruitment and enrollment planning activities supporting pharmacy enrollment in the COVID-19 Vaccination Program. The Task Force will assess the interest of pharmacists and student pharmacists in participating in mass vaccination efforts, closed PODs, or other onsite vaccination services for critical populations.

The Task Force will play a critical role in identifying ways to distribute COVID-19 registration information to pharmacies across the state. The Task Force will also assess pharmacies' storage capacity readiness, and documentation in the state's IIS prior to enrollment phases.

Information will be shared with the California State Board of Pharmacy and the California Pharmacists Association. Local health departments will also play a key role in recruiting independent pharmacies that may not see statewide messages. The Pharmacy Task Force will work with chain pharmacies, independent pharmacies, and schools of pharmacy to coordinate with CDPH and local health departments in developing and implementing pharmacy-related COVID-19 vaccination activities.



Section 6: COVID-19 Vaccine Administration Capacity

Instructions:

- A. Describe how your jurisdiction has or will estimate vaccine administration capacity based on hypothetical planning scenarios provided previously.*

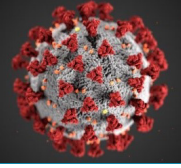
Within California, vaccination administration capacity will be handled and assessed at the local level. Local health departments have, for the last 15 years, been working on mass prophylaxis plans. These plans provide a solid foundation to identify how essential workers and critical infrastructure personnel can receive protective vaccines during a pandemic and how throughput estimates can be calculated.

Based on previously provided hypothetical planning scenarios, California jurisdictions will estimate vaccine administration capacity based on:

- The number of registered vaccination providers in local jurisdictions and who they have the ability to vaccinate (e.g. their employees or their patients, adult vs. pediatric populations).
- The number of sites that can serve as closed PODs to vaccinate emergency responder and critical infrastructure personnel who cannot be vaccinated by their employer.
- The COVID-19 vaccine storage capacity at the different vaccination settings/sites.
- The staffing levels at vaccination sites.
- The occupancy levels at indoor locations, taking all social distancing and infection control precautions into account.
- Possible clinic closures for outdoor settings due to inclement weather, fires, poor air quality etc.

Local jurisdictions have used tools such as [CDC's PanVax tool for Pandemic Vaccination Planning](#) in order to model different capacity scenarios. They have conducted collaborative exercises, measured patient throughput, and retained and documented best practices. Local health departments communicate with each other on a monthly basis to share best practices and they have also developed relationships with a variety of emergency responder agencies.

For instance, the San Francisco Bay Area has a regional planning group, the Bay Area Mass Prophylaxis Working Group (BAMPWG), which is working on a phone application to provide information and screening questions for point of dispensing (PODs) locations. Another regional group, the Southern Region Public Health Exercise and Emergency Response (SRPHER) Committee, is also pursuing cross-jurisdictional strategies to standardize communication tools in recognition that viruses do not adhere to geographical limitations.



At the time of this writing, California is surveying its acute care settings and health systems. The goal of this survey is to determine which settings have the capacity to not only vaccinate their own staff, but additional populations as well (e.g., employees employed at skilled nursing facilities not affiliated with a certain hospital). When this data is available, CDPH will share it with local departments so they can assess the throughput capacity and storage capacity of entities in their jurisdiction.

Additionally, when vaccine providers enroll in the new COVID-19 Provider Enrollment and Ordering Management System, they will be required to provide key data including storage capacity, staffing levels, and patient populations. Local health departments will be able to aggregate and assess this data for their entire jurisdiction, enabling officials to make data-driven allocation decisions to best maximize vaccination throughput.

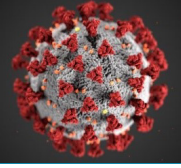
In September 2020, another COVID-19 survey conducted revealed that 34% of responding local health departments had calculated their estimated maximum daily throughput. Numbers ranged from 300 vaccinations per day (Madera County) to 118,750 per day (Los Angeles County). Those who did not include throughput estimates cited lack of knowledge about the vaccines to be administered.

Finally, this fall the majority of California's local health departments are conducting multiple seasonal influenza clinics to train staff and test the building blocks of their mass COVID-19 vaccination plans. Local plans emphasize prioritized and equitable dispensing of prophylaxis, transparency, communications, and collaboration between internal and external partners. It is, therefore, likely that the above-mentioned throughput estimates will be updated as more flu clinics and statewide exercises are conducted.

B. Describe how your jurisdiction will use this information to inform provider recruitment plans.

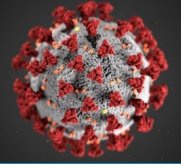
Local health jurisdictions will be equipped with data and information from numerous sources, which they will use to inform their provider recruitment plans. This data and information include:

- Metrics related to registered providers from the COVID-19 Provider Enrollment and Ordering Management System
- Vaccine volumes (based on county allocations)
- Guidance about priority groups from CDPH/ACIP about which populations are eligible for vaccination at any given time. During each phase of the vaccination program, state guidance will emphasize equity within priority groups, vaccine access for vulnerable populations, and vaccine access for those disproportionately impacted by COVID-19.



With this information at their disposal, local health jurisdictions will be able to determine which providers should be targeted for intentional recruitment. For instance, as California moves into Phase 2, local entities will be provided further guidance on recruiting primary and community care providers, school health centers, and providers who are able to vaccinate in alternate settings (such as group homes for individuals with disabilities or homeless shelters).

California will be providing rich data sets to local health jurisdictions that will contain, in many instances, health care facility information. Local jurisdictions, in turn, will be able to cross-reference these master lists with the lists of registered COVID-19 vaccine providers in order to identify gaps and then recruit to fill the gaps. Recruitment plans will also be informed by disease epidemiology. If, for example, outbreaks are identified within specific vulnerable populations in a specific city through reporting and contact tracing, local jurisdictions could reach out to the providers who traditionally see members in that population in an effort to address the outbreak. We anticipate that if recruitment and communication plans work as intended, California's primary challenge will be managing vaccine volume as opposed to provider recruitment.



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

Instructions:

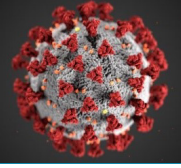
- A. Describe your jurisdiction's plans for allocating/assigning allotments of vaccine throughout the jurisdiction using information from Sections 4, 5, and 6. Include allocation methods for populations of focus in early and limited supply scenarios as well as the variables used to determine allocation.*

Due to the size and complexity of California's population, there will be multiple levels of allocation. All allocation decisions will be data-driven with an emphasis on equity and on protecting California's critical and vulnerable populations, especially during the early phases when vaccine supply will be limited.

As the first step in the allocation process, the federal government will allocate vaccines to the state. Next, the state will allocate vaccines directly to large multi-jurisdictional entities, such as health providers and systems with locations in multiple counties. After this direct allocation, the state will allocate vaccines to local health departments. Lastly, local health departments will allocate doses of vaccine directly to enrolled providers. Equitable distribution and transparency will be emphasized through every step of this process. The allocation decisions will be guided by the volume of vaccine related to the particular phase of distribution and the guidance of the Drafting Guidelines Workgroup, which is part of the Allocation Framework line of effort within the Governor's COVID-19 Vaccine Task Force.

The methodology for vaccine allocation, variables to consider during the different vaccine availability scenarios, and overall policies guiding vaccine allocations are still in the process of development. While CDPH's vaccination allocation methodology is still to be determined, allotments of doses to providers will consider the following variables:

- ACIP recommendations (when available)
- Estimated number of doses allocated to the jurisdiction and timing of availability
- Populations served by vaccination providers and geographic location to ensure distribution throughout the jurisdiction
- Vaccination provider site vaccine storage and handling capacity
- Minimizing the potential for wastage of vaccine, constituent products, and ancillary supplies
- Statewide epidemiologic data demonstrating areas with highest COVID-19 burden of disease
- Additional metrics including California's health equity metric, and other local factors



The allocation process will be a dynamic process and will need to respond to different scenarios as the vaccine becomes available. Once vaccine supply becomes available, approved allocation methodology will be applied to allot vaccine doses to each jurisdiction via the COVID-19 Provider Enrollment and Ordering Management System.

During the provider enrollment process, key information will be collected, including the specific numbers of critical populations of focus served by the providers. This information, including provider type, setting, and populations served will be used as guiding factors not only when the State allocates vaccines to local health departments, but key pieces of information (i.e., type of vaccine storage unit, or critical populations served) will be presented to local health departments in order to facilitate their allocation process within the vaccination scenarios listed in Section 5.

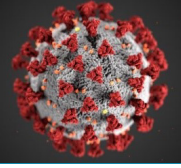
For information on our Allocation Data Team and how the vaccine will be allocated to critical populations, see Section 4.

B. Describe your jurisdiction's plan for assessing the cold chain capability of individual providers and how you will incorporate the results of these assessments into your plans for allocating/assigning allotments of COVID-19 vaccine and approving orders.

Local health departments are responsible for assessing the cold chain capacity of individual providers within their jurisdictions. To support these efforts, the state is incorporating fields related to cold chain capabilities as part of the new online provider enrollment system (COVID-19 Provider Enrollment and Ordering Management System, discussed in Section 5). As providers enroll via the system, they will be required to provide information related to their vaccine storage and temperature monitoring capacity. Local health departments will review this information as they decide whether to approve or deny the provider's enrollment (which they will have the authority to do).

During enrollment, the system will collect critical information related to providers' cold chain capabilities. This information includes data and photo uploads of the providers' storage and temperature monitoring equipment. Providers with unacceptable cold storage capacity will be alerted during the enrollment and flagged by the system, and local health department officials will be able to deny or cancel their enrollment. The system will not allow vaccines to be allocated to these providers.

To better understand current cold chain capabilities across the state, CDPH recently surveyed local health departments and hospitals to assess their current cold chain capacities for refrigerated, frozen and ultra-cold temperature storage transfer. The purpose of this survey was to better understand and assess the quantity and types of cold chain storage available in the state. The survey asked for the volume of each type of storage, the availability of



temperature monitoring equipment, the availability of transport equipment and the ability to surge if required. The results are currently being analyzed.

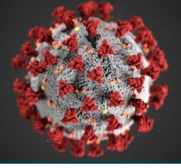
While the new provider system will provide an upstream mechanism for local health departments to assess the cold chain capacities of providers during enrollment, CDPH will develop a plan for ongoing assessment of cold chain capacities. The information collected by the new provider system during provider enrollment will be presented back to each local health department to help them make allocation decisions. CDPH will be able to provide critical data points related to cold chain capabilities for each individual provider. This data, alongside data about each local health department's vaccine balance and enrolled entities, will help local entities make informed allocation decisions.

C. Describe your jurisdiction's procedures for ordering COVID-19 vaccine, including entering/updating provider information in VTrckS and any other jurisdictional systems (e.g., IIS) used for provider ordering. Describe how you will incorporate the allocation process described in step A in provider order approval.

Orders will be placed on behalf of new and existing providers by local health departments via a COVID-19 Provider Enrollment and Ordering Management System which, in addition to processing enrollments, will also have the functionality to process orders. Each local jurisdiction, having received a total vaccine allocation, will be able to allocate doses to enrolled and approved providers following a set of guiding principles, processes, and timelines. These provider allocations will be pulled from the local health department allocations for state review, approval, and conversion to approved vaccine requests at a set frequency that is yet to be determined. After conducting their review and approval, state reviewers will place the vaccine order with the CDC using a different system that is currently in place. Orders will be exported out of the COVID-19 Provider Enrollment and Ordering Management System into VTrckS twice daily.

Vaccine re-orders will be submitted by enrolled providers via the COVID-19 Provider Enrollment and Ordering Management System. Provider re-orders for COVID-19 vaccines will require the reporting of on-hand inventory at the time of the vaccine order, and a summary of vaccine doses administered. Any vaccine wastage or authorized transfer must be reported through the same system. Vaccine re-order requested submitted by enrolled providers will be forwarded to the respective local health department for review, re-allocation, and approval.

While not necessarily a part of the ordering process, we have also developed rigorous procedures around shipping and delivery with a focus on address verification and accuracy. This begins with collecting provider shipping information upfront, which will be captured by the new



system as part of the provider enrollment process. Upon vaccine reorders, providers will be required to confirm current clinic receiving hours.

Prior to vaccine shipments being processed and submitted for fulfillment, several notifications of shipment processing will be sent to each site approved to receive vaccines. These notifications will take place at the following intervals:

- Shipment Processing Alert: One notification at least 48 hours prior to file transmission to CDC for fulfillment (Program generated email notification)
- Shipment Confirmation: One notification the day the order is submitted for shipment (System automated communication)

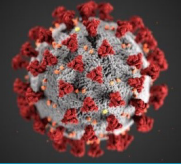
Notification will include timelines for receipt, information, and timelines for reporting shipment incidents (Shipment receipt acknowledgment built in the system). A key role for CDPH's COVID-19 Provider Customer Service Call Center will be to support enrolled providers with vaccine ordering, distribution, and shipment inquiries. This call center will be the primary point of contact to triage an array of vaccine management inquiries.

D. Describe how your jurisdiction will coordinate any unplanned repositioning (i.e., transfer) of vaccine.

Vaccine shipments must be stored at the location identified and approved as part of the provider enrollment application. However, in the rare cases that an unplanned transfer of the vaccine is required, local health departments will be primarily responsible for this repositioning. A repositioning request will be reported via the COVID-19 Provider Enrollment and Ordering Management System, indicating the reason for the repositioning, receiving location information, and vaccine inventory information. Upon approval, the receiving provider/location will have to accept the vaccine delivery and report received inventory within the system. Vaccine temperature documentation will be required to be provided upon request. Unauthorized redistribution of the COVID-19 vaccine will not be allowed.

CDPH can work with Cal OES and assist local health departments with both the transport and storage of vaccine if needed. CDPH has two locations and the vaccine can be repositioned to either the State RSS in West Sacramento (for Northern California) or to the Direct Relief® warehouse in Santa Barbara (for Southern California). Both locations have refrigerated and frozen storage capabilities.

In addition to offering these storage locations, CDPH has leased climate-controlled transportation equipment to assist with unplanned vaccine repositioning. This equipment, including active pallet shippers and box trucks, can be sent to local health departments to provide temporary storage space. For instance, if a rural provider experiences difficulty with



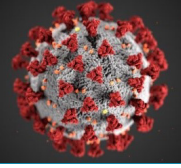
their cold chain storage equipment, CDPH is prepared to lend assistance in the form of replacement equipment.

CDPH is working with OES logistics and has developed a logistics annex document, which details the state's contingency plan in the event that vaccine administration sites, local health departments, and distribution centers cannot store the vaccine as planned. A regional ULT storage capability strategy is under development. State purchased ULT freezers and transport freezers will be positioned geographically to accommodate ULT vaccine redistribution whether planned or unplanned.

E. Describe jurisdictional plans for monitoring COVID-19 vaccine wastage and inventory levels.

Providers who are enrolled in the California COVID-19 Vaccination Program will be required to report inventory of on-hand COVID-19 vaccines as part of each submitted order. State officials who approve orders from local health departments and providers will monitor these levels as well as doses administered.

Currently, the COVID-19 Provider Enrollment and Ordering Management System is being configured to require submission of vaccine doses, lot numbers, and expiration dates as part of the re-order submission process. Additionally, an inventory management module is being built as part of the new system. This functionality will be adapted from existing influenza vaccine system functionality. The module will track overall vaccine supply allocated to the state, vaccine doses allocated, and vaccine doses ordered (both overall and within jurisdictions).



Section 8: COVID-19 Vaccine Storage and Handling

Instructions:

- A. Describe how your jurisdiction plans to ensure adherence to COVID-19 vaccine storage and handling requirements, including cold and ultracold chain requirements, at all levels:*
- *Individual provider locations*
 - *Satellite, temporary, or off-site settings*
 - *Planned redistribution from depots to individual locations and from larger to smaller locations*
 - *Unplanned repositioning among provider locations*

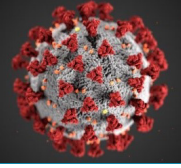
Ensuring adherence to COVID-19 vaccine storage and handling requirements, including cold and ultracold chain requirements, will be a joint effort between CDPH and local health departments. Based on CDPH's recent survey of local health departments, we determined that while many responding jurisdictions have some capacity to handle refrigerated vaccines, few have frozen capabilities for either storage or transport. Roughly half of the responding health departments have plans for purchasing or leasing additional cold chain storage equipment. If the vaccine requires frozen or ultracold chain storage and transport, and if enrolled providers cannot meet this requirement, CDPH will need to assist local health departments with cold chain. CDPH's preparations for this scenario are discussed in Section 7D.

The plans for ensuring adherence at all levels are as follows:

Individual Provider Locations

Provider adherence to storage and handling requirements will begin with an accurate assessment of a provider's capabilities during the enrollment process (see Section 5 for additional details). During enrollment, every provider will be required to complete training on proper vaccine handling and storage requirements. Furthermore, during their review of potential providers, local health departments will be able to approve or deny providers for enrollment based on vaccine storage and temperature monitoring equipment reported as part of the enrollment process. Local departments will review individual providers' storage and handling capacities, including uploaded photos of providers' storage equipment. With this robust upstream enrollment and vetting process, we will deter the enrollment of providers who lack the capacities to adhere to cold chain requirements. This initial assessment of the provider's ability to meet the requirements is the first step in ensuring adherence to those requirements.

If an enrolled provider fails to adhere to proper storage and handling requirements, future vaccine orders from that provider will not be fulfilled. All instances of vaccine mismanagement



and all instances of temperature excursions in any setting, including satellite, temporary, or off-site settings will be reported electronically to CDPH through the COVID-19 Provider Enrollment and Ordering Management System. The temperature excursion reporting process and supporting system functionality is already in place and used in California's Vaccine for Children program. These existing systems and processes will provide the basis for the managing and reporting temperature excursions for the COVID-19 vaccine.

In addition, CDPH will develop policies and processes for reporting such excursions to guide and inform providers. CDPH will receive and review all reports of excursions before sharing the information with local health jurisdictions. As part of the reporting process, providers will be required to submit a plan of corrective action, as well as provide documentation of vaccine viability determination obtained from the manufacturers. Providers must submit this information before they will be allowed to place orders for additional doses of COVID-19 vaccine. Lastly, local health departments will be responsible for determining if an order can be fulfilled.

CDPH plans to develop processes for determining re-orders in instances in which vaccine doses are lost due to negligent handling. Once these processes are developed, CDPH will share them with local jurisdictions. Vaccine viability determination processes will be implemented as soon as information is available from the CDC.

Satellite, Temporary, or Off-Site Settings

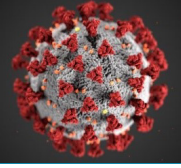
Specific guidance and requirements for COVID-19 vaccine management in these settings will be developed and included as part of provider training efforts (during enrollment and just-in-time trainings conducted at the local level). Additionally, in order to monitor adherence with vaccine management requirements, reporting requirements related to vaccine management, temperature, and inventory management will be developed and communicated to participating providers.

Planned Redistribution from Depots to Individual Locations and from Larger to Smaller Locations

Specific guidance and requirements for COVID-19 vaccine management during redistribution events will be developed and communicated to entities with CDPH approval to conduct vaccine redistribution. Sites will be required to submit protocols for vaccine management at the main depots, vaccine transport and relocation processes, equipment, and temperature monitoring, and receiving protocols.

Unplanned Repositioning Among Provider Locations

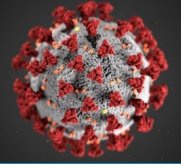
Please see Section 7D.



B. Describe how your jurisdiction will assess provider/redistribution depot COVID-19 vaccine storage and temperature monitoring capabilities.

The assessment and approval of provider/depot redistribution will take place at the state rather than the local level. We anticipate that planned redistributions of COVID-19 vaccine will apply to either: 1) health systems or multi-jurisdictional organizations with depots incorporated into their infrastructure, or 2) smaller providers needing less than the minimum order requirements. All planned redistribution requests will be handled directly by the CDPH Immunization Branch and not by local health departments.

Assessing the storage and temperature monitoring capabilities of entities who plan to redistribute the COVID-19 vaccine is part of the approval process, which is discussed in detail in Section 5F.



Section 9: COVID-19 Vaccine Administration Documentation and Reporting

Instructions:

- A. Describe the system your jurisdiction will use to collect COVID-19 vaccine doses administered data from providers.*

California has a confidential and secure Immunization Information System that will improve immunization coverage to protect all Californians from COVID-19. All COVID-19 vaccine doses administered data from providers will ultimately reside in California's Immunization Registry (CAIR).

California CAIR is comprised of three distinct registries: CAIR2; CAIR San Joaquin; and CAIR San Diego. All three registries support real-time immunization record query messages (QBP) and will return immunization histories or immunization histories plus forecasting in a response file (RSP). Each registry is accessed online to help providers and other authorized users track patient immunization records, reduce missed opportunities, and help fully immunize Californians against COVID-19. Figure 9.1 provides an overview of the California Immunization Registry.

CALIFORNIA COVID-19 VACCINATION PLAN

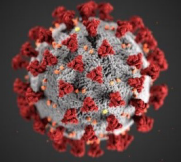
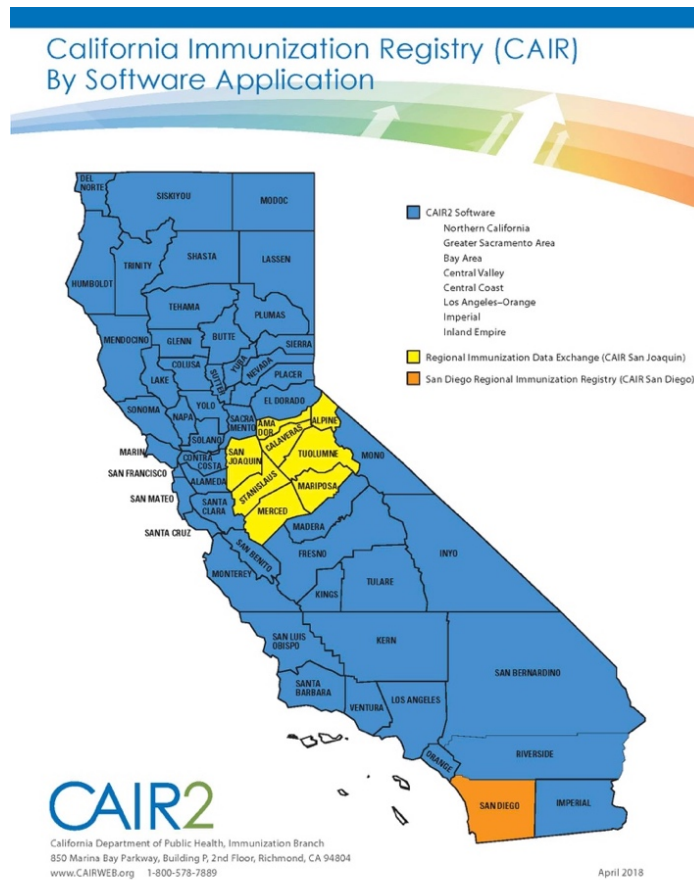


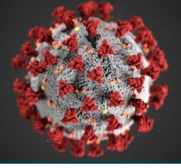
Figure 9.1: Overview of the California Immunization Registry



Dose information administered by providers will be entered into California's IIS through our proven and established methods including:

- 1) Data interface with providers' Electronic Health Records (EHR) systems;
- 2) PrepMod (which includes vaccine inventory control);
- 3) California Immunization Registry (CAIR2) Mass Vax online tools; and
- 4) Manual data entry into one of California's CAIR software applications.

Except for manual entry, all the other methods provide real time submission of standard HL7 VXU messages directly into California's IIS. Most of our providers have a data interface between California's IIS and their EHR system. However, if one of these methods should fail, California's providers will have at least two other alternative methods from the list above to record vaccine administration data.



B. Describe how your jurisdiction will submit COVID-19 vaccine administration data via the Immunization (IZ) Gateway.

During the COVID-19 vaccination campaign, our providers and other vaccine administration sites will be connected to California’s IIS. The CDC has created the IZ Gateway to facilitate a coordinated COVID-19 vaccination response and an up-to-date exchange of immunization data. The IZ Gateway **Connect** component enables large national provider organizations to report and query immunization data with multiple IIS, including California’s. This will also reduce the burden to national provider organizations by streamlining the onboarding process through connection to a single, centralized hub and offering centralized testing procedures.

Every 24 hours, California intends to transmit COVID-19 vaccine administration data from our three registries to the CDC. All three registries are prepared to submit vaccination data either through direct login access to the CDC IZ Data Lake or through the IZ Gateway **Connect** component. Plans are occurring so that CAIR2 is also ready to supply the requested de-identified data.

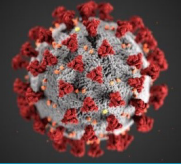
California understands that the CDC is still finalizing the reporting process and that data specifications will be shared as soon as they are available. California also understands that it will not be responsible for reporting data from federal agencies or commercial partners who receive vaccine allocations directly from the CDC.

Figure 9.2 includes each required data element that CDC has requested California transmit. Figure 9.3 includes each data element that will be optional for California to report. The CDC indicates that the optional data requirements will support additional national coverage analysis and vaccination monitoring efforts.

Figure 9.2: CDC Required Data Elements

IIS Required Data Element	Standard or Mass Vaccination*	California Source/Notes
Administered at location: facility name/ID	Standard	California IIS – exists
Administered at location: type	Standard	California IIS – exists
Administration address (including county)	Standard	California IIS – exists
Administration date	Standard	California IIS – exists
CVX (Product)	Standard	California IIS – exists
Dose number	Standard	California IIS – exists
IIS Recipient ID**	Standard	California IIS – exists
IIS vaccination event ID	Standard	California IIS – exists

CALIFORNIA COVID-19 VACCINATION PLAN



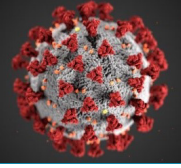
IIS Required Data Element	Standard or Mass Vaccination*	California Source/Notes
Lot Number: Unit of Use and/or Unit of Sale	Standard	California IIS – exists
MVX (Manufacturer)	Standard	California IIS – exists
Recipient ethnicity	Standard	California IIS – exists
Recipient race	Standard	California IIS – exists
Recipient address**	Standard	California IIS – exists
Recipient date of birth**	Standard	California IIS – exists
Recipient name**	Standard	California IIS – exists
Recipient sex	Standard	California IIS – exists
Sending organization	Standard	California IIS – exists
Vaccine administering provider suffix	Standard	California IIS – exists
Vaccine administering site (on the body)	Standard	California IIS – exists
Vaccine expiration date	Standard	California IIS – exists
Vaccine route of administration	Standard	California IIS – exists
Vaccination series complete	Mass Vaccination	California IIS – capability exists by running a query to generate this data element.

* STANDARD = CORE DATA ELEMENT COMMONLY COLLECTED DURING ROUTINE VACCINATION;
 MASS VACCINATION = MAY REQUIRE MASS VACCINATION MODULE OR ENHANCEMENT.

** IDENTIFIABLE INFORMATION

Figure 9.3: CDC Optional Data Elements

Optional Data Element	Standard or Mass Vaccination	California Source/Notes
Comorbidity status (Y/N)	Mass Vaccination	Not collected, no authorization in statute
Recipient missed vaccination appointment (Y/N)	Mass Vaccination	Not collected
Serology results (Presence of Positive Result, Y/N)	Mass Vaccination	Not collected in IIS
Vaccination Refusal (Y/N)	Standard	California IIS – exists



- C. Describe how your jurisdiction will ensure each COVID-19 vaccination provider is ready and able (e.g., staff is trained, internet connection and equipment are adequate) to report the required COVID-19 vaccine administration data elements to the IIS or other external system every 24 hours.*

CDC requires that vaccination providers enrolled in the COVID-19 Vaccination Program report certain data elements for each dose administered within 24 hours of administration. California will assess the capability of our COVID-19 vaccination providers to meet federal and California-specific reporting requirements before or upon enrollment. Each vaccination provider will also sign a Provider Agreement that stipulates the rules of engagement to participate in the COVID-19 Vaccination Program, which includes training, internet connection, and equipment requirements.

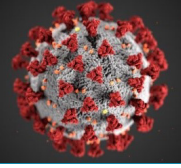
California will facilitate and monitor IIS reporting by enrolled vaccination providers. Each vaccination location will be ready (including trained staff, necessary equipment, and internet access) to report vaccine administration data to our IIS at the time of vaccination. If data will be entered off site, vaccination providers will be required to report dose data to California's IIS or other designated system within 24 hours. CDPH will also encourage that provider use PrepMod (for all three registries) and/or Mass Vax (specific to CAIR2) as they are mobile device compatible and transit the data in real time.

Every day of the week (including Saturdays and Sundays), CDPH will export the doses administered in the previous 24 hours from California's IIS as a flat file and/or HL7 batch file, based on the registry's capabilities. This will be submitted to CDC through the IZ Gateway (pending legal approval) and also retained by CDPH for analysis and state reporting. It remains to be determined whether the CAIR2 files sent to the CDC will be de-identified prior to transmission.

- D. Describe the steps your jurisdiction will take to ensure real-time documentation and reporting of COVID-19 vaccine administration data from satellite, temporary, or off-site clinic settings.*

As mentioned previously, CDPH will encourage providers to use PrepMod (for all three California Registries) and/or Mass Vax (for CAIR2 users) as these applications are mobile device compatible and also transmit an HL7 dataset in real time. All three of California's IISs are also preparing to provide additional support and technical assistance to smaller vaccination providers and for rural clinic settings to help them participate in the COVID-19 Vaccination Program. This includes accelerated onboarding and training using existing and possibly expanded staff based on the need.

We are preparing to provide additional support and technical assistance for smaller vaccination providers and for rural clinic settings to help operate the COVID-19 Vaccination Program. This



includes accelerated onboarding and training using existing and possibly expanded staff based on the need.

E. Describe how your jurisdiction will monitor provider-level data to ensure each dose of COVID-19 vaccine administered is fully documented and reported every 24 hours as well as steps to be taken when providers do not comply with documentation and reporting requirements.

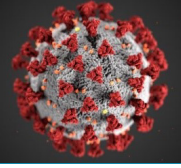
California intends to have 100% of its providers report at least every 24 hours. To ensure that providers are complying with this reporting requirement, CDPH will run daily queries from our IIS to determine whether the date for doses administered and the system entry date comply with the 24-hour reporting requirement. We will also establish robust technical assistance to assist the providers with compliance. Sites in violation will first be sent a warning notification along with information on how to obtain technical assistance to come into compliance. In extreme cases, sites repeatedly out of compliance could be denied vaccine reorders, per their Provider Agreement. CDPH is currently developing the processes to generate these compliance reports along with its specific compliance policies.

F. Describe how your jurisdiction will generate and use COVID-19 vaccination coverage reports.

California relies extensively on data to make informed policy and operational decisions. Our IIS will play a critical role in monitoring vaccine doses administered and generating vaccination coverage estimates among different population groups. Vaccination coverage reports will also help us estimate the percentage of people who have received specific COVID-19 vaccines to better understand how well our communities are protected from COVID-19. We will also use vaccination coverage reports to identify areas and groups with lower vaccination coverage so that our local public health departments, health care partners, and schools can take action to improve vaccination coverage and increase our population's protection from COVID-19.

California will generate a wide variety of county and state-level reports to monitor the vaccination campaign. For example, county coverage estimates will be calculated using census data denominators and whether allocations need to be revised. County level reports will be generated from the three registries comprising our IIS. State-level reports will be generated from a daily extract from the three registries systems.

While most providers will use their EHR system to run vaccine-related reports on their enrollees, both PrepMod and the provider's CAIR registry have ad hoc reporting capabilities available.



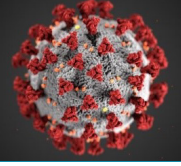
Section 10: COVID-19 Vaccination Second-Dose Reminders

Instructions:

- A. Describe all methods your jurisdiction will use to remind COVID-19 vaccine recipients of the need for a second dose, including planned redundancy of reminder methods.*

In addition to our public communication campaign to educate the public and remind them of 2nd dose requirements described in Section 12, CDPH is also establishing a notification process so that all COVID-19 vaccine recipients who need a second dose can be reminded in multiple ways. We will also deploy redundant processes to reach individuals using a variety of different methods. Dozens of current vaccines require multiple doses and California's providers have a strong track record of effectively reminding individuals to receive all the doses needed.

Each provider vaccination kit contains reminder cards that providers will give to each individual receiving their first dose with instruction when to return for the second dose. Participants will be encouraged to take a picture of the reminder card with their mobile phone so that the follow-up date will be with them at all times. Providers using PrepMod or another Vaccination Administration Management system will also be required to use the second dose reminder functionality in these applications. CDPH is also exploring either enhancing its IIS software or contracting with a vendor to systematically text, email, and/or auto-call individuals when their second dose is needed. If feasible, CDPH may also opt to use the IZ Gateway Docket application **Access** to notify individuals by email or through their cell phone.



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

Instructions:

- A. Describe your jurisdiction's solution for documenting vaccine administration in temporary or high-volume vaccination settings (e.g., CDC mobile app, IIS, or module that interfaces with the IIS, or other jurisdiction-based solution). Include planned contingencies for network outages or other access issues.*

California's COVID-19 vaccination providers will use our IIS to:

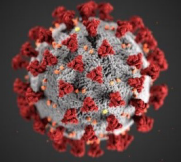
- Preregister or enroll in the COVID-19 vaccination program
- Place orders for COVID-19 vaccine
- Document vaccine administration
- Manage and report vaccine inventory
- Report vaccine spoilage/wastage
- Provide reminders to COVID-19 vaccine recipients indicating when the next dose of a multidose vaccine is due

To carry out these functions, our providers will use the CAIR2 Mass Vax application and the nationally available PrepMod application in both temporary and high-volume vaccination settings. Mass Vax allows easy data entry into a spreadsheet view with subsequent export of each dose to California's IIS in real time using the standard HL7 data format. In addition to these functions, PrepMod also allows providers to set up clinics as well as register critical infrastructure organizations to facilitate inviting employees to designated vaccination clinics. PrepMod also exports using the standard HL7 data format.

Both of these applications require Internet access. CDPH is creating contingency guidelines for the providers in the event that the Internet is not available or goes out. Since the goal is for vaccinations to continue uninterrupted with or without Internet or network access, we envision that in the event of an internet or network outage, the providers would use a pre-downloaded paper vaccine administration form to record vaccination data. After Internet access is restored, providers would then input this data into whichever electronic system (EHR, IIS, Mass Vax or PrepMod apps) they use for data entry within 24 hours.

- B. List the variables your jurisdiction's IIS or other system will be able to capture for persons who will receive COVID-19 vaccine, including but not limited to age, race/ethnicity, chronic medical conditions, occupation, membership in other critical population groups.*

Through its IISs, California is capturing **all** of the CDC-required data elements published in the CDC COVID-19 Vaccinations Program Interim Playbook for Jurisdiction Operations (Version 1.0,



dated September 16, 2020). In regard to the CDC optional data elements, California's IIS captures vaccination refusal data. See Section 9B of this document for additional information.

C. Describe your jurisdiction's current capacity for data exchange, storage, and reporting as well as any planned improvements (including timelines) to accommodate the COVID-19 Vaccination Program.

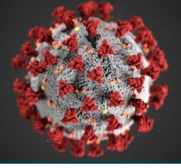
CDPH is committed to scaling up as necessary to meet the COVID-19 vaccine data requirements. For example, to address the anticipated increased demand in IIS transactions CDPH is upgrading its IIS server infrastructure with additional capacity, building in redundancy measures, and creating a more robust hardware and database backup architecture strategy. In addition, CDPH is examining the versions and compatibility of its IIS-related software to determine if any software components can be upgraded. Through these steps CDPH's IT infrastructure will be well positioned to support the COVID-19 Vaccination Program.

D. Describe plans to rapidly enroll and onboard to the IIS those vaccination provider facilities and settings expected to serve healthcare personnel (e.g., paid and unpaid personnel working in healthcare settings, including vaccinators, pharmacy staff, and ancillary staff) and other essential workers.

CDPH has completed analysis of IIS participation among our state acute care hospitals and long-term care facilities (LTCF). In our CAIR2 region, 341 of the 397 acute care hospitals (86%) have been onboarded to the IIS. Of the remaining 14%, rehabilitation hospitals represent the majority of the 56 non-participating acute care facilities. In CAIR San Diego, 23 out of 27 (85%) of the acute care hospitals participate in the San Diego Immunization Registry (SDIR). In CAIR San Joaquin, the Regional Immunization Data Exchange (RIDE) has reported 0 of 25 (0%) acute care hospitals enrolled. CDPH will be collaborating with RIDE representatives to increase these participation rates.

California has 1,109 licensed LTCFs. The LTCFs contract out with other entities to provide its residents with vaccinations and are not a typical partner in our IIS. This is reflected in their IIS low enrollment rates. In the CAIR2 region, 10 out of 1,052 LTCFs are currently enrolled. In the CAIR San Diego region, 1 out of 80 LTCFs are currently enrolled. And California's RIDE reported none of its LTCFs are currently enrolled.

In anticipation of the COVID-19 vaccination program, CDPH will conduct an outreach campaign to the appropriate non-participating hospitals and LTCFs to encourage them to join the IIS. CDPH has staff available to assist with quick onboarding of hospitals and other priority health care providers with both electronic health records and manual data entry. Since the mass vaccination for COVID-19 will be a one-time event, non-participating acute care hospitals and



LTCFs will also be offered use of the PrepMod and Mass Vax applications to document COVID-19 vaccinations.

While the onboarding process is well worked out and not time consuming, CDPH also plans to evaluate and standardize the onboarding process for all providers in California in order to:

- Enhance provider communications and collaboration.
- Improve onboarding process efficiencies by streamlining activities.
- Provide the most appropriate support tools and technologies.
- Monitor the number of providers (such as LTCFs) waiting to be onboarded and the amount of time providers spend in the onboarding process from start to finish. Currently, there are no entities on the waiting list.

*E. Describe your jurisdiction's current status and plans to onboard to the IZ Gateway **Connect** and **Share** components.*

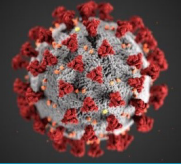
Connect enables large national and non-traditional vaccination providers for satellite, temporary, and off-site clinic settings to report and query immunization data with California's IIS, using an IZ Gateway centralized data exchange. This also eliminates the need for multiple individual and point-to-point connections. It is California's intent to onboard to the **Connect** component but we will first use direct login access to the CDC IZ Data Lake. Two of our registries (CAIR San Diego and CAIR San Joaquin) have completed testing and prepared to submit vaccination data through the **Connect** component. Plans are occurring so that CAIR2 is also ready to supply the requested de-identified data.

Share allows immunization data to be exchanged between California's IIS and other states' IIS for people immunized outside of their jurisdiction. **Share** routes a person's immunization data to their state of residence through the IZ Gateway. California is not planning to participate in the **Share** component at this time. Please see response to Question F3 below.

F. Describe the status of establishing:

- *Data use agreement with the Association of Public Health Laboratories to participate in the IZ Gateway*
- *Data use agreement with CDC for national coverage analyses*
- *Memorandum of Understanding to share data with other jurisdictions via the IZ Gateway **Share** component*

CDPH and APHL have reached consensus on the data use language and will soon be signing the APHL data use agreement.



CDC has not yet released the data use agreement for national coverage analyses but will make it available for our jurisdiction's review when it is finalized.

To enable the **Share** component, California would need to execute an Interjurisdictional MOU with jurisdictions with which we would exchange data. The MOU allows data exchange to occur through the IZ Gateway or an alternative mechanism with any state or jurisdiction that signed the MOU. California is not planning to participate in the **Share** component until we mutually agree on the MOU language with our neighboring states.

G. Describe planned backup solutions for offline use if internet connectivity is lost or not possible.

If a provider loses internet connectivity, California has three contingency plans including:

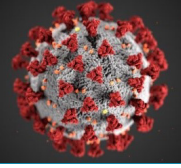
- 1) Providers with EHRs will submit their vaccination data to the IIS when their internet connectivity resumes.
- 2) Providers without EHRs will be encouraged to install and use the PrepMod application, which will continue to record vaccination data until internet connectivity resumes and then submit the data after an internet connection is reestablished.
- 3) In the event California's IIS is not accessible, CDPH is installing a message broker (e.g. Rhapsody) in front of the IIS that will assist in preserving incoming data from the providers.

In addition, CDPH will hold focus groups with its providers in rural areas to determine and implement backup solution(s) that best meet their needs in the event of an internet disruption. As mentioned previously, CDPH will also design a downloadable vaccine administration form that sites will be able to download and print as a back-up in case the internet is down during vaccination events.

H. Describe how your jurisdiction will monitor data quality and the steps to be taken to ensure data are available, complete, timely, valid, accurate, consistent, and unique.

California has robust measures in place to continually improve the data quality within our IIS dataset. Historically this has been very effective to monitor and improve our data quality, as described through the following seven data quality factors:

Available – We have implemented functionality in our IIS that immunization program staff can use to generate both canned and ad hoc coverage assessments. Our IIS has the ability to generate provider level coverage assessments based on numerous query parameters (e.g., a patient age group/DOB range, list of specific individuals, geographic area, recipients of specific COVID-19 vaccines) and use them for provider quality improvement activities. Our IIS can generate population-based coverage assessments



based on query parameters (e.g., a patient age group/DOB range, list of specific individuals, geographic area, recipients of specific vaccines) to identify under-immunized populations. Our IIS data has the ability to support the Healthcare Effectiveness Data and Information Set (HEDIS) and other performance reporting requirements.

Complete – All of the required data fields for each vaccination record is subjected to the data validation and editing rules embedded in our IIS. This helps ensure each dataset is complete.

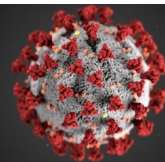
Timely – We regularly assess and improve immunization program and provider workflows to ensure timely vaccination record receipt. We have established bidirectional data exchange with provider sites to ensure that providers can submit immunization data to the IIS in a timely manner as well as query the IIS for evaluations and forecasting. We have previously implemented tools and processes to decrease the time to onboard provider sites to the IIS and committed to increase the associated staffing if warranted. Queries will be run to evaluate the time lag between administering and receipt of the dose by IIS. Providers with lag times of greater than 24 hours will be contacted and warned that their submissions are late.

Valid – All vaccines administered in California are evaluated against ACIP recommendations.

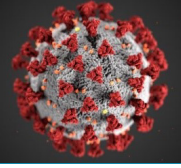
Accurate – The CAIR software contains built-in quality assurance and validation features to identify inaccurate or missing data entered into the registry. We have instituted methods for providers to submit updates of each patient’s status. We have established a collaborative process to update and review status of those receiving vaccines. We will cross reference site shipment data with incoming CVX codes to verify dose submission accuracy. And we will run queries frequently to identify erroneous CVX codes and take action, as appropriate.

Consistent – We actively participate in the American Immunization Registry Association’s (AIRA) Measurement and Improvement (M&I) Initiative in all the topic areas to achieve consistency with IIS standards. To address areas not fully validated within each M&I topic we initiate process and/or IIS system changes. We document local variations from the current CDC HL7 implementation guide, including the policy justification; and actively seek to eliminate variations not required by policy.

Unique – We have developed and documented standard operating procedures for routine matching and merging of incoming patient records. We routinely analyze provider and IIS level patient demographic and vaccination data to identify and correct duplicate vaccine and demographic records. We periodically assess the effectiveness of



our IIS vaccine deduplication algorithm and routinely identify and implement any needed improvements.



Section 12: COVID-19 Vaccination Program Communication

Instructions:

- A. Describe your jurisdiction's COVID-19 vaccination communication plan, including key audiences, communication channels, and partner activation for each of the three phases of the COVID-19 Vaccination Program.*

Introduction

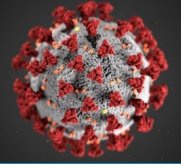
California's COVID-19 vaccination communication plan is focused on ensuring everyone living in California receives timely, accurate and actionable information about COVID-19 vaccination. The communication plan aligns with the COVID-19 vaccine distribution timeline and will be implemented throughout four phases: Pre-vaccine, limited doses available (Phase 1), large number of doses available (Phase 2), and sufficient supply of doses for entire population (Phase 3).

The communications plan also aligns with the State's health equity metric, which helps guide California's counties in their continuing efforts to more effectively fight COVID-19. The equity metric is designed to reduce cases in the most disproportionately impacted communities, as defined by the census tracts in the lowest quartile of the Healthy Places Index within larger counties, and as defined by population and geography by the local health departments in smaller counties (where census tracts cannot be used).

California's vaccine communication planning includes input from subject matter experts (SMEs) in crisis communications, public affairs, and immunizations, and leverages health equity work already underway at the state and local levels. The planning effort includes several key workstreams:

- Education and guidance documents and a public web portal
- External outreach and stakeholder engagement
- A public information/media campaign
- Internal communications
- Media outreach and engagement
- Public information and rapid response/crisis communication hubs

The complexities of the COVID-19 vaccination program require timely, accessible, and effective public health and safety guidance developed by immunization and health education specialists. CDPH subject matter experts will work closely with federal and local partners to create the appropriate guidance and public dissemination through a web portal and other communication channels.



Extensive public and stakeholder engagement is already underway, with a focus on tailoring messages to key populations and vulnerable communities to ensure maximum vaccine acceptance and trust in public health and in the COVID-19 vaccine. These ongoing public and stakeholder engagement efforts will focus on vaccine safety, efficacy, and allocation.

A public information campaign will be conducted throughout Phases 1-3 to support vaccine confidence and uptake by populations to be indicated within each phase. With research-tested messages and creative assets, the campaign will have an all-channel approach including social/digital, broadcast, and out-of-home (OOH). Campaign materials will be available in California's Medicaid ("Medi-Cal") threshold languages.

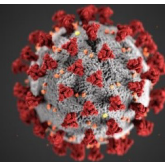
Internal communications for the state and local public health workforce also will be integral to California's communication efforts. Research shows the local and state public health workforce, as well as primary care providers, are the most trusted sources of information for COVID-19. This will be leveraged by ensuring a robust internal communications effort with California's public health and healthcare delivery workforce.

Additionally, the public communication effort will include our existing public information hub (call center) as well as a rapid response and crisis communication team working with our State Joint Information Center that will actively monitor and engage on traditional and social/digital media outlets to ensure the crisis and emergency risk communication (CERC) principles: be first, be right, be credible, express empathy, and show respect. For our providers, we will stand up a dedicated statewide call center to quickly address their questions and provide technical assistance when needed.

COVID-19 Vaccination Communication Objectives

California will ensure effective communications before, during, and after the COVID-19 vaccine is available to help communities understand the importance of vaccination as well as the benefits and any risks. Communicating what is currently known, regularly updating this information, and continuing dialogue with media and other partners throughout the vaccine distribution and administration process is essential to establish and maintain trust and credibility. Therefore, we are employing the following overall communication objectives for this plan:

- Educate the public about the development, authorization, distribution, and execution of COVID-19 vaccines and that situations are continually evolving.
- Ensure public awareness of the approval or authorization process, safety, and efficacy of COVID-19 vaccines, including differences in FDA emergency authorization and FDA approvals (i.e., licensure).



- Coordinate with internal and external partners to understand their key considerations and needs related to COVID-19 vaccine program implementation.
- Engage in active, timely, accessible, and effective public health and safety messaging along with outreach to key state/local partners and the public about COVID-19 vaccines.
- Provide guidance to local health departments, clinicians, and other hosts of COVID-19 vaccination provider locations.
- Monitor public receptiveness to COVID-19 vaccination messaging across the state as well as emerging issues. Rapidly respond to emerging issues using the CERC principles: be first, be right, be credible, express empathy, and show respect.

Messaging Tailoring for Specific Audiences

Communication messaging will be tailored by audience and developed with consideration for health equity using plain language. The recommendations will be appropriate for the social, linguistic, economic, cultural, or religious context of the intended audience. The information will be presented in culturally responsive ways and in languages that represent California's communities. The messages, creative assets, and spokespeople will address all people inclusively, with respect, using non-stigmatizing, bias-free language.

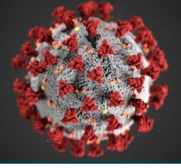
Communication Plan by Vaccination Phases

Pre-Vaccine

Before the vaccine is available, communication activities will be conducted to:

- Improve social acceptance and drive uptake of COVID-19 vaccine by communicating what we know about vaccine development process, safety, and efficacy;
- Identify and engage with partners and stakeholders, and establish plans for convening and communicating throughout vaccine planning and implementation;
- Share and get feedback on vaccine prioritization and delivery plans; and
- Provide guidance and support to interventions focused on achieving health equity among vulnerable populations at the state and local level.

Key audiences during this phase include: local health jurisdictions (LHJs); agencies, organizations, employers, and unions representing vulnerable populations (African American, Latinx, Native American, people with disabilities, elderly) and critical workforce; internal, external, and community partners and organizations; and the general public. Communication channels will vary according to audience, and include traditional and digital media, CDPH-sponsored websites, webinars, email, and more, including our existing public call center to ask questions. California will collaborate with local agencies, our Community Vaccine Advisory Committee, and other partners to disseminate information and reinforce messaging throughout the vaccination phases.



Phase 1: Limited doses of vaccine available

While vaccine dissemination is prioritized for critical infrastructure workforce during Phase 1, communication activities will be conducted to:

- Keep all audiences informed of relevant developments in vaccine authorization, distribution, prioritization, and access;
- Prepare LHJs, providers, and other vaccinators to execute vaccine allocation and administration to critical workforce; and
- Collaborate with agencies, organizations, professional associations, and unions to reach the various critical workforce sectors for vaccine promotion and administration.

Key audiences during this phase include healthcare personnel, long-term care facility residents, and critical infrastructure workforce (e.g., emergency and law enforcement personnel, agriculture workers, grocery and food industry workers). Depending on prioritization guidelines, this phase may also include people in correctional facilities or other congregate living facilities.

Phase 2: Large number of vaccines available

As the vaccine is made available to the general population during Phase 2 communication activities will be conducted to:

- Provide credible vaccine information and dispel any myths surrounding vaccinations;
- Promote vaccination among the general population through a targeted campaign utilizing a mix of traditional and social media; and
- Partner with internal and external stakeholders, such as community-based organizations, employers, public and private health plans, faith-based groups to reach California's most vulnerable communities (African American, Latinx, Native, people with disabilities, elderly, and other populations) and provide outreach and education about COVID-19 vaccination.

Phase 3: Sufficient supply for entire population

When vaccine is widely available and incorporated into the routine vaccination schedule during Phase 3, communication activities will be conducted to:

- Promote vaccination through public information campaigns; and
- Update and develop public and provider materials and resources.

Key audiences during this phase include the general public, providers, public and private health plans, and communities where disparities in COVID-19 vaccination persist. Figure 12.1 provides a preliminary list of key audiences, communication channels, and partners.

CALIFORNIA COVID-19 VACCINATION PLAN

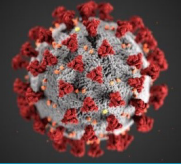
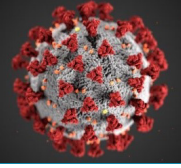


Figure 12.1: Key Audiences, Communication Channels, and Partners

Key Audiences	Phases	Distribution Channels	Partners
Critical Infrastructure (non-healthcare)	Pre-vaccine, Phase 1	Stakeholder and partner networks (e.g., <i>promotoras</i>); traditional earned media and social channels	Employers Trade and other Associations (UFCW) Local Government CBOs FQHCS Health and Hospital Systems
Healthcare Workers	Pre-vaccine, Phase 1	Stakeholder and partner networks; traditional earned media and social channels	Employers Trade and other Professional associations (CAHF, CHA, CNA, SEIU, etc.) State Partners – EMSA, CDSS, DHCS, DSH, DDS, etc. Hospital Systems
General Public	Pre-vaccine, Phases 1, 2, and 3	Traditional and social/digital media, OOH, websites, patient materials and resources	Traditional and social/digital media outlets State and Local Government agencies Employers Trade and other Associations CBOs and faith-based organizations Philanthropic Partners (California Endowment, etc.) FQHCS Health Plans Hospital Systems

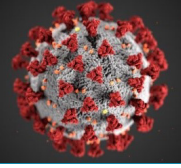
CALIFORNIA COVID-19 VACCINATION PLAN



Key Audiences	Phases	Distribution Channels	Partners
African American communities	Pre-vaccine, Phases 1, 2, and 3	Traditional and social media, OOH, CBOs including faith-based	CBOs including faith-based organizations Earned and social media outlets Philanthropic Partners State and local health departments
Latinx communities	Pre-vaccine, Phases 1, 2, and 3	Traditional and social media, OOH, CBOs	CBOs Earned and social media outlets Philanthropic Partners State and local health departments
Native American communities	Pre-vaccine, Phases 1, 2, and 3	Traditional and social media, OOH	Indian Health Services CA Tribal Advisor Office CBOs
Local Health Departments	Pre-vaccine, Phases 1, 2, and 3	All County Calls, email, webinars, LHD website	IZ Coordinators, CCLHO

In addition to the key audiences, the Communication Plan will include information about vaccination logistics along with other critical messages. We will establish points of contact (POCs) for each organization, employer, or community (as appropriate) within the critical population groups to improve message dissemination. Partnerships with trusted community organizations will facilitate early agreement on communication channels and methods for rapidly disseminating information and ultimately ensuring these groups have access to vaccination. Some of these partners include:

- Community Health Centers
- FQHCs
- RHCs
- Critical access hospitals
- Pharmacies
- Organizations and businesses that employ critical workforce
- First responder organizations
- Non-traditional providers (e.g., community health workers, doulas) and locations (e.g., dialysis centers, community centers) serving people at higher risk for severe illness
- Other locations or facilities for shared or congregate housing serving people at higher risk for severe illness (e.g., homeless shelters, group housing, correctional facilities, senior living facilities)



- Locations where people 65 years of age and older gather (e.g., senior centers, food pantries)
- Religious groups and other community groups
- In-home care organizations
- Schools and institutions of higher learning

Communications to local health jurisdictions, multi-county entities, health plans, providers, and other partners are an integral part of our overall communications plan.

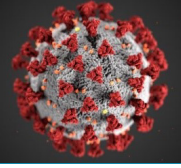
B. Describe your jurisdiction's expedited procedures for risk/crisis/emergency communication, including timely message development as well as delivery methods as new information becomes available.

Clear and effective communication will be essential to implementing a successful COVID-19 vaccination program. Building vaccine confidence broadly and among groups anticipated to receive early vaccination, as well as dispelling vaccine misinformation, are critical to ensure vaccine uptake. From the pre-vaccine phase and onward, our key approach to COVID-19 vaccine communications is to be transparent and proactive. We will establish a rapid response and crisis communication hub that will employ the CERC principles, used by public health professionals and public information officers, to provide information that helps people, stakeholders, and entire communities make the best possible decisions for themselves and their family members.

Anticipating changing public demand, adverse events, distribution errors, and other occurrences, we will develop messages and talking points that utilize traditional and social media, community-specific trusted messengers, and other established channels to widely disseminate updated messages quickly. Timely, proactive, and transparent communications with HCPs and other vaccination partners as issues arise will also be critical, and our established communication channels (professional associations, listservs, health plans, etc.) will allow for information to be relayed quickly.

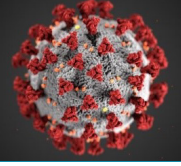
California has an expedited process in place to issue urgent public health communications. For COVID-19 vaccinations, we are establishing a rapid response and crisis communication hub that will include trusted spokespeople and ambassadors to support positive vaccine messaging throughout the implementation phases, including when responding to risk and crisis situations. Our rapid response and crisis communication efforts will augment the multi-channel communication activities to ensure early, effective communications throughout entire vaccination program:

- Communicate early about the safety of vaccines in general and have easily-accessible government information to address myths, questions, and concerns.



- Keep the public, public health partners, and healthcare providers well-informed about COVID-19 vaccine(s) development, recommendations, and public health’s efforts.
- Engage and use a wide range of partners, collaborations, and communication and news media channels to achieve communication goals, understanding that channel preferences and credible sources vary among audiences and people at higher risk for severe illness and critical populations, and channels vary in their capacity to achieve different communication objectives.
- Communicate proactively whenever possible, anticipating issues and forecasting possible problems before they reach broad awareness.
- Ensure that communications meet the requirements of the Americans with Disabilities Act, the Rehabilitation Act, the Patient Protection and Affordable Care Act, the Plain Language Act, and other applicable disability rights laws for accessibility.
- Use information and education campaigns to extend reach and increase visibility of vaccine recommendations and resources.
- Work closely with partner agencies, representatives of local communities with critical populations, and intermediaries to achieve consensus on actions, consistency in messages, and coordinated communication activities.
- Communicate transparently about COVID-19 vaccine risks and recommendations, immunization recommendations, public health recommendations, and prevention measures.

California’s COVID-19 Vaccination Program will have lasting effects on the nation’s immunization system and overall vaccination efforts in the future. Using risk communication principles along with the CDC’s recently developed Vaccinate with Confidence framework, jurisdictions can develop and implement timely, evolving plans as the foundation for their overall COVID-19 vaccination communication efforts.



Section 13: Regulatory Considerations for COVID-19 Vaccination

Instructions:

- A. Describe how your jurisdiction will ensure enrolled COVID-19 vaccination providers are aware of, know where to locate, and understand the information in any Emergency Use Authorization (EUA) fact sheets for providers and vaccine recipients or vaccine information statements (VISs), as applicable.*

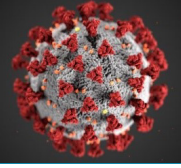
In order to enroll for receipt of the COVID-19 vaccine, providers must agree to the provisions of the CDC COVID-19 Vaccination Program Provider Agreement. When providers enroll through the COVID-19 Provider Enrollment and Ordering Management System they will move through a multi-step registration, training, enrollment, and approval process. During this robust process they will sign and agree to the CDC provisions, complete required training, and acknowledge the receipt of training and educational materials. These materials will include any Emergency Use Authorization (EUA) fact sheets, Vaccine Information Statements (VISs), and links to related background or supporting materials. As a whole, this rigorous provider onboarding process is designed to ensure that all providers are aware of, know where to locate, and understand all information they need in order to safely administer the COVID-19 vaccine.

For further details on the COVID-19 Provider Enrollment and Ordering Management System, see Section 5A. For further details on provider training, see Section 5E.

- B. Describe how your jurisdiction will instruct enrolled COVID-19 vaccination providers to provide Emergency Use Authorization (EUA) fact sheets or vaccine information statements (VISs), as applicable, to each vaccine recipient prior to vaccine administration.*

Enrolled COVID-19 vaccination providers will be instructed to provide EUA fact sheets or VIS statements (as applicable) to each vaccine recipient at multiple points, including provider enrollment/registration, training, and upon shipment of vaccine to the provider. As providers move through the onboarding process discussed in Section 13A above, they will not only receive training on the materials themselves, but on how to provide those materials to recipients. For further details on the COVID-19 Provider Enrollment and Ordering Management System, see Section 5A. For further details on provider training, see Section 5E.

Due to the size and diversity of California's population, it is critical that all vaccine recipients have the opportunity to receive and understand any applicable fact sheets or statements in their threshold language. California has a successful history of providing equitable access to such information by producing and sharing fact sheets in additional languages and it will continue with this tradition.



Section 14: COVID-19 Vaccine Safety Monitoring

Instructions:

- A. Describe how your jurisdiction will ensure enrolled COVID-19 vaccination providers understand the requirement and process for reporting adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).*

In order to enroll for receipt of COVID-19 vaccines, providers must agree to the provisions of the CDC COVID-19 Vaccination Program Provider Agreement, which requires providers' organizations to report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS). When providers enroll through the COVID-19 Provider Enrollment and Ordering Management System, they will be required to sign and agree to all of the terms and conditions in the CDC agreement. Moreover, the new system will deliver training to providers on a number of topics, including the use of VAERS. For further details on the COVID-19 Provider Enrollment and Ordering Management System, see Section 5A. For further details on provider training, see Section 5E.

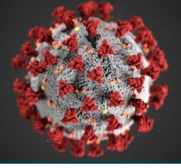
Through these mechanisms, CDPH will continue to build on its longstanding practice of directing immunizers in California to VAERS. Through its communications and website regarding COVID-19 immunization, CDPH will continue to provide information about VAERS and refer providers to VAERS to report adverse events after immunization. Providers contacting CDPH regarding adverse events will continue to be referred to VAERS for reporting. CDPH will also share the below information below about how to report to VAERS and find VAERS data.

How to Report to VAERS

- You can report to VAERS online at <https://vaers.hhs.gov/index>
- For further assistance reporting to VAERS, visit <https://vaers.hhs.gov/index> or contact VAERS directly at info@VAERS.org or 1-800-822-7967.

VAERS Data are Available to the Public

VAERS data can be downloaded at <https://vaers.hhs.gov/data/index> or searched at <http://wonder.cdc.gov/vaers.html>. Privacy is protected and personal identifying information (such as name, date of birth, and address) is removed from the public data.



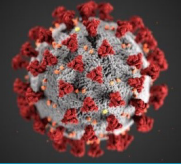
Section 15: COVID-19 Vaccination Program Monitoring

Instructions:

- A. Describe your jurisdiction's methods and procedures for monitoring progress in COVID-19 Vaccination Program implementation, including:*
- *Provider enrollment*
 - *Access to COVID-19 vaccination services by population in all phases of implementation*
 - *IIS or other designated system performance*
 - *Data reporting to CDC*
 - *Provider-level data reporting*
 - *Vaccine ordering and distribution*
 - *1- and 2-dose COVID-19 vaccination coverage*

Regular progress monitoring will be key to successful implementation of the COVID-19 Vaccination Program. One or more project managers (PM) will be assigned to monitor progress across all aspects of the implementation, including provider enrollment, access to vaccination services, IIS and other designated system performance, data reporting to CDC, provider-level data reporting, vaccine ordering and distribution, vaccine coverage, and other areas as defined by the COVID-19 Vaccine Task Force Working Group. The PM will work with Task Force leadership and members to identify required metrics and standards and to develop reports for all identified areas; the Task Force will also receive input during regular meetings from all Task Force workgroups and the PM. The PM will identify recipients of these reports at county and state levels; develop processes for gathering, documenting, and reporting data from county and state-level sources; and prepare reports and dashboards, including CDC dashboards, to share collected data at agreed-upon frequencies. Our methods and procedures include:

Provider enrollment – California has over 4,000 vaccination providers enrolled in our Vaccines for Children program and over 500 federally qualified health center enrolled in our Vaccines for Adults program. We also have contact information for all acute care hospitals and licensed long-term care facilities. We will not only be sharing this information with local health jurisdictions so that they can check their enrollment numbers, we will also be able to cross reference our lists with data derived from the COVID-19 Provider Enrollment and Ordering Management System. Cross referencing this data with the vaccine distribution phase will enable us to identify gaps and thus perform targeting recruitment or investigations to bring on more applicable providers for that point in time.



Access to COVID-19 vaccination services by population in all phases of

implementation—Access to vaccination services will be monitored from reports generated by our IIS platforms and from additional applications such as PrepMod or potentially VAMS. Access issues will primarily be identified at the county level and will be discussed during our regular conference calls. We already have a robust call infrastructure set up for different audiences, including hospitals, long-term care, providers, and local health jurisdictions where vaccine implementation including access issues will be discussed and best practices shared. Finally, we will be monitoring the CDPH public call center for issues/complaints about access and perform subsequent follow-up as appropriate.

IIS or other designated system performance – The IIS platforms in California are continuously monitored and they will be even more scrutinized with the additional data traffic as a result of COVID-19 vaccine program. Please see Section 11 for more detail.

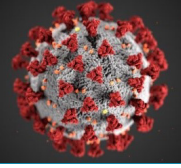
Data reporting to CDC – This is described in detail in Section 9.

Provider-level data reporting – Provider level data reports will be available through our IIS platforms to local health department staff who will be able to compare their allocations with the number of administered doses to take action when necessary. Provider-level reports will also be available to CDPH staff for state-wide data monitoring. This is also described in greater detail in Section 9.

Vaccine ordering and distribution – Both CDPH and local health jurisdictions will have the ability to monitor vaccine orders through the Provider Enrollment and Ordering Management System. CDPH will also be able to track shipments from McKesson and other central distributors to assist with troubleshooting if there are unforeseen delays or problems with shipment quantities. If there are large scale issues that could necessitate informing the public of delays, we will employ our Communications team to get the updates out quickly. See Sections 5 and 12 for additional information.

1- and 2-dose COVID-19 vaccination coverage – Vaccination coverage reports will be pulled regularly from our IIS platforms and ancillary applications such as PrepMod or VAMS. One and two-dose coverage reports are a foundation of the COVID-19 vaccine monitoring plan and data will be available to both the local health jurisdictions and CDPH so that targeted outreach or interventions can take place where needed to improve completion and/or coverage rates.

CDPH has established a robust chain-of-command infrastructure to ensure timely information sharing occurs and identified problems are quickly escalated to executive leadership, evaluated,



and acted upon to mitigate any disruptions in ordering, tracking, distribution, supplies, or administration.

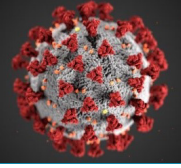
Evaluation of the monitoring data against allowable thresholds will allow the State to make mid-course corrections to meet its vaccination goals. The Governor's COVID-19 Vaccine Task Force will address areas or efforts that fall short of expected metrics or deadlines, developing and implementing intervention and resolution plans as needed.

The State will also conduct regular meetings with the local health departments and providers, leveraging these opportunities to report on progress and obtain input on local jurisdictions' progress. The State will also hold regular calls with local jurisdictions' emergency preparedness groups and the State Emergency Preparedness Office (EPO) and emergency management infrastructure to identify and address needs at the State level. Based on the criticality and impact, COVID-19 vaccine issues will be reported promptly to CHHS and the Governor's Office, as needed.

B. Describe your jurisdiction's methods and procedures for monitoring resources, including:

- *Budget*
- *Staffing*
- *Supplies*

Ensuring adequate levels in terms of budget, staffing, and supplies is critical to the success of the state's COVID-19 Vaccination Program. California has a robust mutual aid system and CDPH will be closely monitoring and employing assistance and resources as needed. In addition, CDPH will use regular communication channels to monitor and discuss real-time status with the goal of preventing any program interruptions (due to, for instance, lack of trained staff or lack of PPE supplies). The PM's and MHCC will jointly monitor state and local resource levels, ensuring state and local budget, staffing, and supply needs are identified and resolved. There is also ongoing dialogue with the California Department of Finance and California's COVID-19 response teams. Should any gaps in funding occur or should there be a need for unforeseen large acquisitions, we have the ability to raise and resolve these items during our regularly scheduled meetings or an ad hoc meeting, if necessary. Finally, CDPH is securing contracts with at least two nursing registry/staffing companies to support local efforts and needs with staffing at mass COVID-19 vaccination clinics. One contract will be to provide (statewide) vaccinators assistance (via nursing RN or LVN support) to COVID-19 vaccine clinics set up by local health departments. The other contract will be to actually set up mass vaccination clinics with minimal local health department involvement. Both contracts will also be used with seasonal influenza vaccine that is being offered this fall. Requests for either option will be received and coordinated by CDPH.



C. Describe your jurisdiction's methods and procedures for monitoring communication, including:

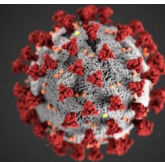
- *Message delivery*
- *Reception of communication messages and materials among target audiences throughout jurisdiction*

CDPH has developed various methods and procedures for monitoring communication, including message delivery and reception of messages among target audiences. Please see Section 12, COVID-19 Vaccination Program Communication, for a detailed discussion of all communication-related topics, including monitoring.

D. Describe your jurisdiction's methods and procedures for monitoring local-level situational awareness (i.e., strategies, activities, progress, etc.).

Local-level situational awareness is a cornerstone of our overall response. We have many systems in place to ensure that current information is shared between our local partners. Specifically, the strategies/activities include:

- **Regular surveys of local health jurisdictions** – Through our existing communications infrastructure, we have already conducted a number of surveys with local health jurisdictions to gauge their level of readiness for COVID-19 vaccine and where they anticipate challenges. We will continue to survey locals on a regular basis throughout the entire COVID-19 response to gain their feedback and suggestions for improvement on vaccine implementation.
- **Regular coordination between workgroups on the Governor's COVID-19 Vaccine Task Force** – The Governor's COVID-19 Vaccine Task Force contains many workgroups, and coordination between some of these workgroups will help us maintain situational awareness and adapt to changing scenarios. Specifically, the Information Management Monitoring & Reporting workgroup will cross-walk their data with epidemiology data managed by the Allocation Data Team. This synthesis will enable CDPH to determine if any adjustments should be made to vaccine recommendations. For example, in Phase 2, if certain hot spots of disease are recognized via situational awareness in food processing plants, CDPH may determine redistribute vaccine from local providers to vaccinate food processing employees. Through the regular coordination between Task Force workgroups, we will be made aware of and empowered to respond to changing situations, enabling us to make strategic adjustments as needed.
- **Regular calls with Health Officers, Immunization Coordinators, and Preparedness Planners** – CDPH will continue its regular status calls with local officials to discuss new trends, concerns, or issues. CDPH will also continue to participate in California Conference of Local Health Officers, County Health Executives Association of California,



and California Immunization Coalition meetings to ensure up-to-date awareness of broad, situational issues.

- **Use of field staff in five regions** – CDPH Immunization Branch has field staff in five regions across the state who currently serve as communicative liaisons between immunization provider offices, county health jurisdictions, and CDPH. We will continue to rely on them for situational awareness. In addition, the COVID-19 Pandemic response has Local Coordinators assigned to each jurisdiction that meet with local health departments frequently to gather local situational awareness and concerns.
- **Leverage California’s Standardized Emergency Management System** – Ensure a coordinated response in providing public health and medical resources including medical equipment and supplies, medical transportation, or healthcare personnel from both the private and public sectors to requesting local jurisdictions.
- **Participation in association and network discussions** – CDPH will continue to participate in regular conversations with health care and health system organizations (e.g., California Hospital Association, California Association of Health Plans, etc.) to obtain their feedback on current processes and opportunities for improvement.

When new, far-reaching strategies are created as a result of the cross communications, they will be incorporated into CA’s response dashboard/website and also into the Governor’s COVID-19 Vaccine Task Force Strategic Management Plan, which is a living document.

E. Describe the COVID-19 Vaccination Program metrics (e.g., vaccination provider enrollment, doses distributed, doses administered, vaccination coverage), if any, that will be posted on your jurisdiction’s public-facing website, including the exact web location of placement.

CDPH has drafted key COVID-19 Vaccination Program metrics and is currently cross-referencing them to system capabilities and data sources. The draft key metrics used for internal monitoring are presented in Figure 15.1. After the exact metrics are determined they will be posted and/or referenced on both of the following websites:

- CDPH public-facing website, located here: <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx>
- California COVID-19 Dashboard, located here: <https://covid19.ca.gov/data-and-tools/>

We will closely monitor our data for continuous quality improvement opportunities and to help identify gaps in equity or coverage.

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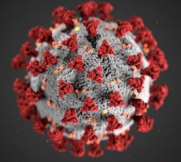
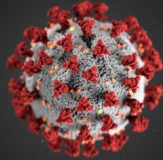
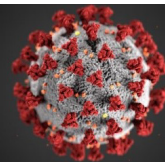


Figure 15.1: Draft Key COVID-19 Vaccination Program Metrics

Draft Key Metrics	
# doses allocated to California from CDC (by vaccine type) <ul style="list-style-type: none"> - # doses allocated to CDPH - # doses sent directly to providers 	# individuals receiving vaccine <ul style="list-style-type: none"> - By occupation (# HCW) - By occupation setting - By priority group
# doses allocated to local providers by LHDs <ul style="list-style-type: none"> - By vaccine type 	# individuals with high-risk conditions receiving vaccine
# providers registered in CDPH online system <ul style="list-style-type: none"> - By LHD/county - By provider type 	# mass vaccination clinics <ul style="list-style-type: none"> - # doses administered - # individuals receiving vaccine
# providers newly enrolled in CAIR <ul style="list-style-type: none"> - # providers onboarded - # providers exchanging data 	# unused/wasted doses
# doses ordered <ul style="list-style-type: none"> - By LHD/county - By provider type - By occupation setting 	# reminder/recall messages sent
# doses distributed <ul style="list-style-type: none"> - By vaccine type - By LHD/county - By provider - By provider type - By distributor - By date of distribution 	# vaccine refusals
Time between order placement and shipment to LHDs	# adverse events reported
# doses administered <ul style="list-style-type: none"> - By vaccine type - By LHD/county - By provider - By health system - By provider type 	Vaccination coverage <ul style="list-style-type: none"> - % target population vaccinated - % CA population vaccinated - % active CAIR users vaccinated



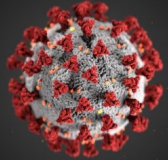
Draft Key Metrics	
# individuals receiving vaccine <ul style="list-style-type: none">- By vaccine type- By number of valid doses- By date of vaccination- By age- By race/ethnicity	Change from previous report



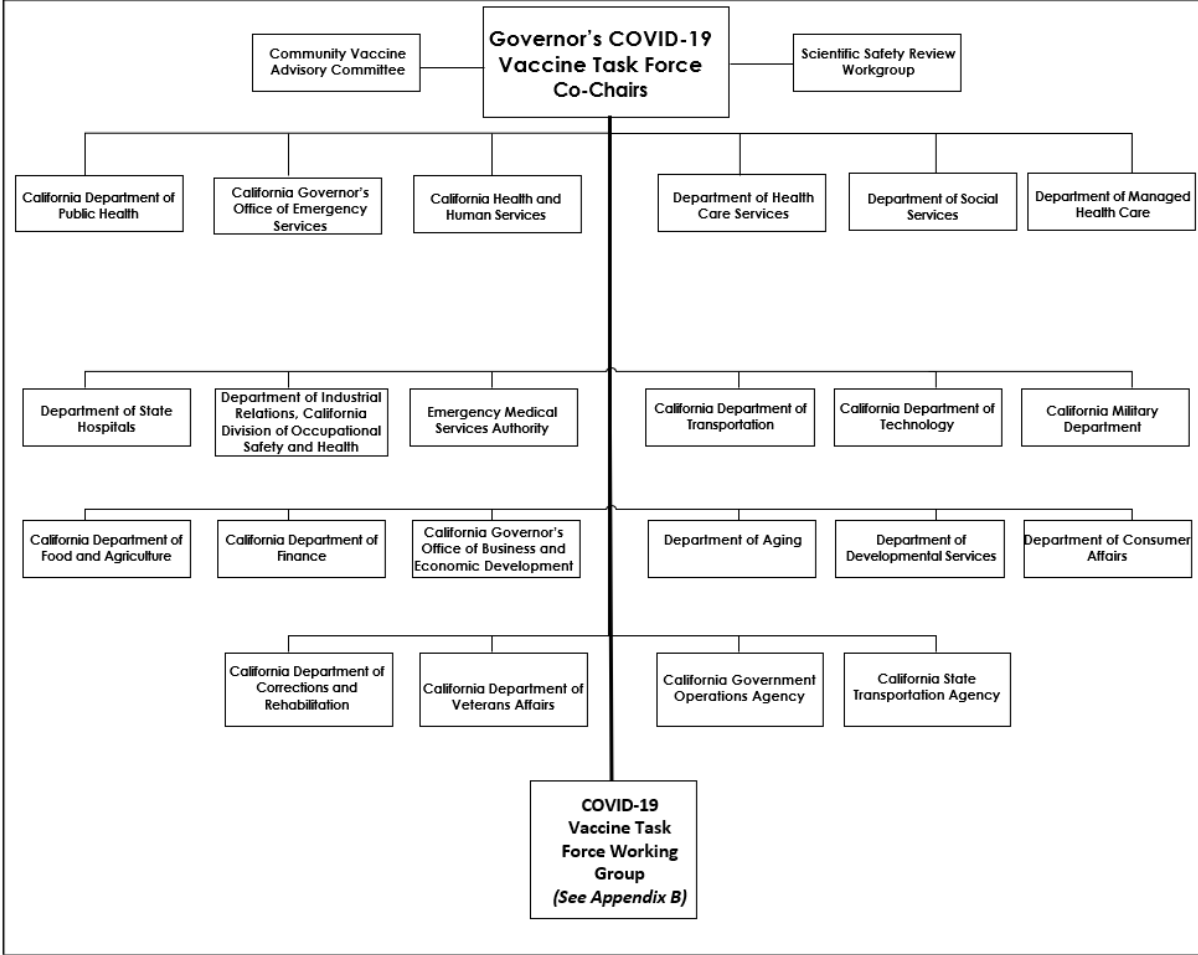
Appendices

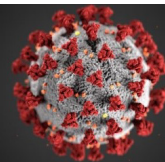
Instructions: Jurisdictions may choose to include additional information as appendices to their COVID-19 Vaccination Plan.

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Appendix A – Governor’s COVID-19 Vaccine Task Force Organizational Chart

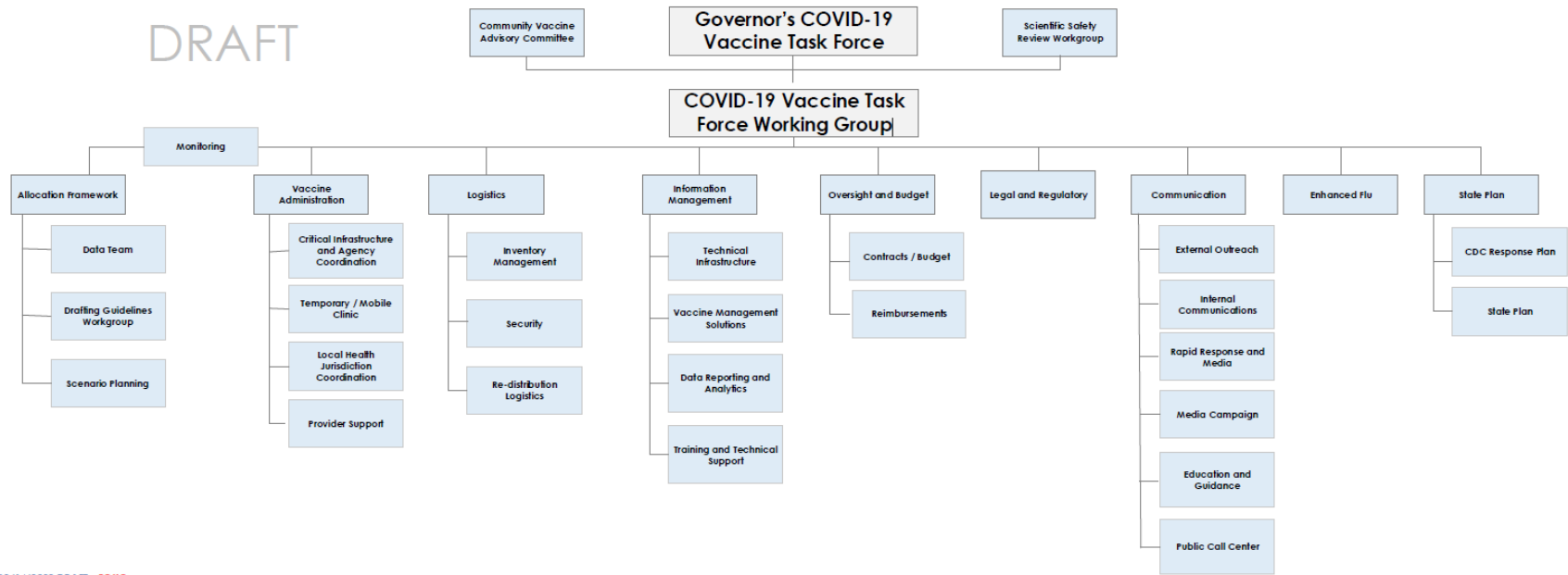




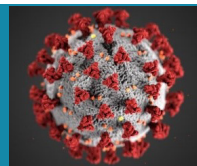
Appendix B – COVID-19 Vaccine Task Force Working Group Organizational Chart

See next page.

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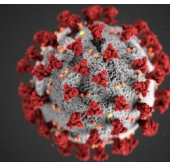
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Appendix C – Acronyms and Abbreviations

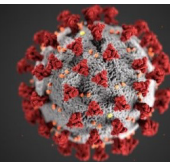
Acronym/Abbreviation	Definition
ACIP	Advisory Committee on Immunization Practices
AIRA	American Immunization Registry Association
APHL	Association of Public Health Laboratories
BAMPWG	Bay Area Mass Prophylaxis Working Group
CA-ESF	California Emergency Support Functions
CAHF	California Association of Health Facilities
CAIR	California Immunization Registry
Cal OES	California Governor’s Office of Emergency Services
CBOs	Community-based Organizations
CCLHO	California Conference of Local Health Officers
CDC	Center for Disease Control
CDPH	California Department of Public Health
CDDS	California Department of Developmental Services
CDSS	California Department of Social Services
CERC	Crisis and Emergency Risk Communication
CHA	California Hospital Association
CHEAC	County Health Executives Association of California
CHHS	California Health and Human Services
CIC	California Immunization Coalition
CMA	California Medical Association
COVID-19	Coronavirus Disease 2019
CPCA	California Primary Care Association
CSV	Comma Separated Values
DHCS	California Department of Health Care Services

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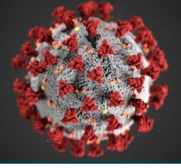


Acronym/Abbreviation	Definition
DSH	California Department of State Hospitals
EHR	Electronic Health Records
EMSA	Emergency Medical Services Authority
EOC	Emergency Operations Center
EOM	Emergency Operations Manual
EPO	California Department of Public Health, Emergency Preparedness Office
EUA	Emergency Use Authorization
FDA	U.S. Food and Drug Administration
FQHCs	Federally Qualified Health Centers
H1N1	Influenza A Virus Subtype H1N1
HCP	Health Care Personnel
HCW	Health Care Worker
HEDIS	Healthcare Effectiveness Data and Information Set
HL7 VXU	Data file type. Health Level Seven (HL7) is a nationally recognized standard for electronic data exchange between systems housing health care data.
IIS	Immunization Information System
IMATS	Centers for Disease Control, Inventory Management and Tracking System
IZ Gateway	Centers for Disease Control, Immunization Gateway
JSON	JavaScript
LHD	Local Health Department
LHJ	Local Health Jurisdiction
LTCF	Long-Term Care Facility
LVN	Licensed Vocational Nurse
M&I	Measurement & Improvement
MCE	Multi-County Entity
MCM	Medical Countermeasures

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Acronym/Abbreviation	Definition
Medi-Cal	California's Medicaid
MHCC	Medical and Health Coordination Center
MHOAC	Medical Health Operational Area Coordination Program
MOU	Memorandum of Understanding
OOH	Out-of-Home
PM	Project Manager
POC	Point of Contact
POD	Point of Dispensing
RDMHC	Regional Disaster Medical and Health Coordination Program
RHC	Regional Health Center
RIDE	Regional Immunization Data Exchange
RN	Registered Nurse
RSS	Receiving, Storing, and Staging
RSS-MC	Receiving, Storing, and Staging Mobilization Center
SDIR	San Diego Immunization Registry
SEIU	Service Employees International Union
SEMS	Standardized Emergency Management System
SMEs	Subject Matter Experts
SRPHER	Southern Region Public Health Exercise and Emergency Response
ULT	Ultra-Low Temperature
VAERS	Vaccine Adverse Event Reporting System
VAMS	Vaccine Administration Management System
VFA	Vaccines for Adults
VFC	Vaccines for Children
VIS	Vaccine Information Statement
VTM	Viral Transport Media
VTrckS	Vaccine Tracking System



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