Huron Perth Public Health

COVID-19 Vaccine Implementation Plan

Overview

January 2021 Version 2

www.hpph.ca

1-888-221-2133

Huron Perth Public Health

Table of Contents

Background

Lessons learned from previous vaccine programs including H1N1

HPPH serves the communities of Huron County, Perth County, Town of St Marys and City of Stratford since January 1, 2020, when former Huron County Health Unit (HCHU) and former Perth District Health Unit (PDHU) were amalgamated. HPPH will build on the history of strong vaccine programs and established local relationships of the former HCHU and PDHU, including successful H1N1 vaccine campaigns, annual school vaccine programs, and annual Universal Influenza Immunization Programs, to deliver an effective COVID-19 vaccine program.

Huron Perth Region

- Huron Perth is semi-rural, comprised of 4 upper tier and 13 lower tier municipalities covering 5,500 km^2.
- The largest population centres are:
  - Stratford: 31,465
  - Goderich: 7,628
  - Listowel: 7,530
  - St Marys: 7,265
  - Exeter: 4,649
  - Mitchell: 4,573
  - Clinton: 3,201
  - Wingham: 2934
  - Seaforth: 2,680
  - Milverton: 1,576
  - Brussels: 1,143
  - Blyth: 989
- Huron Perth is home to several distinct Plain populations (whose mode of transportation is horse and buggy). A 10-minute car ride is equivalent to a 60-minute drive by horse and buggy, which may be longer in snow or rain. As background, there are 10 separate Cultural Communities (CC) of Anabaptist Plain People which include self-described “horse and buggy” groups and are estimated at > 4,000 people which make up > 5% of the HP population and growing.
- There is a public transit system in Stratford, and limited public transit between our rural communities. Existing public transit would not adequately serve rural residents to attend one or two centralized clinic locations, therefore client accessibility to clinics will be considered across the region.
- The population of Huron Perth is 136,093 (Statistics Canada, 2017).
- The population of those ≥ 15 years old is 112,305 (Statistics Canada, 2017); therefore, the population ≥ 16 years is estimated to be 110,000 for planning purposes.

Planning assumptions:

- HPPH will lead COVID-19 vaccine planning.
- The Huron Perth Mass Advisory Committee (HPMVAC) will inform local implementation plans.
- All vaccines will be administered in accordance with provincial guidance and the provincial ethical framework.
- All vaccines will be administered in accordance with accepted vaccine indications and intervals in accordance with the National Advisory Committee on Immunization (NACI).

- HPPH, in collaboration with partners, will aim to vaccinate 75 % of eligible recipients in Huron Perth (currently those ≥ 16 years old without a medical contra-indication).
- 75% of the eligible population is estimated at 82,500 people in Huron Perth (approximately 110,000 eligible residents x 0.75 = 82,500 people).
    - When residents (LTCH and RH residents, and healthcare providers) who are already or soon to be vaccinated in the first part of Phase 1 are subtracted, we estimate 75,000 people in Huron Perth will need to be vaccinated (82,500 subtract an estimated 2,500 residents + estimated 5,000 HCP already vaccinated = 75,000 people).
- Multiple methods will be used to achieve the goal of vaccinating 75% of the eligible population.
- Vaccine inventory will be maintained by HPPH.
- Vaccine will be stored at HPPH-owned sites (Clinton and Stratford), or HPPH designated sites, with appropriate security and cold chain methods. Based on our experience with Pfizer, we can successfully transport the amount needed per clinic with adherence to cold chain guidelines.
- Vaccine will be forward deployed to partner sites as appropriate.
- HPPH will implement a model that will provide access to vaccine throughout the counties, which may require numerous smaller clinics.
- To improve accessibility, we will be prepared to offer clinics seven days a week and ensure evening clinic times are available, based on need.

COVID-19 Vaccination Scenarios

Until we receive confirmation on total doses and type of vaccine we will receive, we have considered the following scenarios for Huron Perth:

Scenario 1

- It has been projected that Canada will receive 1 million does of vaccine beginning in April. If we estimate that Ontario will receive half the allotment, then Huron Perth (0.9% of the population) will receive up to 5000 doses weekly starting in April.
- HPPH, in collaboration with partners, will prepare to vaccinate up to 750 people per day (5250 per week) with the ability to scale up if supplies permit, moving from Phase 1 through Phase 3.
- 75,000 divided by 750 = 100 days = 3 months for one dose, and 6 months for 2 doses.

Scenario 2

- It has been projected that everyone will be vaccinated by the end of September.
- With an estimated 75,000 people x 2 doses = approximately 150, 000 doses.
- Estimated vaccine supply is stable and predictable starting in mid-April.
- April 15 – Sept 30 = 24 weeks
- 150,000 doses ÷ 24 weeks = 6250 doses per week = 892 doses per day for 7 days.

Given these two possible scenarios, HPPH will plan for 750 – 1000 doses (vaccinations) per day, with the ability to increase capacity as needed based on vaccine type and doses available (by expanding clinic hours and/or activating additional clinics). Work is underway to determine primary care and pharmacy capacity for administering vaccine as well (based on data from the Universal Influenza Immunization Program partnerships).

COVID-19 Vaccine

As of December 29, 2020, two COVID-19 vaccines have been approved by Health Canada: the Pfizer-BioNTech COVID-19 mRNA vaccine and the Moderna COVID-19 mRNA vaccine. Additional vaccines may be approved by Health Canada and added to Ontario's vaccine program.

In preparation for immunization of local priority groups, vaccine distribution and mass immunization, Huron Perth Public Health (HPPH) has developed a COVID-19 Vaccination Plan for Huron and Perth. The purpose of this plan is to ensure local readiness for distribution of vaccine and mass immunization clinics. This plan will be updated as we receive new information and as planning evolves.

Ontario's Phased Plan

The Government of Ontario is overseeing COVID-19 vaccine distribution in Ontario and has released a phased plan, identifying priority populations. Note that timelines may change with vaccine availability.

Table 1: Summary of Ontario's Phased Vaccination Plan

Phase 1	• Priority populations:
	  o Residents, essential caregivers and staff of congregate living settings for seniors
	  o Healthcare workers
	  o Indigenous communities
	  o Adult recipients of home care
	• Limited doses
	• Started with two pilot hospital sites and expanded to additional hospital sites in a regional model

Phase 2	• Increased vaccine supplies and expanded vaccination sites • Continued vaccination of phase one priority populations, with expansion to other priority populations such as other congregate living settings and essential workers.
Phase 3	• Anyone who wants to be immunized can be immunized

Huron Perth Public Health's Role in COVID-19 Vaccinations

Implementing the COVID-19 vaccination plan across Huron and Perth is a collaborative process involving many community partners. Huron Perth Public Health's main role in COVID-19 immunizations is to coordinate a successful COVID-19 immunization and administration model across Huron Perth. Key areas of focus include:

- Vaccine supply and management
- Long-Term Care Home (LTCH)/Retirement Home (RH) roll out
- Supporting training and education for immunizers

- Communication across community and stakeholders
- Logistics (facilities, transport, staffing, etc.), IT and data support and management

Vaccine Implementation Plan Goals

- Protect the public by providing/supporting COVID-19 vaccinations for residents of Huron and Perth following Ontario's phased implementation plan, in collaboration with community partners. Vaccinate 75% of eligible residents.
- Ensure the community is informed; provide timely reliable information to partners and public; promote public confidence in the public health system and vaccines.
- Monitor the effectiveness of our local COVID-19 vaccination plan.

Governance

Huron Perth Public Health, governed by our Board of Health, will lead the COVID-19 response in Huron Perth in alignment with our public health mandates.

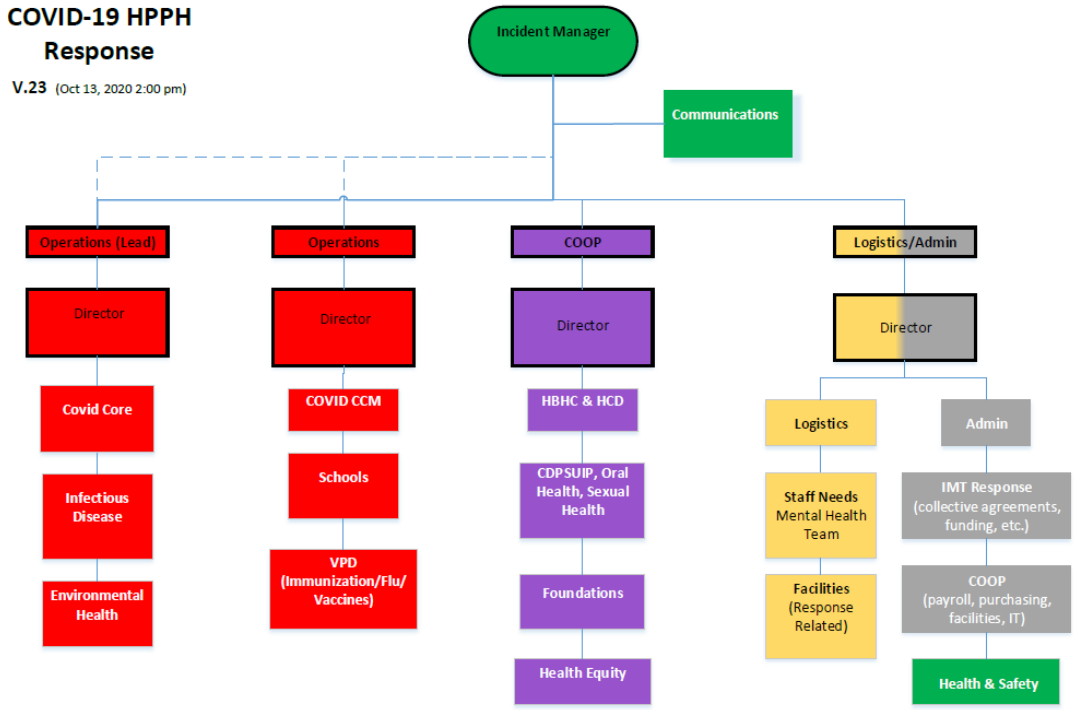
HPPH COVID-19 Incident Management System (IMS)

Huron Perth Public Health has established an internal Incident Management System (IMS) that identifies within our organization appropriate human resources to support overall direction to operations in order to effectively roll out our COVID 19 response. See Figure 2 for our IMS structure.

COVID-19 vaccination planning is led by our COVID-19 Vaccine Implementation Team. Within our IMS Operations Sector, our COVID-19 Vaccine Implementation Team is within the Vaccine Preventable Disease (VPD) team. Given the ability of the IMS to expand and contract, additional resources can be redeployed to the VPD team as required.

Figure 2: HPPH COVID-19 Incident Management System (IMS)

Huron Perth Public Health



Huron Perth Public Health COVID-19 Vaccine Implementation Team

HPPH has initiated an internal Vaccine Implementation Team to lead the planning and implementation of COVID-19 vaccinations in Huron Perth. See Figure 3 for the team structure.

Figure 3: HPPH COVID-19 IMS Operations Sector: Vaccine Implementation Team Structure

Director/Manager (IMS Leads) Report to IMT, Human Resources, Partner Liaisons, HPMVAC			
Vaccine Supply, Management and Clinic Logistics Sector - Staff Leads + Working Group	**Vaccine Administration Sector & AEFI management** - Staff Leads + Working Group	**IT, Data & Evaluation Sector** - Staff Leads + Working Group	**Communications Sector** - Staff Leads + Working Group
• Storage • Supply Management • Supplies • Logistics • Transportation • Distribution • Cold chain methods	• Directives • Materials • Staffing and Immunization Support • Training	• Data collection, tracking, and reporting • Evaluation • IT	• Communications (to partners, community, internal staff, Board of Health) • Webpage • Key message development • Resource sharing
Partner Support			

Huron Perth Mass Vaccination Advisory Committee (HPMVAC)

In December 2020, the Huron Perth Mass Vaccination Advisory Committee (HPMVAC) had its first meeting. This group consists of representatives from Huron Perth Public Health, the Huron Perth and Area Ontario Health Team (representing more than 60 organizations including, but not limited to Hospital, EMS, Primary Care, Community and Home Care, Mental Health and Addictions Services, Long-Term Care) and municipalities. This partnership will support an effective, efficient and fair vaccine program for all of Huron Perth.

- The HPMVAC is considering implementing a working group(s) structure for aspects of planning.
- The HPMVAC will guide the local sequencing plan.
- A Terms of Reference (TOR) has been developed for the group. See Appendix A for the draft TOR.

As the committee evolves we will endeavour to create a roles and responsibilities matrix. This will support working groups and other more specific tasks as identified as part of operational roll out. Documenting roles and responsibilities will help ensure all partners have a clear understanding of their own role and responsibilities, and those of the other partners.

Communications and Community Engagement

Huron Perth Public Health (HPPH) is the central source of COVID-19 information locally, and we will continue to work to ensure the dissemination of reliable and evidence based information. We will continue to communicate Ministry information and direction to partners and to the public. HPPH will leverage established relationships, communication channels, and expertise to ensure the community and partners are informed and engaged throughout vaccine rollout. HPPH's communication strategy aligns with the province's phased approach.

Communication Plan

HPPH has developed a communications plan identifying key messages and channels for communication, based on each phase of Ontario's plan.

HPPH's communication plan considers:

- Communication with partners
- Communications with priority populations and the public
- Vaccine information, addressing vaccine hesitancy, and promoting trust in the vaccine program.

See Appendix B for a summary of our communications plan.

Partnership and Engagement

Huron Perth Public Health will continue to identify key partnership priorities and partner roles throughout each of the three phases. See Appendix C for Huron Perth's Vaccine Plan Overview chart, which identifies potential points of partner engagement throughout the province's 3 phased plan. This document is undergoing continuous review and revision as more information is received.

Early engagement with partners (including but not limited to health, emergency and social services, and municipalities) was initiated through weekly calls, as well as through the establishment of the HPMVAC.

As per our communications plan, local leaders (including leaders of Plain communities) and community partners will be engaged to support communications with various population groups within the community.

Prioritization of Populations and Promotion of Vaccine Uptake

The Ministry of Health directs the allocation of the vaccine. Ontario has developed a three-phase COVID-19 vaccination plan as well as an ethical framework: Ontario's Ethical Framework for Vaccine Distribution (see Figure 1 and Table 1 above for a summary of the Provincial vaccination plan). These resources inform Ontario's plan to ensure a fair, equitable, transparent and science-based plan that maximizes benefits and minimizes harms.

Vaccine supply will differ by regions, and further prioritization and local sequencing will be completed by local Public Health Units.

Local Sequencing

Purposeful and respectful engagement and inclusion of diverse populations, including Indigenous residents and other racialized populations, as well as those who may experience barriers to accessing service, will be essential to ensure equitable distribution of the vaccine.

In addition to provincial prioritization, we are also working with Southwestern Public Health (SWPH) and the Middlesex-London Health Unit (MLHU) in regional planning led by the COVID-19 Vaccine Prioritization Advisory Committee to ensure consistent prioritization regionally. See Terms of Reference and Membership in Appendix D. This will ensure consistent and aligned decisions regarding prioritization and providing regular updates on the eligibility criteria for recipients of the COVID-19 vaccine in the region. Furthermore, local prioritization of sub-populations within each phase of the vaccination program will be guided by the HPMVAC.

HPPH is utilizing 2016 census data for sub-population estimates, and is collecting more detailed data with support from the HPMVAC on the numbers of local Health Care Workers (for example, in Primary Care, Home Care, Dental Care, Paramedicine, etc.). HPPH is also collecting data on priority populations (for example, clients served by our local Home and Community Care and clients served by our local methadone clinic) as well as other essential workers (Police, Fire departments, etc.) to inform local planning and method of vaccine delivery, as more information becomes available on the types and amounts of vaccine we will receive.

Health equity will be considered at each phase of the plan. A health equity impact assessment (HEIA) may be considered as needed, to inform equitable community clinic planning and vaccine rollout, and to ensure the community's needs will be met. As we set up clinics we will be considering barriers to access.

Indigenous Residents

An equity-based approach has led to the inclusion of Indigenous communities within the Province's list of priority groups that will get the vaccine first. While many understand and value the approach, it has also led others to questions of why certain populations are treated differently. According to Elisa Levi, "equity seeks to increase access to immunization services to reduce health inequities without further stigmatization or discrimination" (Levi, 2021).

The Ontario Public Health Standards (OPHS) specifies that boards of health shall engage with Indigenous communities and organizations, fostering the creation of meaningful relationships and collaborative partnerships, in recognition that Indigenous People's experiences with health care and systems are greatly influenced by their Indigenous identity.

According to the 2016 Census, 1.3% of the population of Huron and Perth identifies as Indigenous (First Nations or Métis), compared to 2.8% of the Ontario population (First Nations, Métis or Inuit). This self-reported identification is likely underreported. Approximately 85.5% of Indigenous people live off-reserve in Ontario. The Indigenous population in Ontario may live on and off reserve, in urban, rural and remote areas, each with their own histories, languages, cultures, organizational approaches, and jurisdictional realities.

Huron and Perth counties do not have First Nations communities or Indigenous Health Agencies within our borders. HPPH health equity staff have been planning and begun to engage with community partners who are also seeking Indigenous engagement and relationship building with Indigenous-identified residents. The Vaccine Implementation Team recognizes the need to engage the Indigenous residents in our region to determine if the community requires support, and if so, what support is needed.

HPPH health equity staff and the Vaccine Implementation Team will determine how best to seek input from existing and new Indigenous partners to tailor the vaccine rollout plan which supports personal, familial and community resilience, self-determination, and Indigenous identity. This will be done in collaboration with partners and consultation with neighbouring public health units. HPPH will look to local resources including, but not limited to, the Huron County Indigenous Working Group, local Indigenous Talking Circles (if appropriate), Town of Stratford Diversity and Inclusion Sub Committee, and neighbouring health units.

Guiding Principles for engagement include:

1. Relationship Building
2. Recognition, Respect and Mutuality
3. Self-Determination
4. Timely Communication and Knowledge Exchange
5. Coordination

Supplies Management and Distribution

All vaccines must be stored and handled according to manufacturer and provincial storage and handling requirements, including cold chain and light sensitivity of the vaccine (as applicable). The MOH Vaccine Storage and Handling Protocol outlines roles, responsibilities, and processes for current storage and handling: Vaccine Storage and Handling Protocol, 2018 (gov.on.ca). The MOH resource for Vaccine Storage and Handling Guidelines: Vaccine Storage and Handling Protocol, 2018 (gov.on.ca) is followed by all healthcare providers who store and handle publicly funded vaccine.

The Vaccine Implementation Team's Vaccine Supply & Management Sector plans and facilitates the storage, supply management, distribution, transportation and cold chain methods for the vaccine. The Vaccine Implementation Team has extensive expertise in the storage, handling, cold chain maintenance and management of vaccines. All vaccine distribution will be managed according to the manufacturer's requirements.

Resources

- Vaccine Statistics Form
- Transportation and Reconstruction of Vials Form
- Medical Directive
- Product Monographs
- Ministry COVID Vaccine Storage and Handling Guidelines:

Vaccine Approaches

HPPH's Vaccine Implementation Team is responsible for directives, materials, immunization training, staffing, and facilities (as well as supply, management and distribution). The Vaccine Plan Overview chart (see Appendix C) identifies various potential channels of vaccine delivery and expansion during each phase.

Vaccine Approaches (Draft - still under consideration)

a) **Facility Clinics**: On-site Long-Term Care Home and High Risk Retirement Home (LTCH/RH) clinics led by HPPH (vaccine delivery and preparation) and administered by partners (LTCH, RH, other congregate care settings).
   - On-site LTCH/RH clinics will be held in Phase 1.
   - All LTCH and High-risk RH residents have received their first dose of vaccine as of January 27. Our current plan aims to complete second doses by Feb 27.
   - HPPH is working closely with LTCH/RH to gather resident, staff, and essential caregiver numbers to determine vaccine ordering and staffing needs.
   - HPPH has developed a schedule for LTCH/RH based on outbreak status, geographic locations, resident numbers, and home readiness.
   - A survey was sent to LTCH to determine readiness and support needed for successful vaccine rollout and administration. Survey data were assessed and data has contributed to vaccine rollout planning and communications planning.
   - LTCH/RH are sent a pre-clinic check list to ensure sites are ready and prepared.
   - LTCH/RH are to complete consent forms in advance.

b) **Hospital based clinic:** LTCH and RH staff in Huron and Perth are receiving vaccinations through London Health Sciences Centre (LHSC) Agri-plex vaccine site in London, ON.
   - HPPH is collaborating with the Middlesex-London Health Unit (MLHU), Southwestern Public Health (SWPH), and London Health Sciences Centre (LHSC) in vaccinating LTCH/RH staff during Phase 1.

c) **Mobile clinics:** led by HPPH, supported by paramedic services and other partners.
   - During phase 2 and 3 HPPH will be working with paramedicine and other partners to identify mobile vaccine options for homebound individuals and other groups as appropriate.

d) **Healthcare Worker Clinics:** Healthcare staff in hospitals and the community may be provided with vaccine for on-site clinics , supplies permitting, in accordance with Ontario's phased plan. These may also be referred to as facility clinics or workplace clinics.

e) **Community clinics:** led by HPPH, and supported by partners.
   Community clinics include mass vaccination clinics as well as smaller community clinics.

   Determining community clinic locations:
   - A health equity lens will be used to inform equitable community clinic planning and vaccine rollout.
   - Community clinics will be held on a rotating basis in a selection of our population centres to improve access for residents geographically.
     - This will also ensure municipalities will not need to give up access to their facility for an entire 3-6 month period, but rather commit to one or two days per week.

    - Access to clinics is an important consideration given geographic spread and the mostly rural area that HPPH serves. Some of our clinics will be larger scale, and some smaller scale to improve access for rural communities.
    - We will also consider the need for mobile clinics and alternative clinic locations based on identified need of various priority populations.
    - We will consider drive-thru options where appropriate.
- HPPH will leverage an already established mass immunization clinic model used for influenza immunizations.
- HPPH will work with partners to determine community immunization clinic location options, assess accessibility, space layout, security, and required conditions at locations. This will be done in consultation with the HPMVAC.
- Assessment criteria (see resources) will be used to assess sites based on requirements. Two metre physical distance between stations will be required; this will be considered when determining site selection.
- Appointments will be required for community clinics to ensure fair access, and ensure public health measures (e.g. physical distancing) are maintained. This will also allow management of wait times.
- An IT system will be required for booking. The system will also need to be accessible for those without a computer. Example layouts of clinics are included in previous PDHU and HCHU vaccine plans.

Resources

- Ontario Ministry of Health COVID-19 Vaccination Clinic Operations Planning Checklist
- Government of Canada Planning guidance for administration of COVID-19 vaccine
- An example of how an immunization clinic can be set-up is provided in Public Health Agency of Canada Planning Guidance for Immunization Clinics for COVID-19 Vaccines (December 7, 2020)
- Training materials and PowerPoint for preparing and administering vaccine
- Training PowerPoint developed by HPPH on administering vaccines during COVID-19 pandemic
- LTCH COVID-19 Vaccine Pre-Clinic Checklist
- Consent forms (COVID-19 Vaccine Screening and Consent Form)
- Additional Ministry factsheets, and vaccine guidance documents
- Mass Vaccination Clinic Supplies Checklist
- Assessment Criteria for Mass Vaccination Sites

Human Resources

Human resources need to be considered for the vaccination program as a whole, including for each of the approaches that will be used: community vaccination clinics, mobile vaccination clinics, and additional clinic settings. Huron Perth Public Health has compiled an inventory of staff skills and has an existing pool of casual nurses to support the vaccination program (informed by Figure 4). Based on our current assumptions of a steady supply of available vaccines, these resources would be sufficient to meet provincially prescribed timelines, albeit with a significant impact on current Public Health resources and programs. Further, if available vaccine supplies increase, timelines become shorter, or COVID-19 case and contact management work escalates, more capacity will be required. Huron Perth Public Health continues to engage with facility health care providers, including primary care, community paramedics, and pharmacies.

Huron Perth has a strong Huron Perth & Area Ontario Health Team (OHT) community partners table. Many offers of assistance have been made. To gather the engagement of staff from partner agencies, a survey was created. HPPH has upwards of 150+ offers of assistance from staff at our partner organizations. We continue to work out the details of the HR components. A Memorandum of Understanding will be created and signed with all partner organizations offering assistance.

Figure 4: Mass Vaccination Clinic Planning – Staffing Requirements Guidance
Note: this is an estimate meant for guidance and numbers may vary.

Mass Vaccination Clinic Planning
Calculation of Staffing Requirements – Paper Consent System

Use this table as a guide to estimating the number of nurses and other staff required to administer vaccines to a given population within a given time frame.

# injectors	# loaders	Clinic RN Leads # assessors	# admin	# volunteers	Shots per hr	Clinic Length *	Total shots
1	0	1	1	1	15	5	75
2	0	1	1	1	30	5	150
3	1	1	1	1	60	5	300
4	1	1	2	2	80	5	400
5	1	1	2	2	100	5	500
6	2	1	2	2	120	5	600
7	2	1	3	3	140	5	700
8	2	1	3	3	160	5	800
9	2	1	3	3	180	5	900
10	3	1	4	4	200	5	1000

Assumption – if only two nurses used at clinic, rate of immunization will only be 15 shots per hour due to need for the nurses to load their own vaccine. Rate rises to 20 shots per hour when a loader is added. Rate drops to 15 shots per hour if population being immunized is exclusively children.

Staffing roles for mass vaccination clinics include:

- Screening of clinic attendees for signs and symptoms of COVID-19 illness (Greeters)
- Clinic registration staff (Registration)
- Clinic flow management (Flow Monitors)
- Security (Security)
- Equipment and supply runners (Runners)
- Vaccine handling and storage oversight (Vaccine Management)
- Preparing vaccine
- Immunizing
- Post-vaccine surveillance
- Data management

Documentation and Reporting

AEFI Reporting

Reporting of adverse events following immunization (AEFIs) for COVID-19 vaccines will follow the same procedure as AEFI reporting for all other vaccines. We will use the Ontario AEFI reporting form for initial reports of AEFIs and iPHIS (integrated Public Health Information System, the provincial information technology system used for surveillance of Diseases of Public Health Significance) for case management, until COVID-19 AEFI reporting functionality is built into the case and contact management system (CCM). The AEFI reporting form has been updated to include Adverse Events of Special Interest (AESI) for COVID-19 vaccine safety surveillance identified by the Brighton Collaboration.

- Partners (LTCH, RH, Healthcare providers, jails etc.) were provided with updated AEFI forms by fax and email, along with instructions for completion.
- Internally we have developed a call triaging model that incorporates reports of AEFI including movement to MOH for review and sign off.

Resources:

- AEFI reporting form
- Internal AEFI reporting process currently being reviewed and revised

Vaccine Surveillance Plan

Data Sources

*Draft: Data sources and surveillance plan under review

HPPH will utilize 2016 census data for Huron and Perth to inform high-level planning and evaluation. HPPH will also use data collected from partners on number of staff and number of clients served at various facilities. HPPH has also requested more recent population data from ICES. These data will feed into the evaluation component of the vaccine plan (e.g. demographic characteristics of those who have received the vaccine). In addition to surveillance and evaluation, these measures may aid in the decision-making process of equitable vaccination distribution in Phase 2 planning.

Key measures from the census:

- Breakdown by age group, especially the following groups:
  - 65 years and over
  - 80 years and over
- Municipality
  - Age
  - # of person(s) in household

b) COVax-ON

- Data required for provincial reporting will be gathered from the COVax-ON system, once further guidance is provided from the province.

Contingency Planning

Huron Perth Public Health recognizes the criticality of correct vaccine storage and handling practices to minimize wastage and preserve vaccine efficacy. Public Health has expertise and responsibility under the Ontario Public Health Standards, Vaccine Storage and Handling Protocol (Ontario Ministry of Health).

- HPPH's IMS structure will support unanticipated events.
- HPPH's communication team is experienced in media relations and would respond to media inquiries.
- HPPH has long standing relationships with local law enforcement which would be leveraged to respond to any protest activity.

Staffing

In the case of staffing shortage (e.g. staff need to self-isolate, are off, or other reasons for staff shortage), HPPH has compiled a list of casual staff, as well as engaged partners about support for staffing if the need arises.

HPPH has a contingency plan for labour disruptions.

Severe Weather

Considering Huron Perth is within a snowbelt, it is routine for HPPH to monitor for severe weather and will plan accordingly. When planning clinics, back-up clinic plans will be considered for severe weather instances. During phase 1, if weather prohibits picking vaccine up from the London depot, a decision will be made by 8:00 AM and communicated by email to the staff scheduled for that day. The facility will be contacted and vaccinations rescheduled.

A plan will be developed for phase 2 with respect to communicating any vaccine clinic cancellations and rescheduling due to severe weather.

Finance

The Board of Health is accountable for using funding efficiently as outlined by the fiduciary requirements domain of the organizational standards within the Ontario Public Health Standards. The Ministry of Health (MOH) must ensure that there is efficient use of public resources and ensuring value for money. Part of the requirements within the standard are for local public health agencies to provide financial reports as requested to the MOH.

COVID-19 vaccination program costs will be tracked separately from the Board of Health approved cost-shared budget for reporting of costs associated with the COVID-19 vaccination program. Huron Perth Public Health has internal financial control measures in place to track and monitor COVID vaccine expenses.

Costs being tracked will include but not be limited to:

- Staff costs in full time equivalents (FTEs) and dollar value; including overtime costs
- Materials and supplies, and other operating costs in dollar value
- Costs associated with the COVID-19 vaccination program
- Other sub-categories to track may include but are not limited to (based on reporting of extraordinary costs in 2020): Travel and accommodation, supplies and equipment, purchased services, communications.

HPPH will consider full scope of practice when planning clinics to ensure efficient use of resources in clinic planning.

Evaluation Approaches

HPPH is currently developing an evaluation plan for our local vaccination plan. Evaluation approaches and data sources included here are in draft, and subject to change based on reporting requirements, plan approval, and staff capacity.

HPPH will evaluate this vaccine program in accordance with the Ontario Public Health Standard's Effective Public Health Practice.

See Appendix E: Summary of HPPH Vaccine Evaluation Plan.

Former Huron County Health Unit and Perth District Health Unit Mass Vaccination Plans

Prior to merging as Huron Perth Public Health, Huron County Health Unit (HCHU) and Perth District Health Unit (PDHU) each had mass vaccination plans. These plans have informed COVID-19 vaccination planning.

References

COMOH Public Health Vaccination Playbook. January 13 2021.

Levi E. 2021. Vaccination rollout must engage with Indigenous communities. First Policy Response. Retrieved from: https://policyresponse.ca/vaccination-rollout-must-engage-with-indigenous-communities/

Statistics Canada. 2017. Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29 2017. Retrieve from: http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

Appendices

Appendix A: Draft Huron Perth Mass Vaccination Advisory Committee Terms of Reference

Huron Perth Mass Vaccination Advisory Committee

Terms of Reference

Purpose

The Huron Perth Mass Vaccination Advisory Committee will advise on the planning and coordination of the mass vaccination campaign against COVID- 19 for the population within the geographic boundaries of the Counties of Perth and Huron.

Assumptions

- The mass vaccination campaign within the region of Huron and Perth will be based on provincial
- direction and the 3 phase provincial plan.
- The Huron Perth Vaccine Administration/Implementation Plan will be led by Huron Perth Public
- Health (HPPH).
- The local model of implementation will be adapted to each phase; for example, personnel in Long-Term Care and Retirement Home settings will implement vaccine to these residents, with assistance of community partners as required, in phase 1. Additional sites and implementers will be mobilized in subsequent phases.

Objectives

1. To advise health system partner leads on how to operationalize provincial mass vaccination campaign
2. To identify local health systems risks and operational implications that may impede campaign
3. To identify strategy/mechanism to allow for the identification/enumeration of vulnerable populations within communities
4. To explore resources, opportunities and supports to allow for health system partners capability and capacity to carry out mass vaccination campaign.
5. To facilitate the coordination, cooperation and communication between heath care organizations and agencies within the identified communities and with the Province and other organizations as required.
6. Develop a localized strategy/plan for community based vaccination distribution/administration.

Committee Membership

The membership will be based on a matrix to ensure representation based on the Ontario Health Team table that had been in place in the past in Huron Perth, as well as other sectors.

Each sector will provide representation for the committee.

- Huron Perth Public Health Unit
- Long Term Care/ Retirement Home
- Acute Care (Hospitals) AMGH, LWHA, HPHA, SHHA
- Paramedic Services
- Primary Care
- Community pharmacies
- Municipalities (representation through CEMCs)
- Mental Health and Addictions
- Home and Community Care
- Community representative
- Other ad hoc members as needed for specific strategies (such as Indigenous, Newcomers, Police
- Services)

The present membership is listed in Appendix A.

Committee Member's Responsibilities

- To actively participate in meeting the committee's objectives
- To carry out the objectives outlined within the Terms of Reference
- Participate in committee meetings and complete assigned tasks

Confidentiality

- Members are asked to keep the information and discussions during the meetings confidential, unless otherwise specified. Key messages will be created at the end of the meeting to be shared within partner organizations.

Chairperson

- Leadership from Huron Perth Public Health or designate

Role of Chair/Co-Chair

The chairperson will:

- Coordinate and chair meetings
- Hold meetings at a location convenient for all committee members
- Disseminate all materials relevant to meetings (not limited to agendas or minutes)
- Retain official committee documents, including but not limited to agendas, minutes and correspondence
- Transfer all official committee documents, including all electronic or hard copies, to the next committee chair.

Role of the Recorder

The recorder of the meeting minutes will be provided by HPPH

The recorder will:

- Track agenda items and ensure that actions to be completed are clearly documented.

- Provide completed minutes to the Chair via email within an agreed upon time prior to next meeting date

Decisions:

Decisions will be made by consensus – see Appendix B Consensus Model for Decision Making

Frequency and Duration of Meetings

- Meetings Frequency: weekly or at the call of the chair
- Duration: 1 hour or determined by chair
- Commencement date: the third week in December 2020.
- Additional meetings may be called at the discretion of the chair, or if there is an identified need
- to complete projects, agreed to by all committee members
- Meeting schedule/dates to be mutually agreed upon by the committee
- Meeting will be done by teleconference and web conferencing options

Quorum

Representation from at least 50% of the membership agencies must be present to proceed with committee business. Committee representation is linked to a respective sector. Participating agencies may have multiple members; however, we are striving for a single vote from each sector.

Review of Terms of Reference

The terms of reference will be reviewed by all committee members.

Appendix A

Attendees by sector in alphabetical order:

Community Representative: pending
Community Pharmacy: Michael Ibrahim
LCTH/RH: Peter Bolland, Joyce Penney, Jeff Renault
Mental Health and Addictions: Catherine Hardman
Municipalities: Neil Anderson, Dave Clarke, Michaela Johnston, Todd McKone
Home and Community Care: Kathy Scanlon
Developmental Services: pending
Hospital: Karl Ellis, Jimmy Trieu, Andrew Williams
Ontario Health team: Lisa Mardlin-Vandewalle
Paramedic Services: Mike Adair, Jeff Horseman, Bill Lewis
Primary Care: Mary Atkinson, Dr Gill, Dr Gilmour, Cate Melito, Kim Van Wyk
Public Health: Adrienne Adas, Donna Bentz, Miriam Klassen, Jaelyn Kloepfer, Rita Marshall, Tanya Sangster (chair), Jacqui Tam

Appendix B

External Mass Vaccination Advisory Committee

CONSENSUS MODEL FOR DECISION-MAKING

The simplest and most basic definition of consensus is, 'general agreement about something' (Soanes, C. and Hawker, S., ed., The Compact Oxford English Dictionary of Current English. 3rd ed. Oxford University Press, 2005.)
In this approach, people are not simply for or against a decision, but have the option to situate themselves on a scale that lets them express their individual opinion more clearly. This model is usually used with a round, so that everyone in the meeting is given the opportunity to state where they are according to the following six levels:

1. Full support
2. Acceptable
3. Support with reservations
4. I am not thrilled with it, but I can live with it and will not block it
5. Need more information or more discussion
6. Cannot support it and cannot accept it

If everyone is at level #4 or above (3, 2, or 1), then by definition, consensus has been reached.

If someone is at level 2, 3 or 4, they have the option of explaining their reservations. These can be addressed by the meeting, if the group wishes to. This is not absolutely necessary for achieving consensus if everyone is already at 4 or higher, but it usually improves the recommendation or suggestions being discussed.

If someone is at level 5, they have the obligation to explain what information or discussion they require from the group.

If someone is at level 6, it is important for them to try and offer a solution that can accommodate their needs and the needs of the rest of the group.

In addressing someone's reservation, it is important to:

- ask everyone for possible solutions (the person expressing the concern and the rest of the
- group have the responsibility to find solutions)
- ask people to suggest improvements as alternatives that meet the objectives of the entire
- group.

IDENTIFYING CONSENSUS

Consensus is a relative term. There are varying levels of agreement with decisions, as indicated in the table below. Levels 1 through 5 all constitute consensus. Only Level 6 lacks consensus.

Level	Position	Feelings and Behaviour		
1	Agree strongly	"I really like it!"	"I'll advocate for it publicly whether or not it's adopted"	"I'll actively support its implementation"
2	Agree	"I like it"	"I'll advocate for it publicly"	I'll support its implementation"

Level	Position	Feelings and Behaviour		
3	Agree with some reservations	"I can live with it"	"I'll support it publicly and privately even with my reservations"	I'll participate in its implementation"
4	Disagree, but willing to go along with majority	"I don't like it. I'm willing to go along with it, but I want my disagreement acknowledged"	"I'll support it publicly and privately when asked"	"I won't work against its implementation"
5	Disagree, and won't be involved in implementation	"I really don't like it, but I'm willing to go along with it because I don't want to stop others"	"I'll not oppose it publicly or privately"	"I will not be involved in its implementation, but won't sabotage it"
6	Opposed, and will work to block	"I hate it and will work to block it!"	"I'll advocate against it publicly if adopted"	"I'll work to sabotage it"

Adapted from the SW LHIN

Appendix B: Summary of Communications Plan

The HPPH communications plan considers targeted communications for various age groups and priority populations throughout the phases of the vaccine campaign. Community leaders and partners will be engaged in communication planning and message dissemination to various priority groups.

Communication planning will be led by the Vaccine Implementation Team's Communication Sector.

Purpose of communication plan:

- Clearly communicate the facts about the benefits of receiving the vaccine; ensure trust in the safety and efficacy of the vaccines. HPPH will utilize and build upon the Ministry messaging.
- Ongoing, clear, effective communication with partners; partners have the information they need to implement vaccine campaign and partners are engaged.
- Community is informed about local vaccine plan implementation; concerns and misconceptions are addressed; the community has access to accurate and evidence based information.

Key target groups

Key target groups identified include:

- Partners and stakeholders in healthcare, social and municipal sectors
- Internal staff and Board of Health
- General public
- Plain communities
- Indigenous persons
- Groups facing barriers to access
- Higher-risk groups as identified by the province and local sequencing.
- Community partners will be engaged as appropriate when planning communication with priority groups and the public. The HPMVAC group's channels will be leveraged to disseminate key messages to groups and the public.

Channels and platforms identified

- HPPH vaccine webpages for the public and for healthcare providers: ongoing updates to the webpage, encouraging community members to sign up for webpage update alerts.
- COVID-19 intake phone line: The Communications Sector provides internal staff with key messages and resources to effectively answer and triage vaccine related calls through our established COVID-19 intake line.
- Weekly calls and meetings with partner organizations: HPMVAC, Primary Care, LTCH/RH, Municipalities, etc.
- Local media channels: ongoing engagement and updates
- Social media platforms: Facebook, Twitter, Instagram
- Newsletters and mail-out packages (E.g. Plain population packages, mail inserts, etc.)

- Community leaders from various groups in the community will be engaged to align approaches across organizations, disseminate key messages to address common questions, concerns, and vaccine hesitancy within the community as well.
- Community champions
- The People with Lived Experience Expert Panel in Huron Perth reported how residents with lived experience of systems access information in 2020, and this data will be used to inform communication channels used to reach priority groups.

Additional Considerations Informing Communications Planning

Vaccine Hesitancy

- The Ipsos poll from August 2020, Vaccine Hesitancy Understanding Belief Information states that adults who responded that they would not get a COVID-19 vaccine if available (approximately 1 in 4), indicated "worries about side effects" and "perception of effectiveness" as main reasons. A December 2020 Ipsos poll highlights "being worried about side effects" as the most common reason reported for not getting a vaccine, followed by "doubts about its effectiveness" (note: results are global).
- A November 2020 Leger North American Tracker Report indicates 61% of Ontarians intend to get the vaccine when it's available and 19% reported they don't intent to get the vaccine once available, and 20% reported "don't know".
- A December 2020 Ipsos poll reported 71% of Canadians intend to get vaccinated when a vaccine is available.

COVID-19 Message Fatigue

- The community is tired, COVID-19 messages saturate the media and conversations.
- Even with the vaccine, to date, everyone is to continue to follow Public Health measures to reduce spread of COVID-19 (mask, washing hands, distancing, staying home when sick, etc.). This will need to be communicated this to the public, with rationale around this continued practice even once vaccinated.

COVID-19 Vaccine Eagerness

- Messaging must take into consideration local eagerness for vaccine as well. When addressing hesitancies, these messages must be balanced with an understanding that many community members are eager to get the vaccine.
- Our webpage FAQ and call intake auto-messaging will support messaging to the public around vaccine availability, in addition to other channels as we receive more information about local rollout.

Appendix C: DRAFT - HPPH Vaccination Plan Overview (reviewing and revising regularly)

HPPH Vaccination Plan - Overview

Last revised: February 9, 2021. **Note:** This is a working document and will be updated as new information is available.
The type of vaccine available will influence decisions. Phases may overlap and will be updated according to Ministry direction.

	Phase 1 Limited vaccine available; 2 pilot hospital sites expanding to more site in regional model					Phase 2 Increase vaccine supplies and expanded vaccination sites					Phase 3 Mass vaccination for rest of population steady-state
Timeline	Starting December 2020					April - August 2021					August onward
Priority populations	LTCH/RH residents	LTCH/RH Staff & Essential Caregivers	Healthcare workers	Indigenous populations	Adult recipients: chronic home Healthcare	High risk congregate settings	Older adults 65-69: 21,521 70-74: 8,652 75-79: 5,826 80+: 8,267	Essential workers**	Individuals with high risk chronic conditions	Other populations facing barriers**	Adults 16-60
***Estimated population**	2,100[1]	EC: 4,200[1] S: 1,200[1]	Data being collected	1,835[2]	1,121[3]	1,440[1] staff & residents (no independent seniors)	Older adults 65+ 44,266[3]	TBD	TBD	TBD	TBD
Lead	Public Health Co-lead: partners applicable to prority group					Public Health Co-lead: partners applicable to prority group					Public Health
Expected doses						Est. 5,000 doses/week; 750-1,000 doses/day					
Approaches	Mobile clinic	Community clinic	Community clinic	Working with leaders to determine best approach	Home vaccine type dependent	Mobile clinic	Community clinics	Community clinic	Community clinic	Community / Mobile clinic	Community Clinics
Locations	LTCH/RH facility	Community Facility	Community Workplace	TBD based on need of population	Home vaccine type dependent	Congregate facility	Older adults: Community site Essential workers: Workplace or community site High risk conditions: Community site				Municipal Sites
Immunizers/ administration	Public Health LTCH staff Paramedicine	Multiple providers	Facility staff	TBD	EMS or service provider	Public Health Primary care Paramedicine	Public Health Primary care	Primary care Paramedicine	Primary care Paramedicine	Public Health Primary care Paramedicine	Public Health Primary care Pharmacies Paramedicine
Public Health role	• Vaccine supply and management • Vaccine delivery and preparation • Support with data and training • Communication / data gathering					• Vaccine supply and management • Training/resources (check lists, criteria, etc.) • Support with data					Vaccine supply and distribution Communications
Partner support	• Communication with priority groups • Support planning for community clinics in phase 2 (begin mid-February after LTCH rollout well underway)					• Communication with priority groups. • Paramedicine to support vaccination of home bound individuals.					Paramedicine to support vaccination of home-bound individuals. Role of pharmacy?

***Data sources:** 1. Survey to partners & providers 2. Statistics Canada. 2017. Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29 2017. http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/-prof/index.cfm?Lang=E. 3. Chung H, Fung K, Ishiguro L, Paterson M, et al. Characteristics of COVID-19 diagnostic test recipients, Applied Health Research Questions (AHRQ) # 2021 0950 080 000. Toronto: Institute for Clinical Evaluative Sciences; 2020. Data are estimates, final numbers to be determined with ICES data. Data is also being collected by partner organizations. Essential caregivers estimate is based on number of residents x 2 allowed caregivers.
Definitions: [Approaches] Community Clinic: Includes mass vaccination clinics and smaller scale clinics.
[Locations] Community site: includes municipal sites, schools, churches, primary care, etc.

****see sequencing plan and provincial ethical framework**

Appendix D: COVID-19 Vaccine Prioritization Advisory Committee Terms of Reference

COVID-19 Vaccine Prioritization Advisory Committee Terms of Reference

Draft – January 19, 2020

Vision: An equitable and risk-based prioritization of recipients of the COVID-19 vaccine in the Huron Perth Public Health, Middlesex-London Health Unit, and Southwestern Public Health regions.

Purpose: Within the provincial government's Ontario's Vaccine Distribution Implementation Plan and considering vaccine supply, determine the regional prioritization of recipients of the COVID-19 vaccine using the ethical framework described by the federal and provincial government.

Background: The province has outlined three-phased vaccination plan for the distribution of the COVID-19 vaccine. These phases represent a system of prioritization based on the objective of minimizing severe outcomes/death associated with COVID-19. That is, the best available evidence and expert opinion suggests that by working in this order of priority, Ontario will be able to limit severe outcomes and death from COVID-19 more than if the vaccine was distributed in any other order. This plan was influenced by the National Advisory Council on Immunization (NACI) which publicly outlines this rationale.

Unfortunately, within the province's first phase, there is insufficient vaccine to immediately vaccinate all eligible individuals. To address this gap, the province has entrusted local public health units to further prioritize within group eligible in Phase 1. The province has provided two documents that support this additional prioritization:

- Ethical framework for COVID-19 vaccine distribution
- Guidance for Prioritizing Health Care Workers for COVID-19 Vaccination

The public health units will continue to follow the direction of NACI and the Province in prioritizing only when there are evidence-based reasons to believe it will positively affect the goal of minimizing severe outcomes/death associated with COVID-19. If there is no evidence-based reason to believe that prioritizing one group over another will positively affect this objective, an orderly sequencing process will be used that ensures everyone (of equal priority) has equal access to the vaccine in a given period of time. Depending on availability of vaccine, this may include a process of randomization.

Composition and Membership:

The membership of the committee is intended to be reflective of relevant populations within the region. It does not aim to represent professions or professional groups.

Representative	Organization	Position
Dr. Miriam Klassen	Huron Perth Public Health	Medical Officer of Health
Dr. Alex Summers	Middlesex-London Health Unit	Associate Medical Officer of Health
Dr. Joyce Locke	Southwestern Public Health	Medical Officer of Health
Dr. Scott McKay	London Health Sciences Centre	Medical Director, Western Fair Agriplex Clinic
Dr. Gord Schacter	London Primary Care Alliance	London Middlesex Regional Pandemic Lead
Dr. Paul Gill		Huron Perth Regional Pandemic Lead
Dr Michael Clarke	Middlesex-London Health Unit	Interim CEO
Dr. Michael Silverman	St. Joseph's Hospital	Infectious disease physician
Jody Paget	Middlesex-London Health Unit	Manager, Vaccine Preventable Diseases
Rob Sibbald	London Health Sciences Centre, Western University	Director, Ethics, Patient Experience, Health Equity, Indigenous Liaison
April Mullen	London Health Sciences Centre	Director, Western Fair Agriplex COVID-19 Vaccination Clinic

Additional representation may be asked to attend at the invitation of the chair to provide information regarding certain populations and sectors.

Role of Committee Membership:

Members of the committee have a duty to:

1. Attend committee meetings
2. Participate in discussions
3. Participate in decision making

Meetings:

The COVID-19 Vaccine Prioritization Advisory Committee will meet weekly to determine the cohorts from priority populations which will receive the vaccine in the subsequent weeks.

Decision Making:

The committee will strive for consensus. A Consensus Model for Decision-Making can be found in Appendix A.

The chair will be determined at the initial meeting.

Key inputs and data required for decision making will include:

- Ontario's Vaccine Distribution Implementation Plan
- Ethical framework for COVID-19 vaccine distribution
- Guidance for Prioritizing Health Care Workers for COVID-19 Vaccination
- Anticipated vaccine doses available for upcoming 2 weeks in the Middlesex and London region
- Estimated number of individuals in each cohort
- Anticipated immunization capacity in the region

Communication and Reporting:

The committee will communicate its guidance to the Medical Officers of Health of Huron Perth Public Health, Middlesex-London Health Unit, and Southwestern Public Health.

The health units will publish decisions regarding eligibility publicly and regularly, as well as relay its decisions directly to impact cohorts and any relevant vaccine administrators.

Appendix A – Consensus Model for Decision-Making

Borrowed with permission from Huron Perth Public Health.

The simplest and most basic definition of consensus is, '**general agreement about something**' (Soanes, C. and Hawker, S., ed., The Compact Oxford English Dictionary of Current English. 3rd ed. Oxford University Press, 2005.)

In this approach, people are not simply for or against a decision, but have the option to situate themselves on a scale that lets them express their individual opinion more clearly. This model is usually used with a round, so that everyone in the meeting is given the opportunity to state where they are according to the following six levels:

1. Full support
2. Acceptable
3. Support with reservations
4. I am not thrilled with it, but I can live with it and will not block it
5. Need more information or more discussion
6. Cannot support it and cannot accept it

If everyone is at level #4 or above (3, 2, or 1), then by definition, consensus has been reached.

If someone is at level 2, 3 or 4, they have the option of explaining their reservations. These can be addressed by the meeting, if the group wishes to. This is not absolutely necessary for achieving consensus if everyone is already at 4 or higher, but it usually improves the recommendation or suggestions being discussed.

If someone is at level 5, they have the obligation to explain what information or discussion they require from the group.

If someone is at level 6, it is important for them to try and offer a solution that can accommodate their needs and the needs of the rest of the group.

In addressing someone's reservation, it is important to:

- ask everyone for possible solutions (the person expressing the concern and the rest of the group have the responsibility to find solutions)
- ask people to suggest improvements as alternatives that meet the objectives of the entire group.

IDENTIFYING CONSENSUS

Consensus is a relative term. There are varying levels of agreement with decisions, as indicated in the table below. Levels 1 through 5 all constitute consensus. Only Level 6 lacks consensus.

Level	Position	Feelings and Behaviour		
1	Agree strongly	"I really like it!"	"I'll advocate for it publicly whether or not it's adopted"	"I'll actively support its implementation"
2	Agree	"I like it"	"I'll advocate for it publicly"	I'll support its implementation"
3	Agree with some reservations	"I can live with it"	"I'll support it publicly and privately even with my reservations"	I'll participate in its implementation"
4	Disagree, but willing to go along with majority	"I don't like it. I'm willing to go along with it, but I want my disagreement acknowledged"	"I'll support it publicly and privately when asked"	"I won't work against its implementation"
5	Disagree, and won't be involved in implementation	"I really don't like it, but I'm willing to go along with it because I don't want to stop others"	"I'll not oppose it publicly or privately"	"I will not be involved in its implementation, but won't sabotage it"
6	Opposed, and will work to block	"I hate it and will work to block it!"	"I'll advocate against it publicly if adopted"	"I'll work to sabotage it"

Adapted from the SW LHIN

Appendix E: Draft - Summary of Vaccine Evaluation Plan

Phase	**Phase 1** (now)	**Phase 2** (Mar - Aug)	**Phase 3** (Aug onward)
	Limited vaccine available; 2 pilot hospital sites, expanding to more sites in a regional model	Increased vaccine supplies + expanded vaccine sites	Mass vaccination of anyone who wants vaccine; Maintenance
Evaluation Approach(es)	Quality Improvement, Elements of real-time evaluation	Process Evaluation, Elements of partnership evaluation	Summative – TBD, Elements of partnership evaluation
Focus	Are we meeting our targets? How can we improve clinic to clinic?	Implementation What does it take to run a clinic? What are the necessary components to prepare the vaccine for administration (backend)? What are the necessary components to "receive" the vaccine (front end-customer service perspective)? Equity and accessibility?	Outcomes Uptake vs. hesitancy Partnership and coordination
Activities	Form for number of vials/doses/wastage/people immunized (healthcare worker, resident, other) etc. COVax Dashboard Debrief after clinics (HPPH staff, LTCH/RH)	Form for number of vials/doses/wastage/people immunized (healthcare worker, resident, other) etc. COVax Dashboard Partner debrief (through survey) Community members (receiving the vaccine) QI – spaghetti diagrams, value stream mapping, etc.	COVax Dashboard (assuming we 100% operate in COVax and are able to pull data) Partner debrief (through survey) HPPH staff debrief Monitoring Health Line and Communications Epidemiology and Data Analytics (including Huron Perth Census Data)

		Monitoring HealthLine and Communications (i.e. what type of questions are people asking) HEIA	
Stakeholders (who needs to be involved)	LTCH/RH EMS	Municipalities Healthcare providers HPMVAC Additional stakeholders TBD	
Foundational Considerations		**Equity** **Accessibility**	