Barrie

15 Sperling Drive

Barrie, Ontario

Phone: 705-721-7520

Fax: 705-721-1495

www.simcoemuskokahealth.org

SIMCOE MUSKOKA COVID-19 VACCINATION PLAN

PUBLIC DOCUMENT

An evergreen plan – Current version February 18, 2021

simcoe muskoka DISTRICT HEALTH UNIT

CONTENTS

ACRONYMS

ABHR	Alcohol-based Hand Rub
AEFI	Adverse Events Following Immunization
AESI	Adverse Events of Special Interest
AODA	Accessibility for Ontarians with Disabilities Act
CANVAS	Canadian National Vaccine Safety Network
CCM	Case and Contact Management
CHC	Community Health Centre
DA	Dissemination Area
EMS	Emergency Medical Services
FHT	Family Health Team
FTE	Full-time Equivalent
HAVA	Hazard Analysis and Vulnerability Assessments
HCW	Health Care Worker
HCP	Health Care Provider
HHR	Health Human Resources
HPPA	Health Protection and Promotion Act
HR	Human Resources
IMS	Incident Management System
IPAC	Infection Prevention and Control
LHIN	Local Health Integrated Network
LTCH	Long-term Care Homes
MIC	Mass Immunization Clinics
OHS	Occupational Health and Safety
OHT	Ontario Health Team
OPP	Ontario Provincial Police
PCP	Primary Care Provider
PHO	Public Health Ontario
PPE	Personal Protective Equipment
Rhome	Retirement Home
RVH	Royal Victoria Regional Health Centre
SIC	Special Immunization Clinic
SMDHU	Simcoe Muskoka District Health Unit
VIM	Vaccine Inventory Management

ABOUT SIMCOE MUSKOKA

Simcoe Muskoka District Health Unit's (SMDHU) jurisdiction is comprised of both the County of Simcoe and the District of Muskoka. Our area is vast in geography, covering over 8,800 square kilometres with 7 office locations and one clinic location spread throughout our region. The main health unit office is located in Barrie, Ontario which is our most populous community with a population of over 150,000 people. Our jurisdiction offers a mix of urban cities like Barrie and Orillia, larger towns like Midland and Collingwood and various small towns and rural spaces connecting our communities. We are also unique in that our population in the Muskoka region more than doubles during the summer months as people from across the province visit or relocate to their seasonal homes in the region. Our southern communities like New Tecumseth and Bradford West Gwillimbury are rapidly growing and have a very high commuter population. There are also four First Nations communities within our health unit jurisdiction.

According to 2019 population estimate data, the total population of Simcoe Muskoka was 594,494. Out of our total population, 7% are visible minorities, 4% identify as Indigenous, and 3% are considered Francophone. At present, the only authorized COVID-19 vaccines are indicated for those 16 years and older. From the 2019 data, there were 496,242 people 16 years and older living in Simcoe Muskoka. To meet the goal of vaccinating 75% of them would equate to 372,182 individuals. Distribution of these residents throughout our jurisdiction is as follows, based on sub-regional health care planning divisions initiated by Local Health Integration Networks:

Table 1: 2019 Population Estimates of Simcoe Muskoka Local Health Integrated Network (LHIN) Sub-regions

Community	Population 15 years and older
Muskoka	58,323
Barrie and area	194,323
Couchiching (Orillia and area)	71,621
South Georgian Bay area	53,545
North Simcoe area	45,900
South Simcoe area	79,063

Data Source: Statistics Canada, Annual population estimates by age and sex, July 1, 2001 to 2020. Populations living in Indigenous communities are included. **Population ages 16+ is unavailable at the LHIN sub-region level**.

A map of these sub-regions is shown in the Prioritization of Populations section: Geographical Distribution.

WHERE WE ARE TO DATE

COVID-19 was declared a global pandemic in March 2020. The infectiousness and virulence of SARS-CoV-2 is substantial, impacting the health and lives of those most vulnerable by age, infirmity and sociodemographic circumstances, and is having great impact on our economic, social and emotional wellbeing. Most recently, the Simcoe Muskoka region has been significantly challenged by the introduction of the more highly transmissible UK B.1.1.7 variant. Effective and efficient delivery of the COVID-19 vaccines is the key means by which we will overcome this pandemic. Throughout the course of 2021, SMDHU is leading the rollout of the local COVID-19 Vaccination Plan as mandated in the Health Protection and Promotion Act (HPPA) and the Ontario Public Health Standards, leveraging our infrastructure, experience and established relationships within our local communities. It will take a whole community approach with participation from many agencies and individuals, to vaccinate the majority of the over half million people in Simcoe Muskoka.

The Simcoe Muskoka COVID-19 Vaccination Campaign requires a phased approach, with various models of vaccine delivery required along the way. We started with the arrival of Pfizer-BioNTech COVID-19 vaccine in our area by launching a very successful central clinic site at 29 Sperling Drive in Barrie, which was a partnership between SMDHU, Royal Victoria Regional Health Centre (RVH) and the City of Barrie. In accordance with the initial sequencing established by the province within Phase 1 of the vaccine roll-out, this clinic was set up initially to vaccinate the following priority groups:

- Long-term care home (LTCH) staff & essential caregivers
- Retirement home (Rhome) staff & essential caregivers
- High risk hospital staff

From December 22, 2020 to February 17 2021, 10,631 first doses and 8,451 second doses have been provided to these priority groups. This clinic location has continued to operate based on vaccine supply, under the leadership of RVH, operated by their staff and a group of volunteer Health Care Workers (HCW) from within our community. This clinic will continue to operate while the Pfizer vaccine is provided to our region.

With provincial approval on January 6, 2021 that the Pfizer vaccine could be moved under strict vaccine storage and handling restrictions, public health staff were redirected from supporting the 29 Sperling Clinic location to creating Mobile Immunization Clinic teams that were deployed the week of January 11, 2021. As of February 17, 2,942 eligible LTCH residents have received their first vaccine dose. Due to limited vaccine supply, the focus of these clinics was on immunizing residents, but any additional doses were provided to staff and essential caregivers to ensure no

vaccine was wasted. Limited dose-one appointments continued to be made available at the 29 Sperling Drive clinic for those staff and essential caregivers not yet vaccinated. All LTCH residents have now been offered their second dose, with 2,743 (85%) residents fully immunized.

Starting the week of January 18, this same mobile clinic model was deployed to Rhomes. However, with the Pfizer vaccine delay announcement that same week, the province directed us to only provide vaccine to high risk Rhomes. Nineteen of the region's 53 Rhomes (including one Elder Care home in Rama First Nation), meet the Ministry's high-risk criteria. Residents in these homes were all offered their first dose of vaccine by end of day Wednesday, January 27. With the confirmation of variants of concern in Barrie, Bradford, Midland and Collingwood, residents and staff in Rhomes in those areas were also offered immunization as an additional strategy to decrease transmission in those communities. This brought the total number of Rhomes vaccinated to 37, with 2,516 (69%) residents vaccinated with their first dose as of February 17. Visits to complete 2nd doses are currently underway with 855 (23%) residents fully immunized to-date. After these homes are complete, we will then resume clinics in the remaining homes when more vaccine supply is available in late February.

To maintain coverage among residents on an ongoing basis, the following interim process has been developed until such time as LTCH & Rhomes can store and handle COVID-19 vaccine:

Existing Residents who become hospitalized who require dose 2:

→ LTCH/Rhome to include this information in their transfer of care to the hospital

→ Hospital to notify public health when they have 6 of these patients along with new ALC patients to be vaccinated (with the goal that patients get their 2nd dose at 21-27 days)

Resident moving to LTCH/Rhome who received dose 1 in hospital:

→ Hospital will provide the facility with the dose 1 information as part of the residents Transfer of Care documentation

→ LTCH/Rhome to notify Public Health ext. 8806 to make arrangements for dose 2

New Residents in LTCH & Rhomes

- If resident came from another facility, confirm with the originating facility if COVID-19 vaccine has been received.
- LTCH/Rhome to notify public health at ext. 8806 when they have 6 residents who are eligible for vaccine

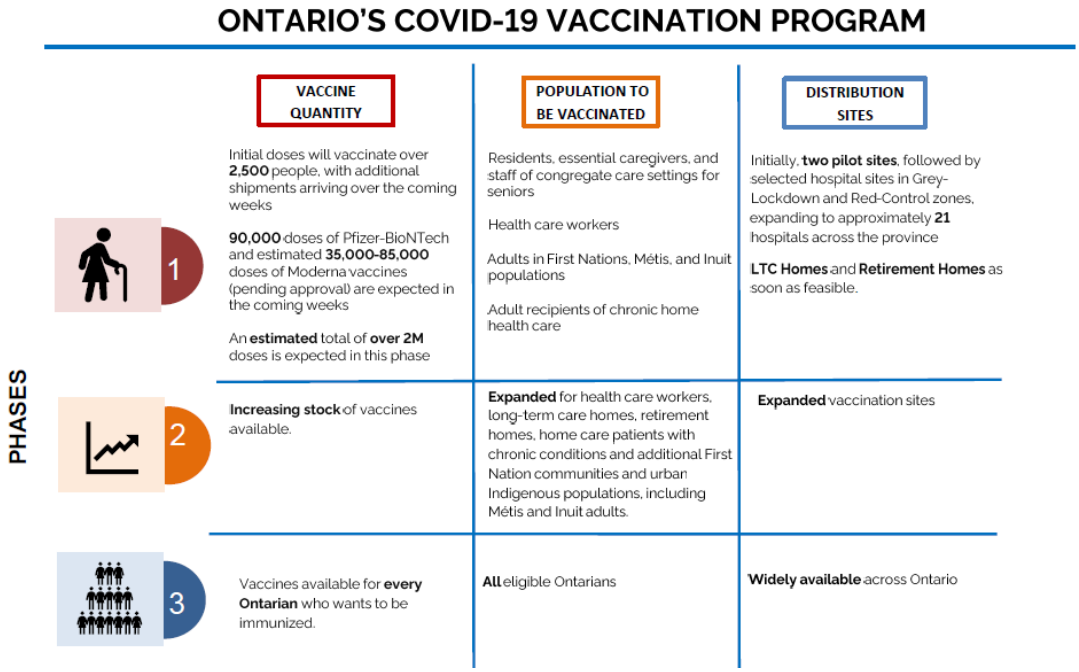
- At this time, we only have Pfizer vaccine – if Moderna is required, will need to connect with facility who started the series for completion

The remainder of this plan is focused on a Community Hub Clinic model, which will be required as vaccine becomes more available to more priority groups in our community, but before we are at a point that vaccine is readily available for primary care and pharmacists to administer, similar to other vaccination programs.

COVID-19 Vaccine Distribution Plan – 3 Phased Approach

The province of Ontario's COVID-19 Vaccination Program is based on a 3 phase approach as depicted below.

Table 2: Ontario's COVID-19 Vaccination Program – 3 Phase Approach



Data Source: Ontario's Vaccine Distribution Implementation Plan. COVID-19 Vaccine Distribution Task Force, December 11, 2020

At this time, we remain in Phase 1, with several groups in that phase remaining to be immunized as soon as more vaccine supply is available. See Prioritization of Populations section for upcoming populations.

Table 3: Immunization Summary by Eligible Priority Groups to Date, Simcoe Muskoka, as of February 17, 2021

Priority Group	Doses Administered on Previous Day	Total Administered (1st Dose)	% Receiving 1st Dose	Total Administered (2nd Dose)	% Fully Immunized (2nd Dose)
LTC Home Staff & Essential Caregivers	0	3,438	64%	2,167	40%
LTC Home Residents	0	2,942	92%	2,743	85%
Retirement Home Staff & Essential Caregivers	0	1,760	46%	1,135	29%
Retirement Home Residents	0	2,516	69%	855	23%
Hospital Staff & Residents	0	5,433	55%	5,149	53%
Other	0	266	N/A	81	N/A
Total	**0**	**16,355**		**12,130**	

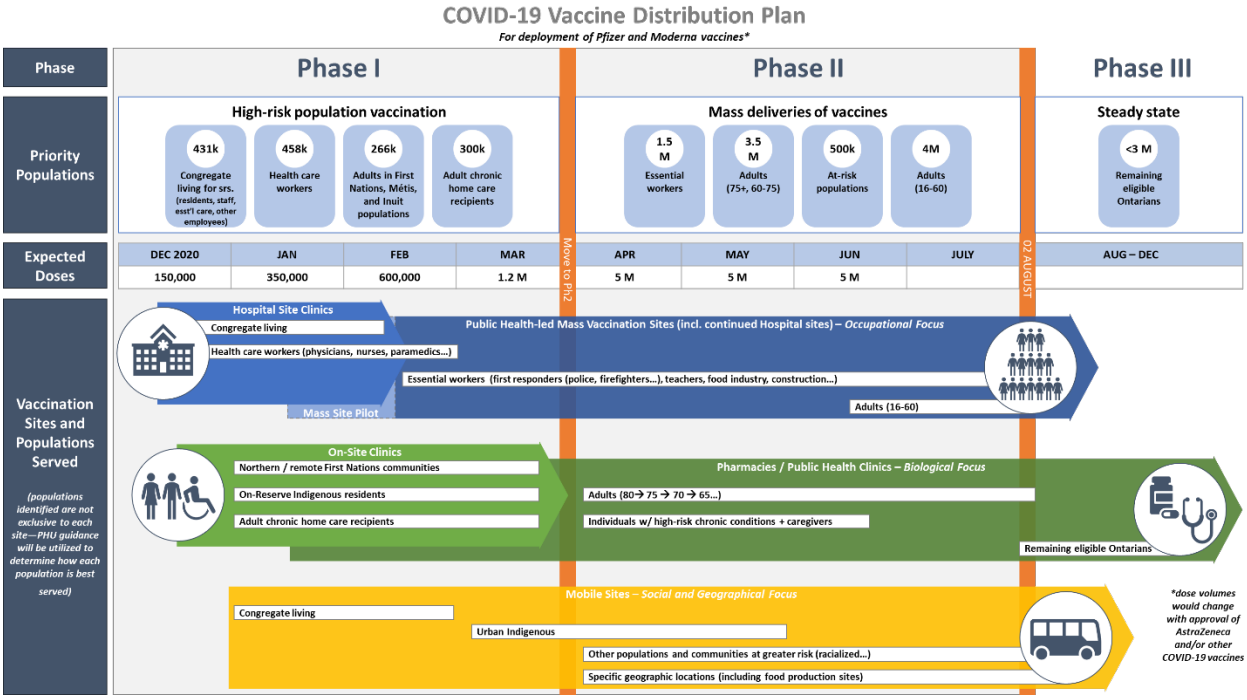
Other includes other public health staff, first responders or other health care workers. ***Facilities located in Indigenous communities are included in the LTCH and RHomes data.***

Table: Click the data source hyperlink for definitions and limitations Source: Vaccine data provided by Royal Victoria Regional Health Centre, last updated: 2021-02-17 Get the data Created with Datawrapper

The province has also developed a more detailed COVID-19 Vaccine Distribution Plan which provides a timeline for how we will continue to move through vaccinating the various priority groups over most of 2021. This is based on the availability of Pfizer BioNTech COVID-19 vaccine and Moderna COVID-19 vaccine. To date we have received only Pfizer vaccine in our area. While some Moderna vaccine was initially allocated to SMDHU in early January, this supply was reallocated to other hardest hit areas of the province to facilitate the immunization of their LTCH & Rhome residents. At this time, we have not received notice if or when Moderna vaccine will be available to SMDHU.

While we know other vaccines that are less restrictive in terms of storage and handling requirements may be authorized for use in Canada in the coming months, at this time we are planning for Pfizer or Moderna vaccine to be the primary vaccine available to vaccinate our remaining phase one and phase two groups. Both of these vaccines are mRNA vaccines, which are recommended to be transported in the frozen state. This is important to minimize shaking and agitation of the vaccine during transport, which can affect the integrity of mRNA vaccines. Onward movement of these vaccines once they have thawed is not recommended.

Ontario's COVID-19 vaccine distribution plan is demonstrated through the following graphic:



A local COVID-19 vaccination plan is a monumental task that will require the combined efforts of many community partners. To meet the goal of vaccinating 75% of the vaccine-eligible population, Simcoe Muskoka as a community must immunize 372,182 individuals twice, as both products currently authorized for use require two doses. In order to do so, we must build on our existing immunization infrastructure and consider new and innovative means of vaccinating.

MANDATE

To ensure the timely, effective, efficient, equitable, and safe delivery of vaccines within the Simcoe Muskoka area in accordance with provincial directions and guided by local needs/capacity.

OBJECTIVES

- Achieve the goal of *at least* 75% of the eligible population in our local public health jurisdiction immunized with a complete series of COVID-19 vaccine by the end of August 2021.

- To use a collaborative approach with our community partners to plan and implement the local mass immunization program.
- To ensure First Nations, Inuit, and Metis people and other populations at higher risk (i.e., racialized populations) are meaningfully engaged in the mass immunization program.

GOVERNANCE

In a traditional vaccination campaign, it takes many partners to achieve success. The Ministry of Health sets priorities and targets and supports healthcare system implementation. Local public health agencies lead local vaccination programs working with partners from health and municipal sectors. Ontario Health supports coordination with local health system partners. Health care organizations support and facilitate operations where requested and develop enabling policies and strategies to support immunization. Unions and colleges work with others to support vaccination of their members. HCWs participate in the vaccination program as immunizers and recipients, counsel patients, address patient concerns and questions and combat myths.

Due to the sheer size and speed of Ontario's phased COVID-19 vaccination campaign, local public health agencies and regions will need to partner across sectors to effectively administer a mass immunization campaign. Local partners, from across sectors will need to be involved in systems level planning, scenario modelling and immunizing within their settings. Such partners could use and build upon the infrastructures already in place to support the vaccination campaign.

In Simcoe Muskoka, SMDHU will lead this campaign with the assistance and advice of many key partners. This campaign plan has been developed by SMDHU, delivered to stakeholders through the Simcoe Muskoka COVID-19 Vaccination Campaign Advisory Committee, and modified based on this feedback.

Our current governance approach is outlined here, recognizing it will continue to evolve over time. We do also note the need to include additional organizations working with vulnerable populations, either via these structures or other key engagement avenues.

SMDHU/RVH Pfizer Sperling Clinic Incident Management System (IMS) Committee

The SMDHU/RVH Pfizer Sperling Clinic IMS Committee was created for senior leadership from SMDHU and the RVH to meet in an IMS structure regarding the central-site clinic (29 Sperling Drive) in order to provide COVID-19 vaccination in accordance with the province's direction on priority populations. This is based on recommendations from the University Health Network from their experiences with their pilot vaccination clinic. The Incident Commander was initially Dr. Charles Gardner, Medical Officer of Health (MOH) of SMDHU, and then transitioned to Janice

Skot, President and CEO of RVH. Refer to Appendix A for the SMDHU/RVH Pfizer Sperling Clinic IMS Committee Terms of Reference.

SMDHU COVID-19 Vaccine IMS Committee

The SMDHU COVID-19 Vaccine IMS Committee is tasked with planning and execution of internal SMDHU vaccination clinics and the logistics of distribution and allocation of vaccination for the larger campaign. Refer to Appendix B for the draft IMS structure and linkages to other committees.

Simcoe Muskoka COVID-19 Vaccination Campaign Advisory Committee

The Simcoe Muskoka COVID-19 Vaccination Campaign Advisory Committee has been created to advise on the planning and coordination of the COVID-19 mass vaccination campaign for the population within the geographic boundaries of the SMDHU, which includes the County of Simcoe and the District of Muskoka.

Membership is based on ensuring representation from the six local Ontario Health Team (OHT)/planning regions (Couchiching, Muskoka and Area, South Georgian Bay, Barrie and Area, North Simcoe, and South Simcoe), and representation by the following sectors:

- SMDHU
- LTCH/ RHomes
- Acute Care (Hospitals)
- Primary Care
- First Nations communities and urban/rural Indigenous populations
- Community pharmacies
- Municipalities
- The Local Health Integrated Network (LHIN), and the Central Region of Ontario Health
- Racialized and newcomer populations
- Marginalized populations (homelessness; mental illness and addictions)

The objectives of the committee are:

1. To advise health system partner leads on how to operationalize the provincial mass vaccination campaign.
2. To identify local health systems risks and operational implications that may impede the campaign.
3. To identify strategy/mechanisms 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 participate in the 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. To develop a localized strategy/plan for community-based vaccination distribution and administration.

For more information, please see the SMDHU Vaccination Campaign Information Page for meeting materials and terms of reference.

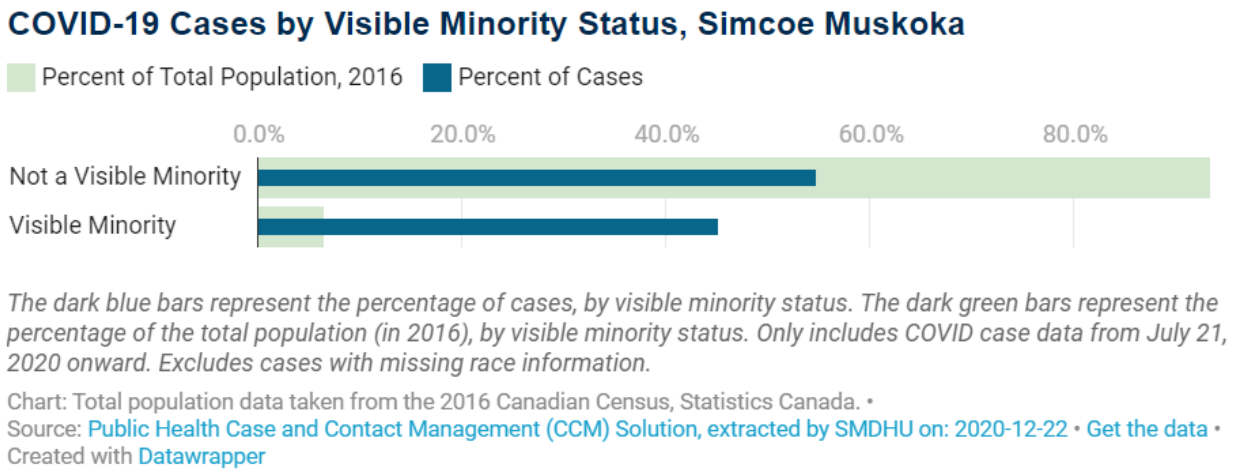
ETHICS AND HEALTH EQUITY

The pandemic does not affect everyone equally. Many of the most disadvantaged in society are suffering the worst burden from COVID-19 both in their physical health and the social consequences that follow from pandemic measures. Social determinants of health, such as gender, socioeconomic position and race/ethnicity are factors that potentially put people at increased risk and severity of COVID-19 infection.

In Simcoe Muskoka, those of older age have had the highest mortality rates. Individuals in LTCHs are particularly vulnerable.

In regards to risk of infection, visible minorities are over-represented in those who have had a confirmed COVID-19 infection. Nearly half of all COVID-19 cases in Simcoe Muskoka that have provided information about their race, report being a visible minority. In comparison, visible minorities only represent 7% of Simcoe Muskoka's total population. Individuals who report a non-official language (neither English nor French) as their mother tongue represent 10% of the Simcoe Muskoka population. However, 43% of local COVID-19 cases report mother tongues other than English and French.

Figure 1: COVID-19 Cases by Visible Minority Status



Data Source: SMDHU COVID-19 HealthSTATS webpage

Unlike other areas in Ontario where COVID-19 cases are more likely to live in low income, that pattern has not been seen in Simcoe Muskoka to date. However, we recognize health inequities are typically faced by this population including barriers to accessing vaccination, therefore they are an important consideration. There is also no data available locally to date regarding impact in First Nations communities and urban Indigenous communities (First Nations, Metis and Inuit populations); however, infection can have disproportionate consequences in these communities, including those living in remote or isolated areas where risk of transmission is high.

See the SMDHU COVID-19 HealthSTATS webpage for more information.

All decisions in this plan should be mindful of health equity and tailored to maximize equity within the constraints of the available technology, vaccine supply, and information. Community engagement will be important in ensuring the vaccination campaign maximizes health for the entire population. Accordingly, SMDHU will expand the membership of the Simcoe Muskoka COVID-19 Vaccination Campaign Advisory Committee suitably to address the needs of priority populations, and – as outlined in other sections of this plan - we will collaboratively identify means of promotion and outreach to them for our community clinics and in partnership with primary care and Emergency Medical Services (EMS), to ensure access to vaccination. We will also monitor and report on vaccination rates in these groups.

Vaccines must also be distributed in an ethical manner that accounts for health equity. Below (and linked) is the provincial ethical framework for COVID-19 vaccine distribution that is based on the principles of minimizing harm and maximizing benefits, equity, fairness, transparency, and legitimacy.

Table 4: Ethical Framework for COVID-19 Vaccine Distribution

Ethical Framework for COVID-19 Vaccine Distribution

- Using the ethical principles outlined below to guide COVID-19 vaccine prioritization and distribution decisions and decision-making processes is critical for ethical and effective distribution and will help to promote consistency, stewardship, accountability, and public trust.
- Appreciating that the application of the following principles will to an extent be context-dependent and that other values and principles may be relevant to decision-making, this framework should serve as a guide and be adapted where appropriate.
- All levels of government have a legal obligation to take preventative steps to stop the spread of COVID-19 and treat people without discrimination. Vaccine distribution and prioritization decisions must comply with existing human rights protections and take additional steps necessary to prevent and treat COVID-19 among vulnerable groups. This Ethical Framework therefore should be read in conjunction with the Ontario Human Rights Commission's Policy statement on a human rights-based approach to managing the COVID-19 pandemic.

Minimize harms and maximize benefits	Equity	Fairness	Transparency	Legitimacy
• Reduce overall illness and death related to COVID-19 • Protect those at greatest risk of serious illness and death due to biological, social, geographical, and occupational factors • Protect critical infrastructure • Promote social and economic well-being	• Respect the equal moral status and human rights of all individuals • Distribute vaccines without stigma, bias, or discrimination[1] • Do not create, and actively work to reduce, disparities in illness and death related to COVID-19, including disparities in the social determinants of health linked to risk of illness and death related to COVID-19[2] • Ensure benefits for groups experiencing greater burdens from the COVID-19 pandemic	• Ensure that every individual within an equally prioritized group (and for whom vaccines have been found safe and effective) has an equal opportunity to be vaccinated • Ensure jurisdictional ambiguity does not interfere with vaccine distribution (e.g., Jordan's Principle)[3] • Ensure inclusive, consistent, and culturally safe and appropriate processes of decision-making, implementation, and communications	• Ensure the underlying principles and rationale, decision-making processes, and plans for COVID-19 vaccine prioritization and distribution are clear, understandable, and communicated publicly	• Make decisions based on the best available scientific evidence, shared values, and input from affected parties, including those historically under-represented • Account for feasibility and viability to better ensure decisions have intended impact • To the extent possible given the urgency of vaccine distribution, facilitate the participation of affected parties in the creation and review of decisions and decision-making processes

Public Trust

Ensure decisions and decision-making processes are informed by the above principles to advance relationships of social cohesion and enhance confidence and trust in Ontario's COVID-19 immunization program

Data Source: Ontario COVID-19 Vaccine Distribution Task

PRIORITIZATON OF POPULATIONS

Populations to be Vaccinated by Provincial Phase

Ontario has developed a three phase COVID-19 immunization plan focusing first on high-risk populations then moving toward mass vaccination, and eventually steady state for any remaining Ontarians who want the vaccine. At this time, the following populations have been outlined in provincial plans for the three phases (see Section 'Where we are at to date' for a graphical representation):

Phase 1: High-risk population vaccination (December 2020 to March 2021; 2.3 million doses)

- residents, staff, essential caregivers (including family caregivers) and other employees in congregate living settings for seniors
- HCWs, including hospital employees, staff who work or study in hospitals and other health care personnel (non-hospital)
    - Includes Highest priority, Very High priority, and High priority HCWs, in accordance with Ministry of Health's revised COVID-19: Guidance for Prioritizing Health Care Workers for COVID-19 Vaccination (Feb 9, 2021)
- adults in First Nations, Métis and Inuit populations
- adult recipients of chronic home health care
- adults 80 years of age and older

Phase 2: Mass deliveries of vaccines (March to July 2021, depending on availability of vaccines; 15 million doses)

This Phase is under consideration provincially for further specification, but at the present time includes:

- older adults, beginning with those 79 and below and decreasing in five-year increments over the course of the vaccine rollout
- people who live and work in high-risk congregate settings (for example, shelters, community living)
    - HCWs in congregate settings are now included in Phase 1
- frontline essential workers, including first responders, teachers and other education staff and the food processing industry
- individuals with high-risk chronic conditions and their caregivers
- other populations and communities facing barriers related to the determinants of health across Ontario who are at greater COVID-19 risk

The provincial task force will use the ethical framework and the best available data to identify other priority populations within this phase, based on available vaccine supply.

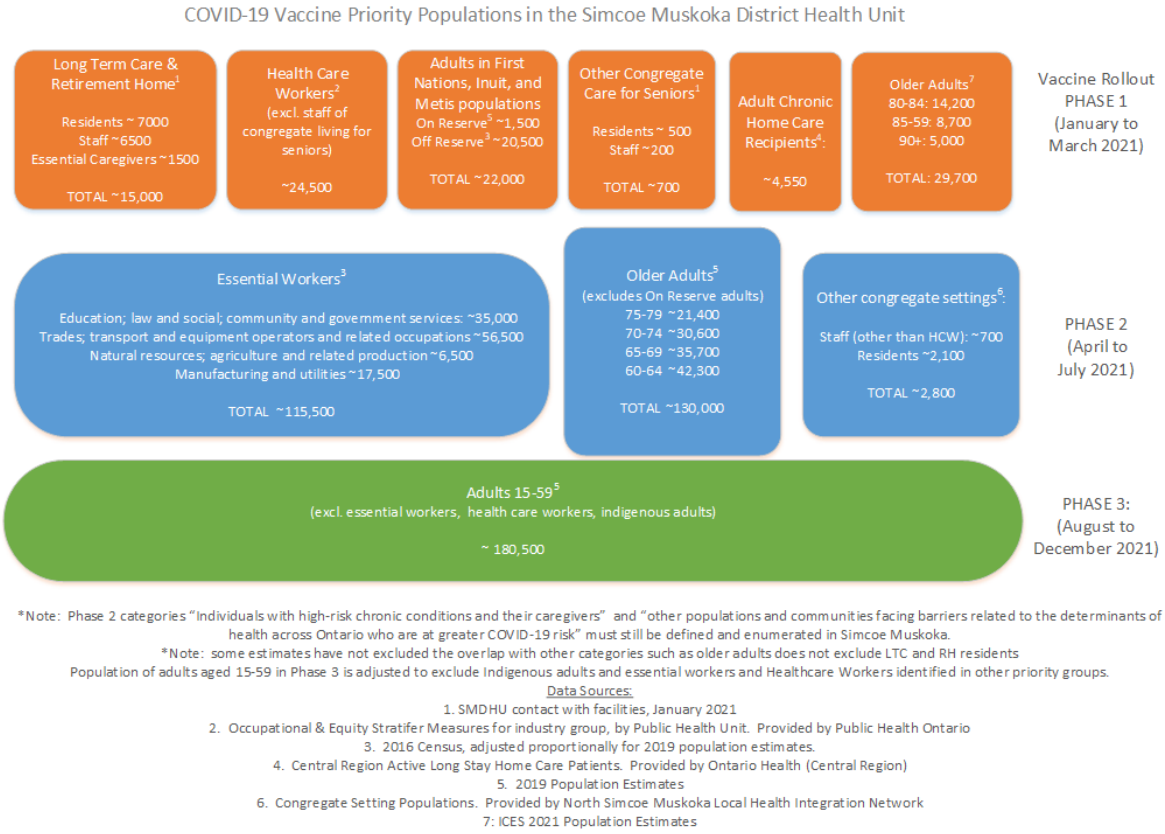
Phase 3: Steady state (August 2021 and beyond, depending on availability of vaccines; doses to be confirmed)

- remaining Ontarians in the general population who wish to be vaccinated

The ethical framework, data and available vaccine supply will help the province to prioritize groups in this phase.

Local Population Profile and Approach to Prioritization

The following graphic shows the count of many of the priority groups in SMDHU by phase:



*Note: Phase 2 categories "Individuals with high-risk chronic conditions and their caregivers" and "other populations and communities facing barriers related to the determinants of health across Ontario who are at greater COVID-19 risk" must still be defined and enumerated in Simcoe Muskoka.
*Note: some estimates have not excluded the overlap with other categories such as older adults does not exclude LTC and RH residents
Population of adults aged 15-59 in Phase 3 is adjusted to exclude Indigenous adults and essential workers and Healthcare Workers identified in other priority groups.

Data Sources:

1. SMDHU contact with facilities, January 2021
2. Occupational & Equity Stratifer Measures for industry group, by Public Health Unit. Provided by Public Health Ontario
3. 2016 Census, adjusted proportionally for 2019 population estimates.
4. Central Region Active Long Stay Home Care Patients. Provided by Ontario Health (Central Region)
5. 2019 Population Estimates
6. Congregate Setting Populations. Provided by North Simcoe Muskoka Local Health Integration Network
7: ICES 2021 Population Estimates

Within the provincial phases, more detailed prioritization is coming provincially over time. There is also the need for some degree of local prioritization/sequencing. To complete this work, a Vaccine Prioritization & Engagement Workgroup has been struck led by SMDHU, with representation from various programs at SMDHU as well as RVH. This work is further informed by the SMDHU/RVH Pfizer Sperling Clinic IMS Committee and the Simcoe Muskoka COVID-19 Vaccination Campaign Advisory Committee. Prioritization decisions are based on consideration of provincial population-specific prioritization guidance, the provincial Ethical Framework for COVID-19 Vaccination Distribution, federal guidance on prioritization of initial doses and further guidance on prioritization, and local considerations. Key principles for local prioritization of populations include:

- Population-based risk-benefit analysis, taking into consideration:
    - Risk of severe illness and death from COVID-19
    - Risk of exposure to COVID-19
- Health equity
- Local COVID-19 epidemiology

- Vaccine supply
- Feasibility of vaccination

Prioritization of Phase 1 Populations

Prioritization of HCWs

A key need for prioritizing within Phase 1 is amongst HCWs, as demand for vaccine will initially exceed supply. The Ontario Ministry of Health has issued an updated document on COVID-19: Guidance for Prioritizing Health Care Workers for COVID-19 Vaccination (Feb 9, 2021), which has been used to guide local HCW prioritization efforts. In it, a HCW is defined as:

- Any regulated health care professional, staff member, contract worker, student/trainee, registered volunteer, or other essential caregiver currently working in a health care organization including workers in non-direct patient care roles such as cleaning staff, food services staff, information technology staff, security, research staff, and other administrative staff.

Workers providing a healthcare service or direct patient service in a congregate, residential or community setting outside of a health care organization (e.g., nurse providing patient care in a school, worker performing personal support services in an assisted living facility, medical first responder in the community, peer worker in a shelter).The rationale and process for prioritizing HCWs is outlined in detail in the Ontario Guidance. Health care workers are prioritized based on risk of exposure, patient populations served, and incidence of COVID-19 outbreaks. An ethics and equity lens are to be applied to all prioritization decision-making. The following step-wise approach is outlined:

1. Prioritize health care sectors and other settings (Ministry of Health)
2. Sub-prioritize settings and sectors at the community level (performed by Public Health Unit)
3. Prioritize among workers (performed by local partners including associations, unions and colleges in collaboration with the PHU)

HCWs are to be vaccinated in parallel with vaccination of other Phase 1 priority populations, in keeping with provincial guidance. HCWs are divided into the following levels of priority for sequencing: Highest, Very High, High, and Moderate.

Collaboration with Indigenous Communities

SMDHU has engaged each of the four First Nations communities in the region to ensure equitable vaccine delivery. Planning and partnership with Wahta, Moose Deer Point, Beausoleil and Rama First Nations is underway, in order to provide and administer vaccine shortly as well as support local Health Care Providers (HCP) in vaccine delivery. It has been noted by community partners that delivery of vaccine by Indigenous health care organizations will be important to help address vaccine hesitancy.

Initial rough estimates for immunization needs and resources in First Nations communities in Simcoe Muskoka include:

Community	Location	Immunizers Available	# to be Immunized
Rama	Community Hall	Rama Paramedics, Community Health Nurses (2), SMDHU, Couchiching OHT	800
Beausoleil	Event Centre	Mamaway (4-5), Dr. Cameron, SMDHU	675
Wahta	Administration Building	Nurse Practitioner, FHT, Muskoka Paramedics, SMDHU	150-160
Moose Deer Point	TBD	2 Nurse Practitioners on Wednesdays SMDHU could transport and draw vaccine.	150-160

Data Source: Information compiled by SMDHU

Partnership and planning is also underway for a strategy to support vaccination efforts for urban and rural Indigenous populations. This is a collaboration between SMDHU and the Mamaway Wiidokdaadwin Primary Care Team, Barrie Area Native Advisory Circle, and several other urban and rural Indigenous leaders and organizations in the region. The strategy arose out of an expressed need from these Indigenous leaders for a central strategy for this population, to build further from the participation of Indigenous organizations in the Simcoe Muskoka Vaccination Advisory committee and Regional task force.

The intention of the strategy is to address systemic barriers to accessing the vaccine, including understanding the fear involved in the vaccine, and that Indigenous community members may feel uncomfortable going into the larger clinic venues. Indigenous fears and doubts are historical in nature and resulting from negative experiences within the health care system.

The urban and rural Indigenous adult population is 20,500 individuals, and prioritization guidance within this population is forthcoming provincially.

There are several components under consideration for the strategy, including:

- Targeted communications efforts – robust plan led by Mamaway, with support from SMDHU
- Vaccination settings and access - mobile clinics in smaller venues that are close and familiar to Indigenous populations, as well as welcoming Indigenous navigators and/or other Indigenous supports to the larger community clinics at any time - with such plans communicated out within Indigenous communities
- Data and privacy considerations
- Timing and sequencing - All Indigenous adults are included as Phase 1 populations,; provincial guidance has indicated that the immediate priority is “Indigenous adults in northern remote and higher risk communities (including on-reserve and urban communities)”, followed by remaining Indigenous adults.
- Indigenous Cultural Safety (ICS) - Providing a foundation of ICS for all health agencies involved in vaccination planning and implementation.

Simcoe Muskoka Vaccination Prioritization Plan – Phase 1 populations

Based on recent provincial guidance on sequencing of remaining Phase One Priority Populations, and consideration of Simcoe Muskoka’s local principles for prioritization of populations outlined previously, the following prioritization plan has been developed:

Simcoe Muskoka Vaccination Prioritization

Current as of: February 18, 2021

Notes:

- Subject to revision based on provincial direction or local considerations
- Within Provincial Phases, proposed sequencing (if required by vaccine supply/feasibility) is indicated by Tiers
- The order of Groups listed within Tiers does not indicate further sequencing; any order of Groups may be acceptable, pending other operational and epidemiologic considerations
- Priority/high incidence neighbourhoods (all COVID and/or variant-specific) should be considered first within each of the below Groups where additional prioritization is required

PHASE 1 POPULATIONS

Tier	Group		Group Composed of	Notes	Simcoe Muskoka Population Size	Sub-regional population size (where relevant/ available)
Tier 1	LTCH, High-Risk RH, First Nations Elder Care homes		Residents, staff & essential caregivers	To complete before moving to Tier 2	15,000	
	Hospital staff, patient facing		Hospital staff who received at least 1 dose in Tier 1		5,239	
	Alternate Level of Care (ALC) patients		Going forward: those with confirmed admission to LTCH, RH or other congregate care home for seniors	ALC Congregate Settings	40	
Tier 2	Remaining RH		Residents, staff & essential caregivers		See Tier 1	
	Highest Priority HCWs & Others (frontline)	Hospital and acute care staff in frontline roles with COVID-19 patients and/or with a high-risk of exposure to COVID-19 (including those performing aerosol-generating procedures)	CCU, ED and Urgent Care, COVID-19 Medical Units, Code Blue Teams, rapid response teams, General internal medicine and other specialists involved in the direct care of COVID-19 positive patients	Included in Tier 1	See Tier 1	
		Medical First Responders	Paramedics		280	
			Firefighters providing medical first response		1,421	

PHASE 1 POPULATIONS						
Tier	Group		Group Composed of	Notes	Simcoe Muskoka Population Size	Sub-regional population size (where relevant/ available)
Tier 2	Highest Priority HCWs & Others (frontline)	Patient-facing health care workers involved in the COVID-19 response	COVID-19 Specimen Collection Centers (e.g., Assessment centers, community COVID-19 testing locations)		195	
			Teams supporting outbreak response	If not included in other groups	TBD and additional determined as needed during outbreak response	
			COVID-19 vaccine clinics and mobile immunization teams	To include immunizers, screeners and clerks. Some included in other vaccinated groups.	5 + upcoming clinic staff TBD	
			COVID-19 laboratory services	PHO Orillia Lab	17	
			Mobile testing teams		57	
			High risk walk-in clinics	Included in Assessment Centre #s		
		Community health workers serving specialized populations	Home and community care HCWs caring for recipients of chronic homecare and seniors in congregate living facilities or providing hands-on care to COVID-19 patients in the community (Highest priority) AND Home and community care (other – Very High Priority)	Home care + Staff in Congregate living settings for seniors other than LTCH, RR, and ALC	1450	
			Needle exchange/syringe programs		150 (incomplete)	
			Aboriginal health access centres	Mamaway Wiidokdaadwin Primary Care Team	Included in HCWs in Remote Communities	

PHASE 1 POPULATIONS						
Tier	Group		Group Composed of	Notes	Simcoe Muskoka Population Size	Sub-regional population size (where relevant/ available)
Tier 2	Highest Priority HCWs & Others (frontline)	Community health workers serving specialized populations	Special Consideration: CHCs serving disproportionally affected communities and/or communities experiencing highest burden of health, social and economic impacts from COVID-19	All CHCs Pending South Georgian Bay CHC #s. Other CHC's included above in AC/WIC	TBD	
			Special Consideration: Highly critical HCWs in remote and hard to access communities, e.g., sole practitioner	First Nations communities	125	
		Remaining acute care and other hospital settings (from Very High Priority HCWs)	Patient care areas not included above, for hospital staff not vaccinated in Tier 1	Awaiting #'s from GBGH, Waypoint	608	
		Hospices and palliative care settings (from Very High Priority HCWs)	Staff in Hospice		200	
	Indigenous adults in northern remote and higher risk communities (including on-reserve and urban communities)		Adults in First Nations Communities	2019 Population Estimate	1,550	
			Urban and rural Indigenous adults (Initiate in Tier 2 – highest risk)	2019 Population Estimate	Some of: 20,500	Barrie & Area: 6100 Couchiching: 3500 Muskoka: 1800 North Simcoe: 6500 South Georgian Bay: 1300 South Simcoe: 1300

PHASE 1 POPULATIONS						
Tier	Group		Group Composed of	Notes	Simcoe Muskoka Population Size	Sub-regional population size (where relevant/ available)
Tier 3	Very High Priority HCWs	Congregate settings	HCWs in assisted living, correctional settings, residential facilities, shelters, supportive housing (outside of the Highest Priority HCWs)	Excludes congregate settings for seniors. Pending CNCC.	2,220	
		Community care with high risk of exposure and serving specialized patient populations	Adult day programs for seniors		TBD	
		Other health care services for Indigenous populations	Community agencies with patient-facing providers delivering any type of health services to First Nations communities and Indigenous Peoples that are not captured in Highest Priority HCWs		TBD	
		Community care with high risk of exposure and serving the general population	Offices of physicians: Gynecology/obstetrics , Medical and surgical specialties, Otolaryngology (ENT), Primary care, Walk-in clinics, Psychiatry	2019 Population estimates derived from census via PHO	1,780	
			Other Health Practitioners **(Enumeration data includes both Very High Priority HCWs and High Priority HCWs):** Mental health and addictions services, Midwifery, Nurse practitioner-led clinics / contract nursing agencies, Paramedics, Dietary / nutrition, Independent health facilities (e.g., Opticians, Podiatry, Audiology), Naturopathy / holistic care, Chiropractic, Kinesiology, Occupational Therapy, Physiotherapy, Psychology, Psychotherapy, Acupuncture, Other therapy	2019 Population estimates derived from census via PHO	1,885	

PHASE 1 POPULATIONS						
Tier	Group		Group Composed of	Notes	Simcoe Muskoka Population Size	Sub-regional population size (where relevant/ available)
Tier 3	Very High Priority HCWs	Community care with high risk of exposure and serving the general population	Out-patient care centres **(Enumeration data includes both Very High Priority HCWs and High Priority HCWs):** Urgent care centres, Community health centres, Immunization clinics, Mental health and addictions services, Respirology (Respiratory Therapy), Sexual health clinics, Chronic pain clinics, Registered massage therapy	2019 Population estimates derived from census via PHO	1,445	
			Birth centres	Included in categories above		
			Community Based Specialists	Included in categories above		
			Death investigation professionals	Included in categories above		
			Dentistry	2019 Population estimates derived from census via PHO	1,945	
			Gynecology/obstetrics	Included in office of physicians (above)		
			Midwifery	Included in Other Health Practitioners (above)		
			Nurse practitioner-led clinics / contract nursing agencies	Included in Other Health Practitioners (above)		
			Otolaryngology (ENT)	Included in office of physicians (above)		
			Pharmacies	2019 Population estimates derived from census via PHO	2,765	
			Primary care	Included in office of physicians (above)		
			Respirology (Respiratory Therapy)	Included in Outpatient Care (above)		
			Walk-in clinics	Included in office of physicians (above) (Those not included in Highest Priority HCWs)		
		Laboratory services	Laboratory Services	Other than PHO Orillia lab (included above in COVID lab)	705	

PHASE 1 POPULATIONS						
Tier	Group		Group Composed of	Notes	Simcoe Muskoka Population Size	Sub-regional population size (where relevant/ available)
Tier 3	Adults age 80 and over			2021 Population Estimate	29,700 80-84: 14,200 85-89: 8,700 90+: 5,000	Barrie & Area: 9350 Couchiching: 4750 Muskoka: 4200 North Simcoe: 3150 South Georgian Bay: 4500 South Simcoe: 3800
	Staff, residents and caregivers in other congregate care settings for seniors (e.g., assisted living)			Residents of Congregate Settings other than LTCH, RH and ALC, for seniors	420	
	Adult recipients of chronic home care				4,850 including 800 home bound	Barrie & Area: 1650 Couchiching: 800 Muskoka: 600 North Simcoe: 600 South Georgian Bay: 650 South Simcoe: 600
	Urban and rural Indigenous adults (Complete in Tier 3)				Remaining of 20,500 from Tier 2	
	High Priority HCWs	Community care with lower risk of exposure and serving special populations	Developmental services, mental health and addictions services	Included in Outpatient Care Centres and Other Health Practitioners (above)		
		Community care with lower risk of exposure and serving general population	Campus health	2019 Population estimates derived from census via PHO	25	
			Community diagnostic imaging	Included in Laboratory Services (above)		
			Daycare/school nursing	2019 Population estimates derived from census via PHO	35	
			Dietary / nutrition	2019 Population estimates derived from census via PHO	110	

PHASE 1 POPULATIONS						
Tier	Group		Group Composed of	Notes	Simcoe Muskoka Population Size	Sub-regional population size (where relevant/ available)
Tier 3	High Priority HCWs	Community care with lower risk of exposure and serving general population	Independent health facilities (e.g., Opticians/Optometry , Podiatry, Audiology, medical and surgical specialties)	Included in Offices of Other Health Practitioners (above)		
			Naturopathy / Holistic care	Included in Offices of Other Health Practitioners (above)		
			Social work		TBD	
			Sexual health clinics	Included in Outpatient Care (above)		
		Non-acute rehabilitation and therapy	Chiropractic, Chronic pain clinics, Kinesiology, Occupational therapy, Physiotherapy, Registered massage therapy / Acupuncture, Other therapy Psychiatry, Psychology, Psychotherapy	Included in Outpatient Care Centres and Other Health Practitioners (above)		
		Public health	All front line public health not already captured		TBD	

Prioritization of Phase 2 and 3 populations

Further provincial direction on prioritization of Phase 2 and 3 populations is forthcoming. The following local population data will help inform Simcoe Muskoka's considerations. The use of mapping can be used to target priority groups, identifying where the majority of particular groups are located. This information will also help determine high needs locations for clinic setup, and areas where community engagement and outreach may be particularly important.

As highlighted earlier in this plan, local SMDHU data on COVID-19 infection demonstrates:

- Seniors 80 years of age and older have been disproportionately impacted by the pandemic, in terms of acquiring COVID-19 and experiencing severe outcomes. As of February 18, 2021, seniors had the second highest incidence rate (1268 cases/100,000) and the highest hospitalization rate (26.9 hospitalizations/100 confirmed cases) and case fatality rate (32.9

deaths per 100 confirmed cases) of all age groups. Local hospitalization and fatality rates increase with each age group from 35-44 yrs and up.

- Visible minorities are highly over-represented among confirmed COVID-19 cases in Simcoe Muskoka. Nearly half of all COVID-19 cases in Simcoe Muskoka that have provided information about their race report being a visible minority. In comparison, visible minorities only represent 7% of Simcoe Muskoka's total population.
- Individuals who report a non-official language (neither English nor French) as their mother tongue represent 10% of the Simcoe Muskoka population. However, 42% of local COVID-19 cases report mother tongues other than English and French.
- Most COVID-19 cases in Simcoe Muskoka are from the Barrie and South Simcoe areas, and the highest recent weekly incidence rates were in Bradford West Gwillimbury, Barrie, Adjala-Tosorontio, Collingwood, Innisfil and Essa.

The following data and maps provide additional information on these populations:

Older adults

Community-dwelling older adults are a key priority group based on the epidemiology of the outbreak and provincial vaccination plan. The LHIN sub-regions of South Georgian Bay, Muskoka and North Simcoe have the highest proportions of senior populations:

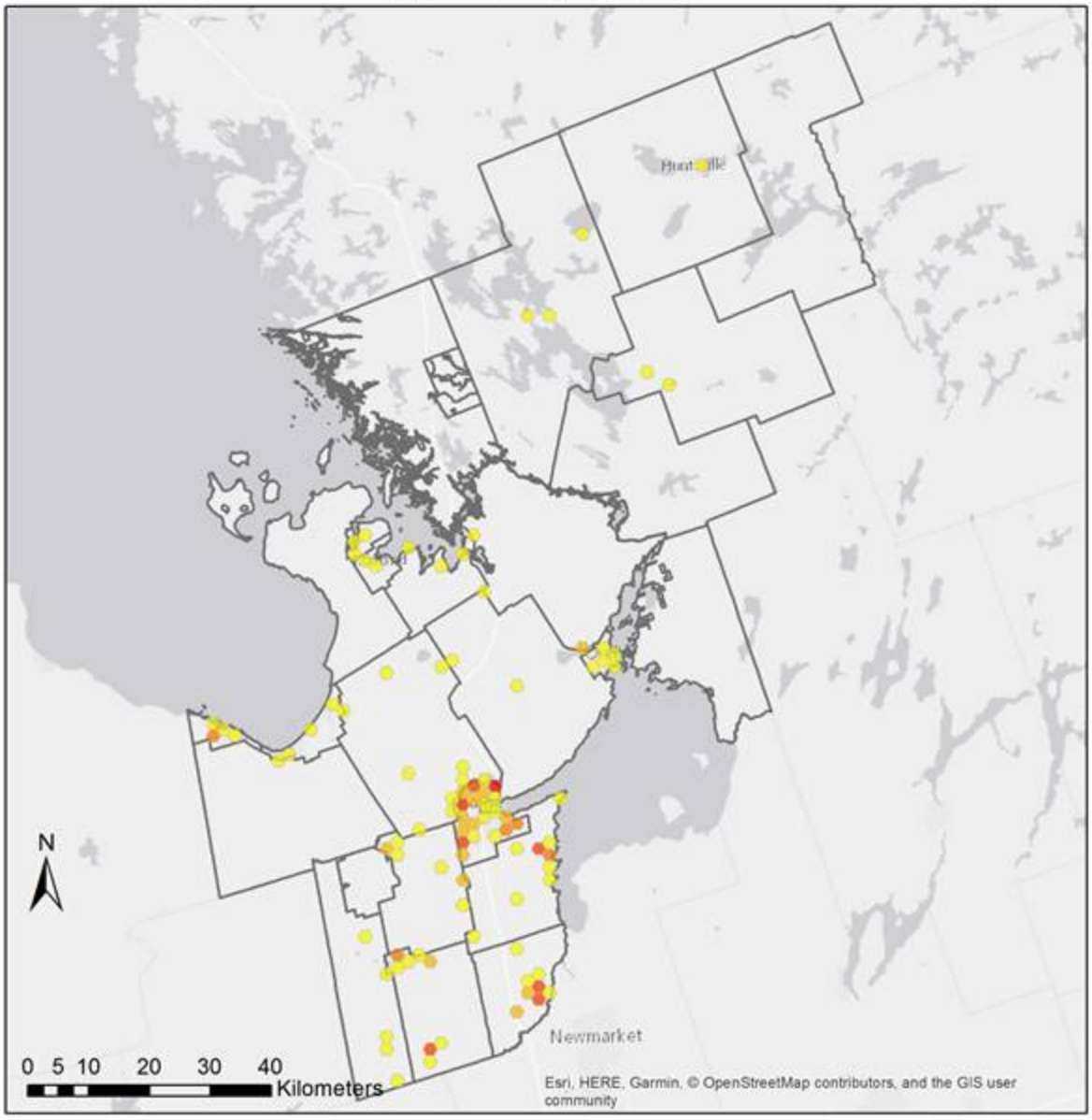
LHIN Sub-region	Population Ages 65+	% of Total Population
South Georgian Bay	17190	27.8%
Muskoka	17557	26.7%
North Simcoe	12930	25%
Couchiching	18764	22.9%
South Simcoe	15010	15.6%
Barrie and Area	33748	14.4%

Geographical Distribution

It is important to consider the locations (based on residence) of the confirmed COVID-19 cases to identify community clusters. Clustering of cases assessed at regular time intervals will be used to identify ongoing patterns of higher risk communities, as well as new needs for mobile clinics or adjustments to already-established clinic sites.

In the map below, confirmed COVID-19 cases (excluding institutional resident cases) living in Simcoe Muskoka with an accurate episode date in the past four weeks have been mapped by address. A heat map is used to remove any possibility of identifying individuals. Results indicate that high numbers of cases, or hot spots, are in north Barrie, Innisfil/Alcona, Alliston, the Town of Bradford area and Tottenham.

SMDHU COVID-19 Confirmed Cases with Accurate Episode Date On or After February 3, 2021 Simcoe Muskoka



Hot Spot Analysis

 # COVID-19 Cases On or After Feb 3

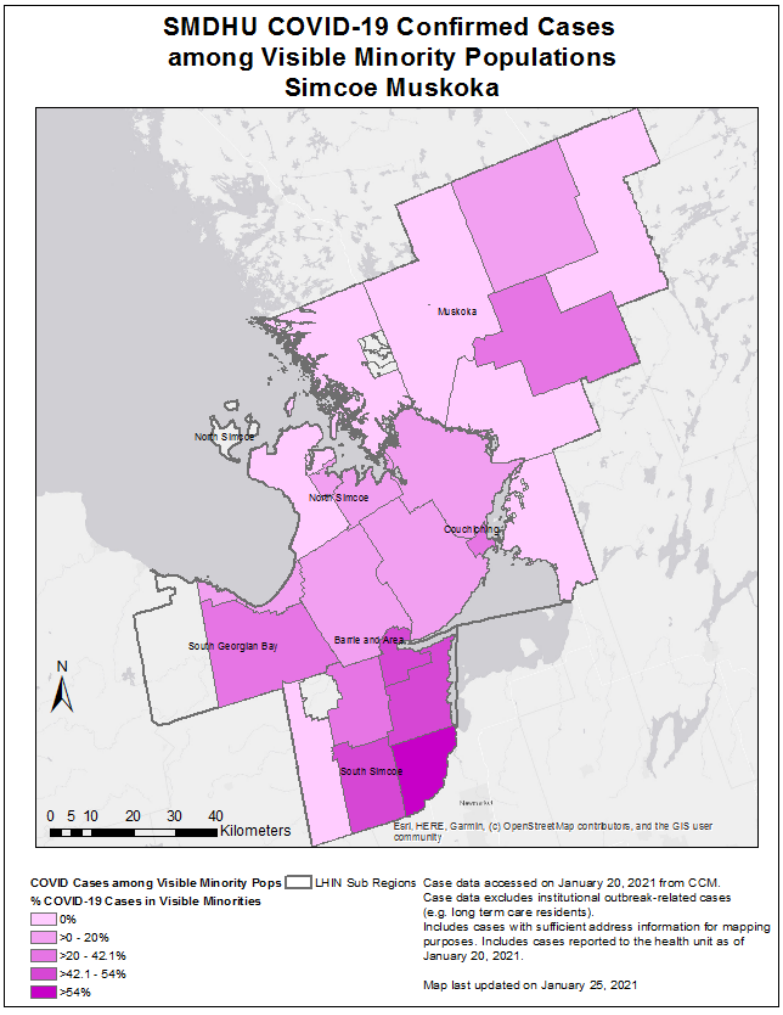
- 1 - 2
- 3 - 5
- 6 - 10
- 11 - 16
- 17 - 23

Case data accessed on February 10, 2021 from CCM.
Case data excludes institutional outbreak-related cases (e.g. long term care residents).
Includes cases with sufficient address information for mapping purposes. Includes cases reported to the health unit as of February 17, 2021.

Map last updated on February 17, 2021

Racialized Communities

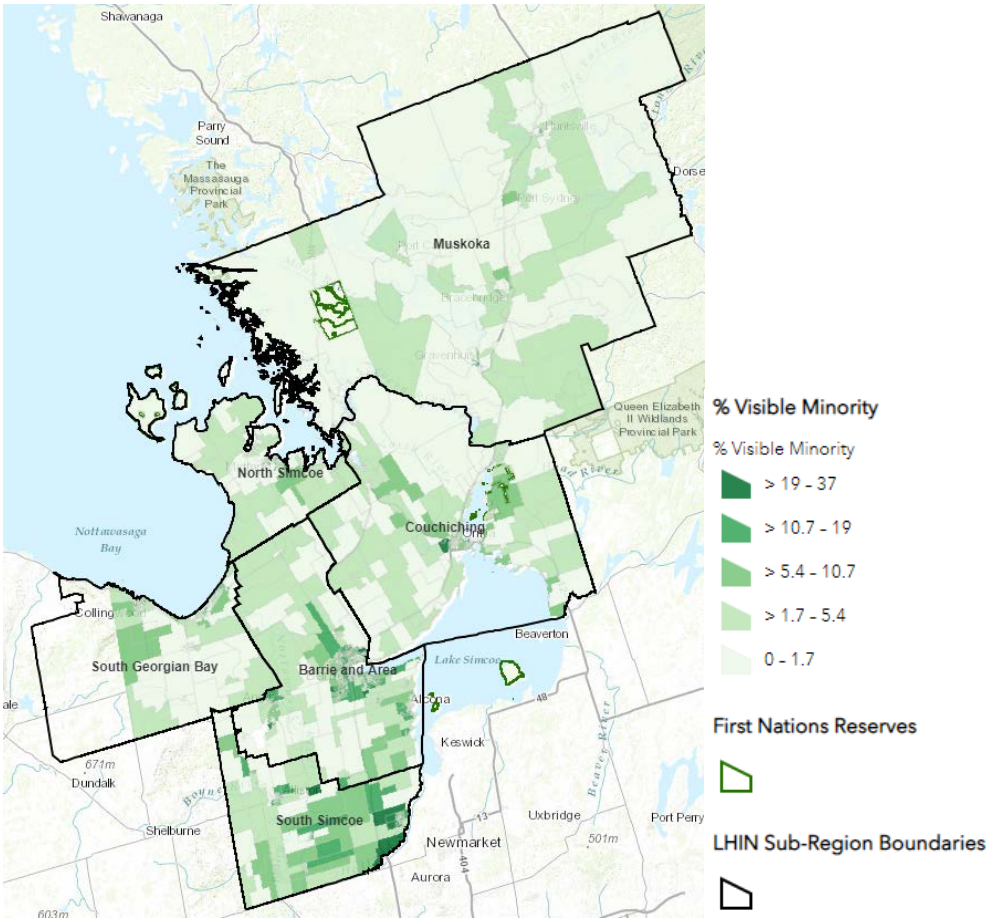
COVID-19 cases that self-identify as a visible minority are geographically located throughout Simcoe Muskoka. The map illustrates that the municipalities of Innisfil, New Tecumseth and Barrie have between 42.2% and 54% of their confirmed COVID-19 cases (those who provided this information) identifying as a visible minority. The municipality of Bradford West Gwillimbury has an even higher percentage with >54% of their COVID-19 confirmed cases self-reporting as a visible minority.



More generally, the map below illustrates the percent of each dissemination area's (DA) population in Simcoe Muskoka that self-identified as a visible minority (2016 Census). The darker green shaded areas indicate higher concentrations of visible minorities (from 19% to 37% of the DA's population). Of note are the populations in the Barrie & Area and the South Simcoe Area. Bradford West Gwillimbury, a municipality in the South Simcoe Area, had the

highest percentage of the population identifying as a visible minority (20.5% or 7,160). The City of Barrie followed with 10.3% of its population identifying as a visible minority.

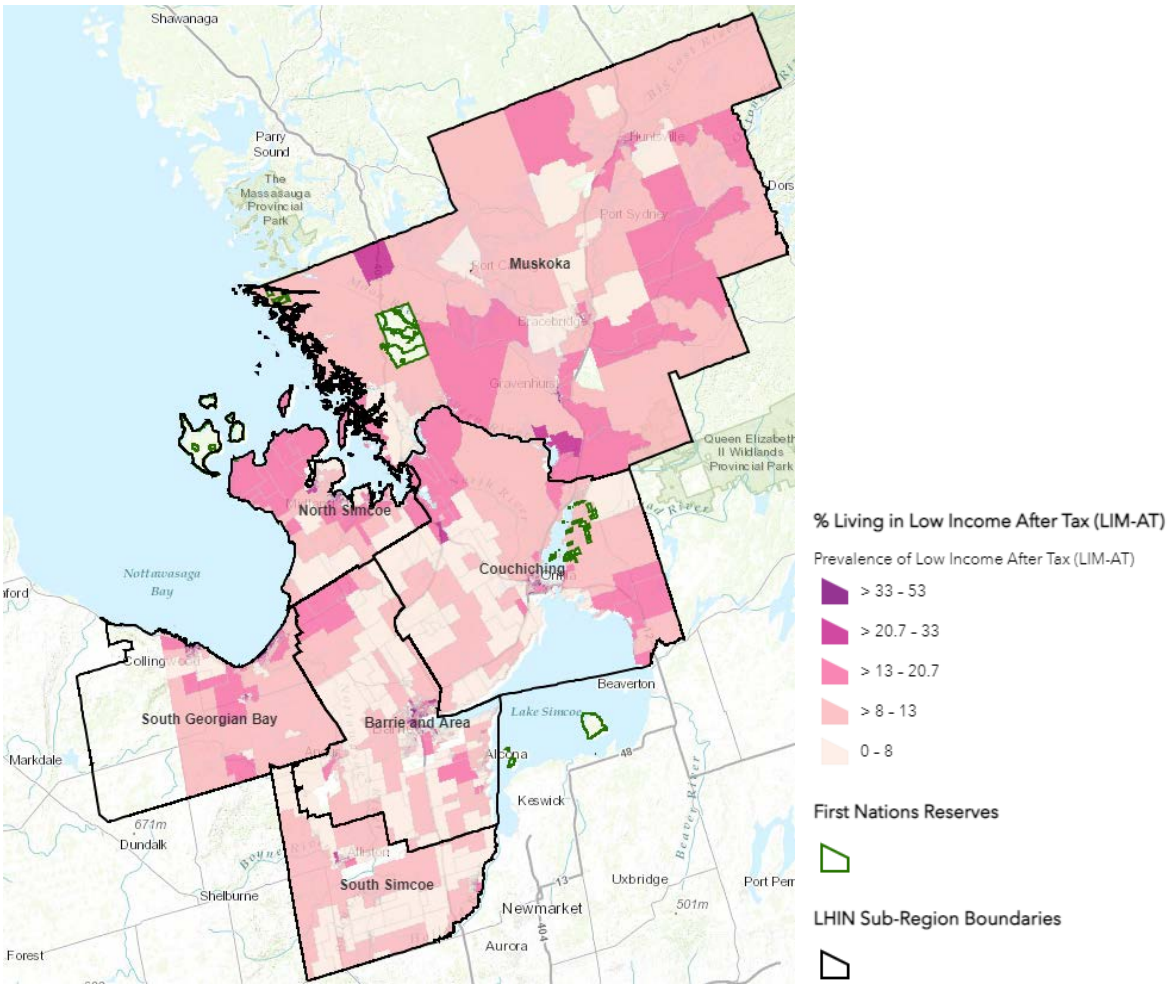
Visible Minority Population, Simcoe Muskoka, 2016



Data Source: Statistics Canada, 2016 Census

Low Income

According to the 2016 Census, the North Simcoe sub-region has a high proportion of its population living in low income (20.7%-33% in certain DAs). In addition, Orillia (Couchiching sub-region) also has a high percentage of its population living in low income at 18.3%, as does the town of Gravenhurst (Muskoka sub-region) at 17.1%.



Data Source: Statistics Canada, 2016 Census

Overlapping Jurisdiction

Health Unit borders do not always neatly align with other jurisdictions such as LHINs, school boards, OHTs, and Family Health Teams (FHT). This plan is focused on the vaccination of those within SMDHU boundaries as defined in the HPPA but recognizes the common goal of vaccinating all Ontarians. Situations may arise where a person might be immunized from outside the health unit. For example, someone may work in a facility within one health unit but live within another health unit area, visiting medical learners may be present, or a FHT's boundaries may overlap two health units.

In general, if a person is in SMDHU boundaries, is currently prioritized for a vaccine, and can receive their second dose in the area they should receive the vaccine regardless of their home address. Vaccinating all Ontarians is in everyone's best interest.

Organizations who are located within two health unit areas should make this known to both health units before receiving vaccine in order to determine which vaccine they should receive

(as they are not interchangeable), the amount of vaccine to receive and from which health unit they should receive it from. This is important to avoid double shipments or under-distribution.

A notable circumstance in Muskoka is the large seasonal increase in population in spring-summer months. This will continue to be raised provincially for consideration within Simcoe Muskoka's vaccine allocation and will also be considered in local allocation plans.

ENGAGEMENT OF COMMUNITY PARTNERS

The vaccination campaign will only be effective if the population trusts the information they are receiving, have access to immunization, and there is adequate support for them to do so. Relationships between public health and community partners are key to building this trust with the broader population, including priority groups. The resources, skills, and networks that community partners bring is imperative in meeting our goal. The public look to their local leadership, HCP, and local organizations for guidance, information, and a plan to address emergencies such as this pandemic. Ensuring that our community partners are involved in the immunization campaign ensures:

- Increasing the capacity of the resources available to ensure that the immunization program can be rolled out in a timely manner
- Better awareness of local community needs
- Opportunity to share responsibilities and improve service delivery
- Support to engage with populations in languages and ways that are most accessible (i.e., adaptation and translation of key messages and communications products)
- Providing a channel to disseminate information to diverse audiences

To support the successful rollout of the COVID-19 Immunization program, partnerships with the following stakeholders will include but not be limited to:

- Primary care providers (PCP), including FHTs, CHCs, etc.
- Community pharmacists
- Emergency services providers including Paramedic, Fire and Police
- Local municipalities and elected officials
- Indigenous communities, organizations, and PCPs
- Racialized and newcomer communities, and organizations serving them
- Hospitals and other health care centres
- LHINs, Central Region of Ontario Health, and affiliated health agencies serving adults receiving chronic home care & seniors in congregate settings
- LTCHs and Rhomes

- Congregate settings including shelters, hospice, group homes

OHTs are required to report to the Ministry of Health on their efforts related to the COVID-19 pandemic. They have an important role in local planning as they are familiar with their communities, resources, and structures.

Two key avenues of local partnership are:

- Simcoe Muskoka COVID-19 Vaccination Campaign Advisory Committee (see Governance section)
- Regional COVID-19 Vaccine Task Groups (see following section)

Challenges currently exist in the recruitment of health Human Resources (HR) due to the ongoing pandemic. The far-reaching consequences of the pandemic mean most HCWs are already working in areas of critical need. Therefore, recruitment of immunizers often means redeployment from other important health care work. Creative solutions may be needed to ensure enough immunizers. Partners involved in each of the Regional Task Groups are also identifying a pool of staff that will be able to staff each of their local clinics in addition to public health staff.

Potential sources of additional health HR can include:

- Nursing agencies/temporary staffing agencies
- Physicians and nurses who work in other health care settings
- Retired physicians and nurses
- Paramedics
- Pharmacists, pharmacy technicians
- Dentists
- Medical residents and pharmacy interns
- Medical, nursing, pharmacy, and paramedic students

Currently, offers to help are being collected by SMDHU through their website. Those interested can fill out an on-line form.

Recent changes to provincial regulations under the Regulated Health Professionals Act now permit pharmacists and nurses to administer COVID-19 vaccines under certain conditions.

REGIONAL APPROACH FOR COMMUNITY COVID-19 VACCINE CLINICS

To achieve the overall goal of immunizing 75% of the eligible population 375,000 people x 2 doses = 750,000 doses in 6 months March – August (Based on Statistics Canada data 502,775 people 15 years and older). This would require:

- 125,000 doses per month for 6 months
- 41,665 doses per month in Barrie
- 16,665 doses per month in other 5 areas

This equates to:

- 4165 doses per day administered across the region based on 30 day month
- 1385 doses per day in Barrie
- 555 doses per day in each of the other 5 regions

To achieve this would require a pool of 120 immunizers based on the following:

- 1385 doses per day in Barrie (28 immunizers per day) = 196 shifts per week based on clinic operating 7 days a week divided by 5 days (full Full-time Equivalent (FTE)) = 40 immunizing staff
- 555 doses per day in each of the other 5 areas (11 immunizers per day) = 77 shifts per week based on clinics operating 7 days a week divided by 5 days (full FTE) = 16 staff per area

The following table outlines various volumes based on the number of immunizers available based on 50 immunizations per immunizer per day:

	5 days a week	6 days a week	7 days a week
12 immunizers	3,000 per wk	3,600 per wk	4,200 per wk
10 immunizers	2,500 per wk	3,000 per wk	3,500 per wk
8 immunizers	2,000 per wk	2,400 per wk	2,800 per wk
6 immunizers	1,500 per wk	1,800 per wk	2,100 per wk
4 immunizers	1,000 per wk	1,200 per wk	1,400 per wk

The following outlines the staffing needs in addition to immunizers if clinics ran 7 days a week in 2 locations in Barrie area and 5 clinic areas outside of Barrie (Muskoka, Orillia, Collingwood, Midland, South Simcoe):

# of shifts to cover based on:	5 days a week	6 days a week	7 days a week	Number of staff needed per clinic location/ area
Screeners	10	12	14	2-3
Clinic Admin Support	30	36	42	6-9
Vaccine Prep	10	12	14	2-3
After care	10	12	14	2-3
Clinic Site Inventory Assistant	6	7	8	
Expeditor	2	2	2	2

The table above is based on having the following number of staff available at each clinic:

- Screeners - 2
- Clinic Support staff - 6 (3 check in/3 check out)
- Vaccine Prep - 2
- After Care - 2
- Inventory Assistant - 1

A group of partners in each community has been pulled together to form a regional COVID-19 Vaccine Task group. Building off of existing regional healthcare planning structures, partners from various sectors including public health, primary care, hospitals, municipalities and other community partners have been engaged in assisting with this planning. Each group is working together to come up with a regional plan for the rollout of the COVID-19 vaccine to their community, with the goal of having the plan submitted by February 19th and community clinics ready to open March 1st.

Each region has identified central COVID-19 Community Clinic locations, and where mobile/outreach clinics will also be required. Innovative approaches are being integrated based

on community needs, resources available in those communities & what will work best in each community (e.g., drive-thru clinics).

Refer to Appendix C for a list of representatives from each of the regions listed above.

A Kick-off Meeting was held February 3rd with all of the task group members from all of the regions to provide an overview of the task at hand, which is for each table to come together to address the following:

- Venue for a main Community Hub Clinic
- Mobile / Outreach Clinic needs for their community
- Partners able to staff clinics
- Security, traffic flow and line management
- Communication strategies
- Special considerations

Task groups have been busy meeting, planning and completing their COVID-19 Vaccination Regional Plan (see Appendix D) for their area, which will be submitted by February 19. All regional plans will then be presented back to the SMDHU COVID-19 Vaccination Campaign Advisory Committee at their Feb 22nd meeting for any final feedback.

The Emergency Management Team worked with Emergency Management Coordinators in each municipality to come up with a short list of potential venues in their communities that could be used as a potential Community Hub Clinic site, along with potential outreach community sites in the broader communities. This list was made available to each regional task group to use as a starting point in selecting their main Community Hub Clinic location. Regional planning leads, along with local stakeholders and partners involved in each of the Regional Task Groups further assessed potential sites to identify proposed Mass Vaccination Clinic HUBS and potential community-based clinics. (Please see Appendix E for the Proposed Community Hub Clinic Sites and Community Clinic Options.)

PLANNING ASSUMPTIONS

- COVID-19 Vaccine will continue to be available in very limited quantities in February which will need to focus on continuing to provide 2nd doses for those immunized to date.
- Starting in March, COVID-19 vaccine supply will start to increase but ongoing phased roll outs to priority groups will need to continue.
- The vaccine available for administration initially in Community Hub Clinics will be Pfizer-BioNTech COVID-19 vaccine which will be stored by RVH in Barrie in an ultra-cold freezer.

- As this vaccine is allocated to RVH, they are ultimately responsible for the vaccine's safe storage and handling. In our partnership agreement, RVH is responsible for the vaccine from freezer to thawed state. SMDHU is responsible for any vaccine provided to them for use in mobile or community clinics from the time it leaves the storage facility until it is administered.
- Work is currently underway with Muskoka Algonquin Health Centre to have an additional ultra-cold freezer available to store Pfizer vaccine.
- Storage and Handling of the COVID-19 vaccines will be in accordance with Ministry of Health – COVID-19: Vaccine Storage and Handling Guidance – Pfizer-BioNTech and Moderna COVID-19 Vaccines.
- A mixed model of Community Hub Clinics (similar to the one that has been operating at 29 Sperling Drive in Barrie since December) and Public Health led Mobile Immunization Teams (like the ones that visited LTCHs in January) will be needed in the coming months in order to continue to meet the needs of the various priority groups in our communities.
- As vaccine supply continues to increase, we need to have capacity throughout Simcoe & Muskoka to ramp up immunization capacity to continue to ensure that vaccine gets into arms in a timely way. Clinics will operate 7 days a week, with hours extending into the evenings based on vaccine supply. Clinic start times will account for vaccine travel and prep time.
- In order to accomplish this, a collaborative approach with various community partners supporting these clinics is required. This will include but is not limited to local physicians, nurses, FHTs, OHTs, hospitals, community pharmacists & EMSs, and municipal staff.
- Ontario will continue to provide direction on which priority groups are to be immunized in the phases above, but Public Health will need to work with local partners to further prioritize and then coordinate the roll out.
- HCW prioritization will be based on the province's Guidance for Prioritizing Health Care Workers COVID-19 Vaccination and further support locally by SMDHU's HCW Prioritization Plan, as outlined previously.

Staffing Planning Assumptions

- Maximum number of hours each immunizer can immunize per a 7.5 hour clinic shift (includes ½ hr unpaid lunch, two x 15 minute breaks, plus 15 mins for each of set up and take down) is 6 hours.
- If using the same location, daily set up and take down could be minimized, maximizing immunizing time to 6.5 hours per immunizer shift.
- An immunizer can administer ~10 shots/hour in Mass Immunization Clinics (MIC) (60-65 per shift).

- All immunizers would be offered COVID-19 vaccination, but it would not be required for staff working in these clinics to be vaccinated for COVID-19.

Clinic Planning Assumptions

Due to the risk of transmission of COVID-19, it is important that public health measures to decrease transmission are reflected in the clinic set up and operations. This will include:

- Clinics by appointment only
- Only the person being immunized to attend the clinic (no family members)
- Provide fact sheets and consent forms to clients ahead of the appointment
- Inform people that they are to arrive just in time for their appointment
- Screeners at the door to complete COVID-19 symptom screening – those with symptoms will be declined and referred to Assessment Centre for testing
- Everyone will be required to wear masks while in the clinic. Staff working the clinics will wear medical masks. The public can wear medical masks or face coverings. A supply of medical masks will be available for clients who arrive at clinic without one
- Based on community needs & facilities available, innovative approaches to immunization may be utilized (e.g., drive thru clinics, people asked to after care in their cars)

Vaccine Supply Scenarios

WEEKLY VACCINE SUPPLY SCENARIOS

Region	% of SM Popn	10,000 doses/wk	25,000 doses/wk	50,000 doses/wk
Barrie & Area	38.7%	3,870	9,675	19,350
Muskoka	11.6%	1,160	2,900	5,800
Orillia & Area	14.2%	1,420	3,550	7,100
North Simcoe	9.1%	910	2,275	4,550
South Georgian Bay	10.7%	1,070	2,675	5,350
South Simcoe	15.7%	1,570	3,925	7,850

WHAT DOES THAT MEAN PER DAY

Region	10,000 doses/wk	25,000 doses/wk	50,000 doses/wk
Barrie & Area	552	1,382	2,764
Muskoka	166	414	828
Orillia & Area	202	507	1,014
North Simcoe	130	325	650
South Georgian Bay	153	382	764
South Simcoe	224	560	1,121
TOTAL	1,427/day	3,570/day	7,141/day

Based on clinics operating 7 days a week.

OVERSIGHT OF CLINIC OPERATIONS

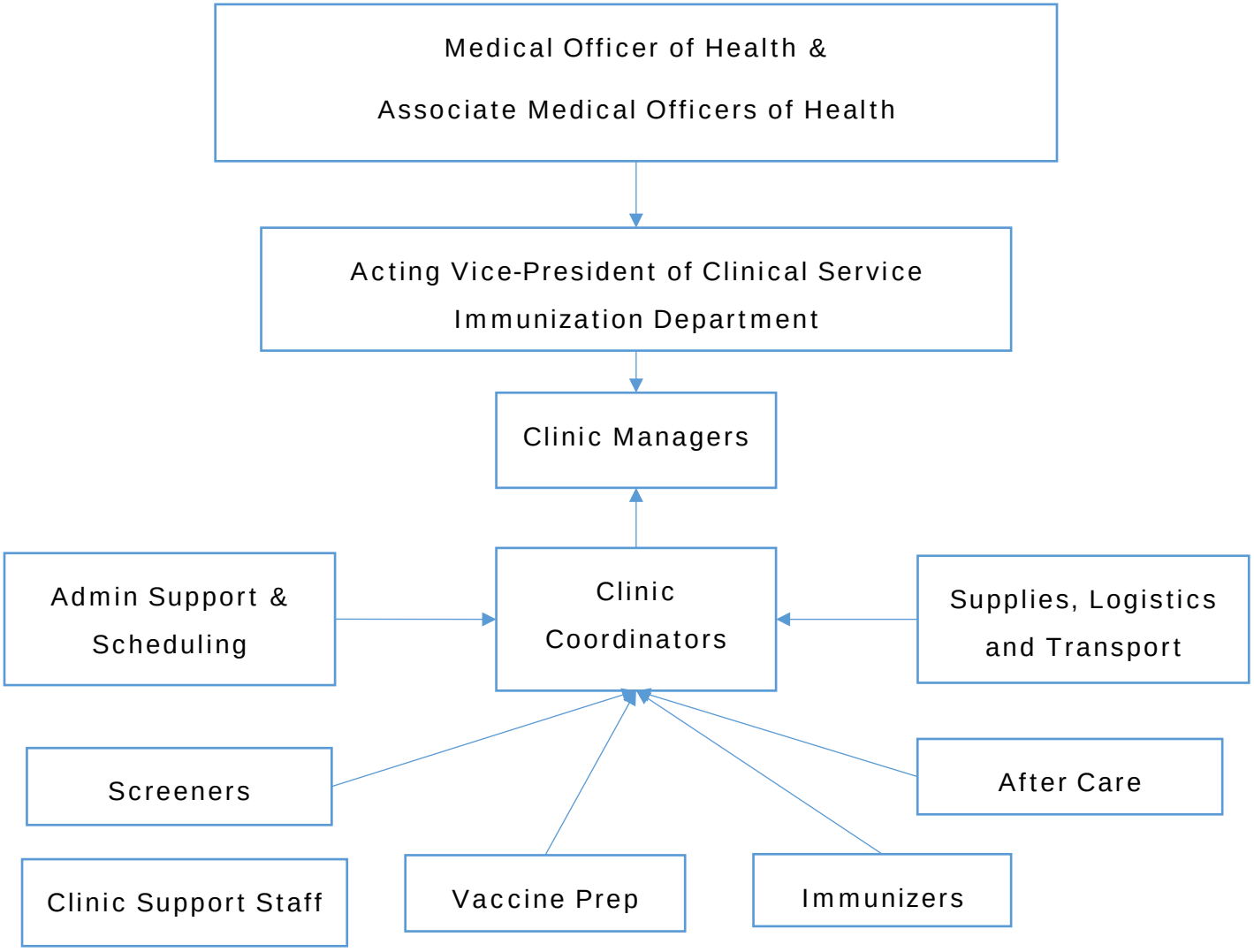
SMDHU will be the lead agency for oversight of the Community Clinic locations. They will be responsible for ensuring responsibility for insurance coverage, biohazardous waste management, clinical supplies, etc.

The MOH or an Associate Medical Officer of Health (AMOH) will be available by phone during clinic operations for any required consults. A public health manager will be available remotely during all clinics to provide management coverage and be available to support the Clinic Coordinators and staff as needed.

Community partners whose staff work at the clinic locations will be responsible for their staff's compensation and benefits, WSIB coverage, and provide Directives for their immunizing staff.

Volunteers must have WSIB coverage in place, preferably through their umbrella organizations where appropriate (e.g., Lions Club, Optimist Club). Consideration must also be given regarding legal indemnification of immunizers. This will vary depending on the associated organizations immunizers work for / report to.

Organizational Structure for Community Based COVID-19 Clinics



Roles and Responsibilities

A variety of roles are required to support the overall operations of community immunization clinics. The following roles provide support for the overall Community Clinic operations:

Medical Officer of Health (MOH) & Associate Medical Officers of Health (AMOH)

- Provide direction to Clinic Managers of needed provision of (MICs)
- Review and sign off on Directives
- Provide support to Clinic Managers as needed (public health medical consultation, key messages, communications, sequencing)

Chief Nursing Officer (CNO)

- Provide support to Clinic Managers in development and roll out of nurses MIC training
- Review Directives —provide input and recommend changes as needed to ensure consistent with nursing best practice, legislation and professional requirements
- Assist with recruitment of staff and volunteers

Acting Vice President of Clinical Service Immunization Department

- Provide direction and support to Clinic Managers overseeing MICs
- Coordination of community partners
- Budgetary oversight & HR planning
- Oversee Directive development, review and sign off by MOH/AMOH/CNO

Clinic Managers

The Clinic Managers will oversee the planning and implementation of the MICs including:

- Planning and provision of role specific training to all staff assigned to work at MICs
- Responsible for coordinating security and communicating security requirements with security personnel as required
- Ensure scheduling of staff as per the agency policy & ONA CA
- Review staffing of clinic with Clinic Coordinators as needed
- Send daily update email to all Clinic Coordinators prior to start of clinics
- Provide direction & support to all Clinic Coordinators
- Provide direction & support to the Supplies Coordinator & the Admin Support Coordinator
- Oversee the efficient running of all clinic sites
- Report to IMS leads on status of clinics prior to each IMS meeting and as needed
- Follow up on any occupational health issues related to MICs in consultation with HR as needed
- Liaise with Logistics/Supply Lead for IMS as needed
- Update & maintain regional Community Clinic plans for assigned area

We have 4 additional program managers providing support for clinics. Each manager has been assigned a regional clinic to support:
Barrie
North Simcoe
Muskoka
South Simcoe
Orillia
South Georgian Bay

This team of managers will also provide coverage to ensure that a manager is available at all times to support all clinic locations remotely.

Inventory Coordinator(s) - SMDHU staff member(s) would be on-site at the supplies warehouse daily to coordinate all aspects of this program. Specific tasks include:

- Update Item/Kit & Vendor Information in NAV
- Meet Delivery Service @ the supplies warehouse
- Receive Delivery Updates from Immunization Team
- Meet Ministry Transport Service for Delivery
- Confirm Quantities, Packing Slip Accuracy, and PO #
- Scan Packing Slips and send to Procurement
- Place Items in appropriate area in Inventory
- Prepare Item Adjustment Journal in NAV for received Kits
- Receive Dosage Estimates by Location from Immunization Team need to determine frequency of this and will need to be determined who within the team
- Determine # of Kits and Other Items to be delivered to each site based on a predetermine delivery frequency
- Communicate Delivery Schedule to Transport Company and track completion of deliveries
- Plan Order assembly and advise the Stores Team not sure who the stores team is
- Contact SMDHU Expeditor with delivery details will they be directing staff?
- Update Item Records in NAV

Clinic Site Inventory Assistant (SMDHU employees) – this role would be assigned to each clinic site to receive deliveries, maintain the secured storage area, and report daily consumption to the inventory coordinator

- Receive Requests for Items/Kits from Immunization Team
- Issue Items/Kits to Team
- Update Usage Excel Spreadsheet
- Send Spreadsheet to Inventory Coordinator Daily
- Unload Deliveries (w/ assistance from Expeditor or Transport Service or facility staff)
- Place Items in Designated Areas/Secure Storage
- Advise Inv. Coordinator of Delivery
- Monitor inventory in relation to upcoming clinics
- Assist with set up of clinics or request from coordinator

Expeditor (outstanding) –a staff member that would be available to resolve inventory stock-outs and other unscheduled supply issues by driving an agency van between storage areas and clinics. Specific tasks include:

- Drive Agency Van to the supplies warehouse for pick up
- Drive to Clinic Site
- Place Items in appropriate area in Inventory

- Report to Coordinator that delivery is complete
- Return Agency Van to 15 Sperling
- Return any items from clinic sites as needed

Administrative Support Coordinator (SMDHU Immunization Program Assistants)

- Book clinic venues and coordinate clinic schedules (venue, staff & clinic appointments).
- Load client lists in COVAX.
- Set up clinic appointments in appointment scheduling system.
- Ensure sufficient staff is scheduled including community partners working in clinics, using the Humanity staff scheduling solution based on schedule provided by Clinic Manager.
- Make adjustments to staffing (schedule additional/cancel staff) as directed by the Clinic Manager.
- Liaise with Clinic Managers & Clinic Coordinators re: daily issues.

IT Support (SMDHU IT team)

- Ensure the required equipment and systems are accessible for all staff required to work in clinics.
- Provide support to those working in clinics during clinic hours.

The following outlines the roles and responsibilities of the staff working onsite at the clinics:

Clinic Coordinators (Experienced Immunization Program Nurses)

Large clinics with five or more immunizers will have two clinic coordinators.

- Access agency email prior to start of clinic to receive the daily update from the Clinic Manager. Hold a brief meeting prior to start of clinic to review the daily update.
- Oversee running of the clinic site (continually assess, make changes as needed).
- Provide support to staff working at the clinic.
- Transport vaccine supplies to the clinic site as needed.
- Ensure internet connectivity via SMDHU wireless internet device to COVAX for documentation.
- Ensure access to cell phone service or that landlines are present.
- Update Clinic Manager re: unresolved issues requiring further problem solving.
- Address client questions that cannot be resolved by immunizers.
- Assist nurses with any incidents/emergencies that may occur and report all incidents/emergencies to the Clinic Manager as soon as possible.
- Ensure completion of required documentation for any incidents/emergencies.

- Ensure clinic is clean and well maintained at all times, waste is removed in a timely manner and Personal Protective Equipment (PPE) and Alcohol-based Hand Rub (ABHR) is readily available and well supplied.
- At end of day report to clinical manager end of day clinic outreach form.
- Ensure breaks are taken by all staff at clinic as follows:
    - One 15-minute paid break must occur during the second hour of work;
    - One 30-minute unpaid break must occur after 3 hours of work and before 5 hours into the shift; and
    - One 15-minute paid break must occur during the fifth hour of work.

Vaccine Prep (HCWs trained in vaccine storage and handling)

- Complete role specific orientation prior to first clinic.
- Ensure cold chain management and vaccine storage and handling throughout the clinic.
- Monitor and record temperature of the cooler every hour.
- Prepare vaccine in accordance with vaccine manufactures specifications.
- Complete vaccine inventory and reconciliation and report to coordinator at end of day.
- Vaccine prep supplies – report supplies needed to the clinic coordinator to arrange with the Supply Coordinator.

Immunizers (HCWs who are authorized to provide immunization)

- Complete role specific orientation prior to first clinic.
- Meet Clinic Coordinator at the health unit office to assist with transport of supplies to the clinic, if requested.
- Assist with set up and take down of clinic at the clinic site.
- Check and sign off Emergency Bag at beginning of clinic (epinephrine doses required and expiry date checked and ensure equipment is working).
- Provide necessary education to clients and address questions.
- Review screening questions with each client, assess clients' health status and eligibility for immunization as per directive.
- Obtain informed consent from client.
- Administer vaccine injections.
- Document in COVAX (or paper if COVAX is not available).
- Ensure supplies (e.g. vaccine & syringes) are secure and restocked at end of clinic.
- Identify any concerns to the Clinic Coordinator.
- Provide any hard copy consent to clinic coordinators for returning to Barrie office in locked bag via nurse or Purolator.
- Will advise clinic coordinator if vaccine is getting low in COVAX so inventory can be adjusted.

Screeners (staff from a variety of areas provided with position specific training)

- Greet people as they arrive at the clinic.
- Review eligibility based on priority groups.
- Actively screen clients for symptoms or risk factors for COVID-19 infection.
- If symptomatic, refuse clients entry and refer to clinic assessment centres.
- Screeners will be in full PPE at all times.
- Ensure client is wearing a mask and have completed hand sanitizing.

Clinic Support Staff (administrative staff trained in the COVAX system)

- Confirm client's appointment in appointment system.
- Obtain consent for collection and use of personal information.
- Enter/Confirm client's personal information in the COVAX system & Check them in.
- Direct clients to the pre immunization waiting area once checked in.
- In the event of a computer malfunction, carry out the registration process using paper consent forms.
- Arrange consent forms in order of arrival at clinic and in alphabetical order at the end of the clinic if used once client is no longer in after care.
- Assist with clinic set up and take down.
- Ensure signage is in place for smooth running of clinics.
- Check people out in the COVAX system, provide them with the receipt and book client's follow up appointment if needed.

After Care Support (staff with emergency response experience – provided with role specific training)

- Monitor clients in after care for signs and symptoms of adverse reactions.
- Alert a HCW in the event of an incident.
- Assist with clinic set up and take down.
- Assist with crowd flow, maintain a steady flow of clients.
- Monitor timelines for client to remain in aftercare (15 minutes - 30 minutes)

Roles	Requirements	# per Clinic	Who could fill this role?
Clinic Coordinators	• Experience working in Immunization Program • CNO certification • CPR certification • Panorama, m-Imms and technical experience (Hubs, WIFI etc.)	1 for up to four immunizers 2 if five or more immunizers	Experienced Immunization Nurses
Vaccine Prep (only required for Pfizer-BioNTech vaccine)	• Vaccine storage and handling experience • Medication preparation	1 for every 4 immunizers	Nurses Pharmacist Pharmacy technicians
Immunizers	• Completed clinic orientation and Directive Training • CNO certification or certified in vaccine admin • CPR certification	3 to 12	RPNs/RNs/PHNs Injection trained pharmacists Paramedics
Screeners	• Communication skills • Problem solving • Able to diffuse situations	1 to 3	Health Unit staff Municipal staff Volunteers
Clinic Support Staff	• Communication skills • Problem solving • Able to diffuse situations • Computer skills • Customer service • Second language an asset	2 for every 5 immunizers (one for Check In, one for Check Out)	Health unit staff New hired staff Health care organization admin staff
After Care Support	• CPR certification • Experience working in clinical settings or filling roles where need to recognize and respond to emergency situations	1 or 2	Nurses HCWs Emergency Services partners

Immunizer Formula

The following formula can be used to determine immunization capacity based on immunizers scheduled:

10 clients/hr x ___ (# of immunizers) x 6 hrs of immunizing (based on 7.5 hr shift – 15 min set up/ 15 min take down, 2 x 15 min breaks and ½ hr lunch) = ___ (# vaccinated per clinic)

Small Scale Clinic – 7 hour clinic (6 hours immunizing per immunizer)

# of Staff Required	# Immunized
Clinic Coordinator – 1 Vaccine Prep* – 1 Screener - 1 Immunizers – 2 to 4 Clinic Support Staff – 2 (check in/check out) After Care – 1	3 immunizers = 180 people 4 immunizers = 240 people

Moderate Scale Clinic - 7 hour clinic (6 hours of immunizing per immunizer)

# of Staff Required	# immunized
Clinic Coordinator – 2 Vaccine Prep* - 2 Screener – 1 to 2 Immunizers – 8 to 10 Clinic Support Staff – 6 (3 check in/3 check out) After Care – 2	8 immunizers = 480 9 immunizers = 540 10 immunizers = 600

Large Scale Clinic - 7 hour clinic (6 hours of immunizing per immunizer)

# of Staff Required	# immunized
Clinic Coordinator – 3	12 immunizers = 720

Vaccine Prep* - 4 Screener – 2 to 3 Immunizers – 12 to 14 Clinic Support Staff – 10 (5 check in/5 check out) After Care – 3	13 immunizers = 780 14 immunizers = 840

Role Specific Orientation

Those working in clinics in each of the identified roles above will receive role specific orientation (i.e., screeners, clinic support staff, vaccine prep, immunizers & aftercare support) including Infection Prevention and Control (IPAC) training specific to their role. The health unit is developing online modules for each person to complete. As a quality assurance measure, the successful completion of orientation by each staff will be tracked by the Immunization Program Manager overseeing orientation.

Clinic Coordinators and Immunizers

- Overview of the Mass Immunization Campaign (sequencing, infectious agent).
- Review of Anaphylaxis & Epinephrine Administration Directive & Adverse Events Following Immunizations (AEFI).
- Immunization station set up/clinic set up/Procedures/ Cold chain.
- Routine Practices and Additional Precautions.
- Directive training for vaccines to be administered.
- Review of Medication Administration (including injection refresher) & Obtaining Consent.
- Documentation - COVAX training.
- HR (timecard completion, breaks, health and safety, scheduling).
- Security procedures will need to be consistent and well-understood by all staff.

Screeners

- Overview of the Mass Immunization Campaign (sequencing, infectious agent).
- Clinic procedures:
    - Overall flow of clinics;
    - Role-specific: greeting people as they arrive, managing flow of clinic, screening process; and

- Routine Practices and Additional Precautions IPAC training.

Clinic Support Staff

- Overview of the Mass Immunization Campaign (sequencing, infectious agent).
- Clinic procedures:
  - Overall flow of clinics;
  - Role-specific: greeting people as they arrive, managing flow of clinic, COVAX, screening process; and
  - Routine Practices and Additional Precautions IPAC training.
- HR (timecard completion, breaks, Health and Safety, scheduling).
- Security procedures will need to be consistent and well-understood by all staff.
- Aware of when to call nurse for assistance.

Aftercare Support

- Overview of the Mass Immunization Campaign (sequencing, infectious agent).
- Clinic procedures (overall):
  - Overall flow of clinics;
  - Role specific-responding to AEFIs; and
  - Routine Practices and Additional Precautions IPAC training.
- HR (timecard completion, breaks, Health and Safety, IPAC, scheduling, ONA).
- Security procedures will need to be consistent and well-understood by all staff.
- Aware of when to call nurse for assistance.

Site Planning

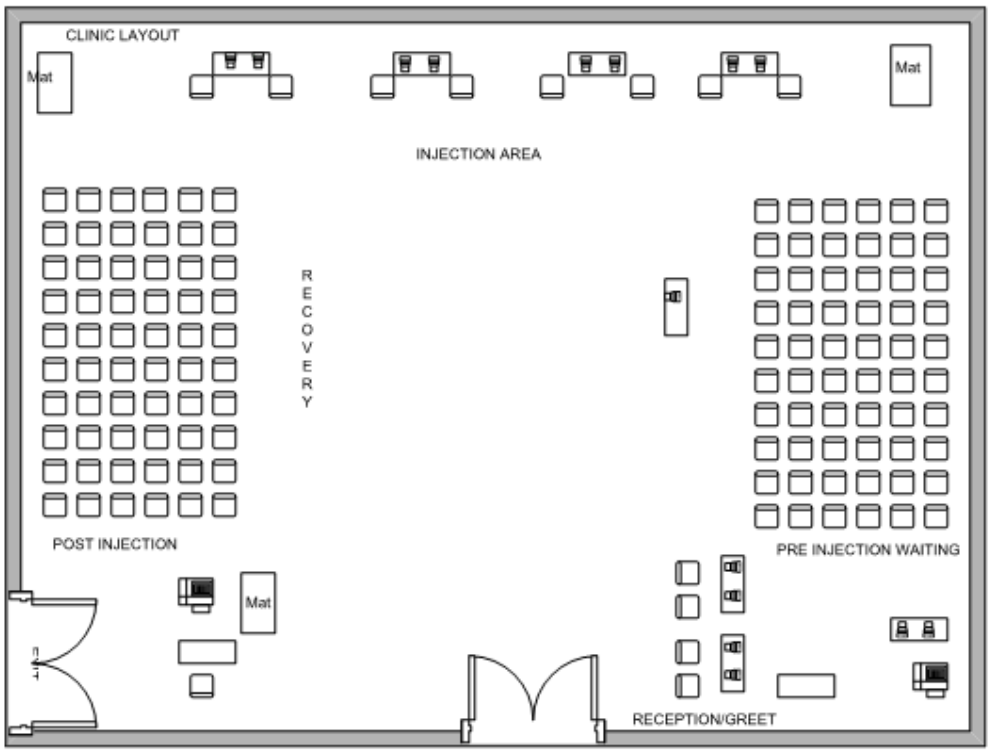
The following criteria have been developed for assessing potential clinic site locations:

- Large open area
- Indoor waiting space
- Chairs available onsite (100–150+)
- Tables available onsite (20+)
- Electrical outlets (min 15 amp circuits) 8+
- Accessible (wheelchairs, stroller) ramps and/or elevator
- Location easily accessible within building

- Parking (adequate, free, well lit)
- 2+ entrances/exits to the room
- Telephone onsite and easily accessible
- Site access for health unit staff (re: keys codes)
- Room temperature control
- Washroom facilities
- Space for staff (breaks/lunches)
- Janitorial services
- Snowplowing (if applicable)
- Waste disposal area for general waste and biohazardous wastes
- Covered waste containers

The following map has been developed to provide a guideline for how ideal clinic space would be set up.

Mass Immunization Clinic (MIC) Space Guide Map



CLINIC DELIVERY

The following information applies to both the Community Hub Clinic as well as any Mobile clinics.

Scheduling

An Immunization Program Assistant will be dedicated to "Scheduling" – booking clinic venues, booking dates & times for clinics, booking the staff for these clinics and setting up the appointment booking system to align with all of this.

Staff Scheduling

The staff schedule for those working in clinics will be maintained in "Humanity", a staff scheduling application that SMDHU uses for other programs. This staff scheduling solution is app based and staff can download the app on their phones to be able to easily access their schedule, update their availability and be notified of any changes in their schedule. Users can be added to this application from outside of SMDHU as well, so all those working at the clinic will be in one staff schedule.

We are currently exploring the option of using Input Health scheduling system to allow our community partners to be able to self-schedule for shifts. If this is a possibility, and it makes sense we may move all staff scheduling to this same system. This will be confirmed and communicated to staff and community partners by February 22nd.

Clinic Site Scheduling

Clinic locations were identified, with support from our Emergency Management Coordinators in each of our municipalities. Refer to Appendix E for the Community Hub Clinic Site Options. The following is a draft community clinic location schedule:

		Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	Operating hours:							
Holly Rec Centre, Barrie	9:00 a.m. - 7:00 p.m.	√	√	√	√	√	√	√
29 Sperling, Barrie	9:00 a.m. - 7:00 p.m.	√	√	√	√	√	√	√
Innisfil	11:00 a.m. - 6:00 p.m.	2 -3 days a week						
Muskoka	11:00 a.m. - 6:00 p.m.	HV	BB	HV	BB	HV	BB	HV
North Simcoe	11:00 a.m. - 6:00 p.m.	√	√	√	√	√	√	√
South Georgian Bay	10:00 a.m. - 5:00 p.m	Cwood	Cwood	WB	Cwood	Cwood	WB	Cwood
South Simcoe	11:00 a.m. - 6:00 p.m.	Alliston	Alliston	Bradford	Bradford	Bradford	Tott	Alliston
Orillia & Area	11:00 a.m. - 6:00 p.m.	√	√	√	√	√	√	√

Barrie & area - the City of Barrie has provided Holly Recreation Centre, which will serve as our 2nd clinic location in the south end of Barrie. This will be in addition to the 29 Sperling Clinic

which RVH will continue to operate. An additional part time clinic site at the Innisfil Recreation Centre has been identified as well.

Muskoka – will alternate between Active Living Centre in Huntsville and Bracebridge Sportplex.

North Simcoe – will alternate between Midland & Penetanguishene

South Georgian Bay – drive thru clinic locations in Collingwood and Wasaga Beach

South Simcoe – will alternate between Alliston, Tottenham and Bradford

Orillia and Area - clinic will be located at the Rotary Place

Additional mobile and outreach clinics to neighbouring smaller communities in surrounding areas will also be utilized based on the groups currently being immunized based on prioritization sequencing and vaccine supply. Based on vaccine supply, we will add additional immunizers, extend hours and add pop up/drive thru clinics to increase capacity as needed.

Appointment Booking System

We will utilize the provincial COVAX pre-registration and appointment scheduling system when it becomes available. By registering for an appointment in COVAX, the person will in turn be creating themselves as a client in the system which will reduce the amount of data entry required at check in. This system is also being set up to assist with operationalizing the provincial prioritization and sequencing that will need to continue until the vaccine is widely available to the general public.

In the interim, we are implementing a central booking system to be used by all 6 regions, which is an online appointment self-booking system by Input Health. By having one shared system:

- it will be easier when adjustments need to be made based on vaccine supply
- it provides the ability communicate with priority groups as they are added with a consistent process to book their appointments (i.e. a home and community care nurse in Midland doesn't have to book an appointment in a different system than a home and community care nurse in South Simcoe)
- Provides flexibility for people to book appointment in the area where it is most convenient for them to receive their vaccine

This system can also be used by all of our partners to book appointments (i.e. via employers to get to their staff, HCPs to book appointments for patients, health unit staff to book for people who don't have access to computers or who don't have a HCP) until we get to the point where we are immunizing more of the general population and the provincial COVAX system is available.

Clinic Set Up Procedures

In addition to setting the clinic space up in accordance with the map included above, the following additional considerations need to also be considered:

- Basic set of color laminated clinic signage will be included in each clinic supply kit. These can be used to help direct people to and within the clinic space.
- Ensure any cords are taped down/covered to prevent tripping.
- Ensure facility/room is clean prior to use (floors, walls, common touched surfaces and washrooms) and that washrooms are fully stocked.
- All tables and chairs to be used for the clinic need to be cleaned with Optim TB wipes.
- Have a private space identified that people can use should they need privacy during immunization or to feed their baby if they wish.

Check In Area

- Ensure those in line standing far enough back they cannot hear or see screens.
- Have PPE and ABHR available.
- Have disinfectant wipes (Optim TB) and gloves available for staff to clean.
- Visual signals on the floor to ensure physical distancing.
- Have tabletop version of Baby Friendly Policy displayed.

Immunization Stations / After Care Area

- Have a private space identified if anyone needs to remove clothing to allow for vaccine administration.
- Have mat available for people who prefer to lay down to be immunized (history of fainting) or people having an adverse event following immunization, who need to be assessed and treated.
- Have a designated private comfortable space if breastfeeding mothers request.

Clinic Take Down Procedures

- All tables and chairs used for the clinic need to be wiped with Optim TB wipes.
- Ensure contract cleaners or facility cleaners are notified to conduct enhanced cleaning.
- Removal of garbage and biohazardous waste.

Security, Traffic Flow and Line Management

Given that COVID-19 vaccine is available in limited supply, ensuring the safety and security of it is critical. All staff & volunteers working in COVID-19 vaccine clinics will be required to have a Criminal Reference Check (CRC) completed by their local police department. Extensive security measures are in place at the vaccine storage facility, where the vaccine is stored until it is

dispensed for clinics. While the amount of vaccine onsite at clinic locations will be smaller, it remains a potential target for security threats. Vaccine will never be left unattended. Vaccine will be stored in coolers at the clinic locations, and these coolers will be held in a secured, lockable area (not out in the open where the public can see or access them).

On-site security will be available. We will also be informing all of our community police departments where our clinic locations are in advance, in the event that their support is required at the clinic location.

Line Management during MICs is very important. Not only is it important to ensure the safe and efficient flow of the clinic, but it is also important from a customer service perspective. Avoiding people waiting in long lineups provides better service and prevents people from becoming disgruntled.

Infection Prevention and Control (IPAC)

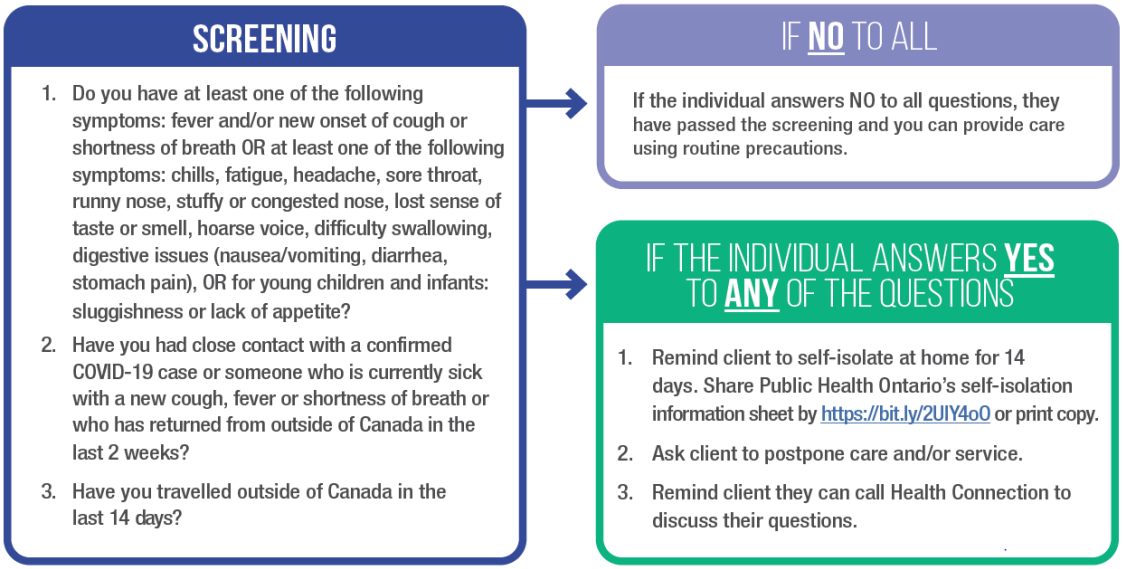
Routine practices must be followed at all times with all clients to protect staff and clients during MICs. IPAC specific training will be includes in the overall training for each role. Everyone working in a clinic will be required to actively screen themselves before reporting for their shift. Anyone who screens yes/positive should not report for their shift and report to the Immunization Program Manager responsible for their clinic location area so that an alternate can be found if required.

Active Screening

Due to the nature of COVID-19 transmission, active screening of clients and staff for symptoms of illness must be done by screeners prior to clients entering the clinic.

Steps for Client Screening

1. Welcome client to the clinic.
2. If client is not wearing a face covering inform them it is required for all clients and let them know they may take one from the stand:
    - If the client indicates they are unable to wear one due to medical, cultural or religious reasons or other reasons, do not insist they wear one, thank them for letting you know.
3. Inform client you need to ask them screening questions before they can proceed into the clinic area.



4. If the client says no to all questions please ask them to sanitize their hands with alcohol based hand rub and direct them to the check in area.
5. If the client says yes to any questions inform them that they have screened positive of possible symptoms or exposure to COVID-19 they should return home and self-isolate and seek further assessment at the local assessment centre.

Hand Hygiene

Staff must follow routine practices at all times and conduct hand hygiene procedures as set out in HSO120 Hand Hygiene Policy. Sites for the purpose of MICs must have hand hygiene facilities such as 70% ABHR and hand washing stations with soap and running water. ABHR will be available at each immunizer's station, at all entrance points to the MIC before coming into contact with staff conducting active screening, waiting areas, and at all tables where screeners are present. Hand hygiene sinks should be made available and stocked appropriately at all times in washrooms.

Cleaning and Disinfection of Environmental Surfaces

All staff are responsible for cleaning and disinfecting surfaces before the start of each immunization clinic, after each client and staff use, and at the end of each day. Disinfectant wipes approved for use will be provided at all screening tables, vaccine administration tables, medication preparation areas, segregated areas and washrooms.

There may be a need to retain contract cleaners to provide enhanced cleaning and disinfection. This will be dependent on the communicability and virulence of the infectious disease, the number of clients seen, and staff time dedicated to enhanced cleaning during the course of the day/or night. (i.e., floors in the winter or rainy days, increase in enteric symptoms such as

vomiting or spills of blood and body substance). Contract cleaners must be up-to-date with all vaccine preventable diseases immunizations and eligible to receive situation specific vaccines during the start of clinic. Contract cleaners must also be trained and provided with the appropriate PPE dependent on the infectious agent and routes of transmission. Facilities is responsible to work with contract cleaners dependent on the facility made available for MIC.

Waste Management/Disposal

Sharps and biological waste (e.g., needles, body fluid-soaked materials) will be disposed of in approved hazardous waste/infectious waste container that is properly labelled. Removal from the facility will be handled by an approved biological waste management company in compliance with current provincial and/or federal requirements. There should be a designated area for waste to be securely stored over the course of a day/night. This room must be lockable and must have a biohazardous waste sign on the door to alert people. The Clinic Coordinator shall monitor the use of sharps containers and when supplies are needed. The Immunization Program Assistants will make arrangements for supplies to be delivered and waste to be picked up on a regular basis.

Garbage bags and, if possible, sealed garbage containers should be provided at the MIC to remove large volumes of waste materials such as covers, gloves, paper towels, and PPE.

Blood and Body Fluid Spills kits are to be provided at MIC for the purpose of cleaning blood and body fluid spills. The Supplies Coordinator is responsible to maintain the supply of kits for each vaccine station created and the Clinic Coordinator is responsible to communicate with the Supplies Coordinator when kits are needed to replenish the stock.

Personal Protective Equipment (PPE)

All staff must be trained on the use of PPE and how to conduct a risk assessment for each interaction with a client and their environment. Based on the transmission of COVID-19, the following are required of all staff working in clinics:

- Clinic Support Staff – medical mask and eye protection. If a glass/Plexiglas barrier, and at least 6 ft from others in work area, eye protection is not required.
- Clinic Coordinators – medical masks.
- Immunizers – medical masks and eye protection. Gowns and gloves available if needed based on point of care risk assessment.
- Vaccine Prep – medical mask. If more than one person working in the area and within 6 feet of each other eye protection is also required.
- After Care Staff – medical masks and eye protection. Gowns and gloves available if needed based on point of care risk assessment.
- Screeners – medical mask and eye protection.

Health & Safety

During all clinics, all staff will work in accordance with SMDHUs Health and Safety policies. SMDHU's Health and Safety lead is Brenda Hadley, and each clinic site will have a designated lead. Any staff member who experiences an injury or potential near miss while working at a clinic will complete the appropriate forms. Copies of all Health & Safety forms will be included in the Clinic Supply kits. If a staff member is injured during a clinic and seeks medical treatment, they will be provided with a "SMDHU Workplaces Injury/Illness Package" to take with them.

In the event a member of the public experiences an injury or near miss while attending a MIC, the staff member involved will complete a Public Incident Form. Blood Borne Exposure policy and forms will also be included in the clinic kits and training on this procedure will be provided during role specific training.

All staff working in the clinic area are required to wear appropriate footwear and closed-toe shoes.

Supplies & Signage

A central supplies depot has been established at the SMDHU 15 Sperling office. For the time being, vaccine must be transported from Barrie each day to the clinic sites so supplies can also be transported at that time. As we move to community Hub clinics, onsite storage of supplies may be possible and will be identified for each for the site lead. For a list of the supplies needed for immunization clinics, see Appendix F. For COVID-19 vaccine, some clinic supplies can be accessed through the provincial stockpile using the Remedy Supply Request system. See Appendix G for the Ancillary Supply Order Form.

Immunization Station Set Up

Immunization station setup will be reviewed with all immunizers during their Role Specific Training. The following principles will be highlighted:

- Ergonomics
- IPAC
- Privacy of client information
- Sharps containers on table (not floor)
- Garbage bags on floor (separate from sharps)
- Only empty vials, syringes & needles in sharps containers (no wipes, cotton, caps)

Consent

Nurse immunizers are required to obtain and document informed written or verbal consent to treatment from clients being immunized at MICs. Nurse immunizers must ensure the client is informed and understands the risks, benefits and potential side effects of the vaccine. Clients

must be provided an opportunity to ask questions or request more information about the treatment. In addition, under Personal Health Information Privacy Act (PHIPA), clients must agree to have their personal health information collected.

There is no specific age of consent. If a nurse finds the client capable providing informed consent based on their ability to understand the information provided, they should obtain and document consent. If a nurse finds a person incapable of providing their own informed consent, consent must be obtained from a substitute decision-maker, which is ranked in priority:

1. Guardian of the person, appointed by the court;
2. Someone who has been named as an attorney for personal care;
3. Someone appointed as a representative by the Consent & Capacity Board;
4. Spouse, partner or relative in the following order:
    a. Spouse or partner;
    b. Child if 16 or older; custodial parent (who can be younger than 16 years old if the decision is being made for the substitute's child); or Children's Aid Society;
    c. Parent who has only a right of access;
    d. Brother or sister; and
    e. Other relative (defined as two persons related by blood, marriage or adoption).
5. Public Guardian Trustee is the substitute decision-maker of last resort in the absence of any more highly ranked substitute, or in the event two more equally ranked substitutes cannot agree.

Vaccine Administration & Directives

A Vaccine Administration Overview will be included in the Immunizer role specific training. This will include:

- Medication administration practices (10 rights)
- Route, Dose
- Infection Prevention & Control
- Landmarking
- Injection technique

SMDHU immunizers will also be oriented to the directives for the Administration of Epinephrine in response to Anaphylaxis and the COVID-19 vaccines. Any updates required to the directives will be completed by VP of Immunization, reviewed by the CNO and AMOH, and then finalized and sent for sign off by all MOH and AMOHs. The Immunization managers will ensure updates are provided to those authorized under the directives.

Immunizers from other agencies working in the Community clinics will have a directive from their home organization if required. There is also a provincial directive by the Chief Medical Officer of Health of Ontario for all nurses and pharmacists that can be utilized as well.

Documentation

Documentation of service to clients is required by SMDHU Policy IM0109 as well as by professional regulatory bodies. Documentation can be either paper or electronic but electronic documentation is preferred.

Electronic Documentation – all COVID-19 vaccines administered in Ontario are to be documented in COVAX Vaccination Management System.

Paper Documentation — A back-up, paper-based system is required should COVAX become unavailable due to technical difficulties.

Both paper and electronic documentation will be handled, transported and stored in a manner consistent with SMDHU information privacy and record management procedures.

Reporting of Medication Errors & Near Miss

Orientation to SMDHU Policy LG0103 will be provided during the Immunizer role specific training, and a copy of the form and the policy will be included in the clinic kits.

Adverse Events Following Immunizations (AEFI) at Clinics

An AEFI is an unwanted or unexpected health effect that happens after someone receives a vaccine, which may or may not be caused by the vaccine. In Ontario, health professionals are required to report AEFIs to their local public health unit. Public health units investigate AEFIs and provide support to immunizers, individuals, and their families. These can occur in the minutes following immunization (e.g., anaphylaxis) or in the days and weeks to follow. When an AEFI or suspected AEFI occurs while a client is still at our clinic location, the nurse who responds to the client needs to complete an AEFI form which the Clinic Coordinator will bring back to the local health unit office and report to ext. 8806 for investigation and follow up. Forms will be included in the clinic kits.

Vaccine Storage and Handling at Clinics

All COVID-19 vaccine needs to be stored and handled according to Manufacturer & Ministry of Health – COVID-19: Vaccine Storage and Handling Guidance – Pfizer-BioNTech and Moderna COVID-19 Vaccines. Vaccines that are not stored appropriately risk spoiling or losing potency.

For the Pfizer-BioNTech COVID-19 vaccine, RVH Pharmacy staff will be responsible for transferring vaccine from the ultra-cold freezer to the coolers. SMDHU staff are responsible from when they receive the vaccine cooler, until the vaccine is administered. The following outlines the storage and handling requirements for Pfizer vaccine:

Storage Condition	Pfizer-BioNTech Vaccine
Frozen Vials	• Kept frozen between -80°C to -60°C • Protected from light • Shelf life is 6 months
Thawed, unpunctured vials	• Thawed and stored at +2°C to +8°C for up to 5 days (120 hours), or at +8°C to +25°C for up to 2 hours • During storage, vials should be protected from light • Do not refreeze thawed vials
Thawed, punctured vials	• Stored between +2°C to below +25°C and used within 6 hours from the time of first puncture • During storage, vials should be protected from light

Preloading Syringes for the Pfizer BioNTech COVID-19 Vaccine

According to the Canadian Immunization Guide, "Pre-loading of syringes may be considered in the hospital setting if vaccines are drawn up and labelled in the pharmacy, or in an immunization clinic to facilitate efficient administration of a single vaccine to a large number of people; in these circumstances, the following principles should be followed:

- Prior to pre-loading, data should be reviewed on the specified time period for stability of pre-loaded product;
- If the vaccine is pre-loaded and administered by different people, a prior agreement on professional accountability should be made;
- Only the number of doses required to keep the clinic running efficiently should be drawn up;
- Labels should be placed on pre-loaded product to indicate the time by which the vaccine should be used;
- All doses should be used as soon as possible; and
- The cold chain should be maintained at all times.

The Pfizer BioNTech COVID-19 vaccine requires reconstitution with very specific handling instructions, comes in a multi-dose vial of 6 doses, and is in a unique dose (0.3 mL) compared to traditional vaccines. Therefore, preloading of syringes is used to ensure minimal wastage and consistent preparation practices. The vaccine must be reconstituted as per the manufacturer's instructions and syringes will be preloaded by a vaccine prep nurse at each clinic in a designated vaccine preparation area. To ensure we consistently get the 6th dose out of every

vial, it is important that those pre-loading syringes are trained and ideally consistently due this to get skilled at this.

Each clinic will use two coolers in the vaccine prep area. One will hold the undisturbed unused vaccine. The other will be used to store preloaded syringes awaiting administration. Baskets will be rotated through to hold the syringes and transport them to the clinic area for administration. Both coolers will be maintained at 2-8°C at all times. Temperatures will be recorded hourly for the cooler holding the unused vaccine and recorded on the COVID-19 Vaccine Clinic Summary form (see Appendix H).

Every dose that is preloaded will have a label attached to the syringe containing the lot #, expiry date, time it was drawn and nurses initials who drew it. 1cc syringes will be used whenever available, as this allows for 6 doses to be drawn from each vial.

When other vaccines are available, the practice of preloading syringes will be revisited. Regardless of the vaccine being used, all vaccine needs to be stored and handled according to Ministry Vaccine Storage and Handling requirements. Vaccines that are not stored appropriately risk spoiling or losing potency. The following outlines the storage and handling requirements for Moderna COVID-19 vaccine:

Storage Condition	Moderna
Frozen Vials	• Kept frozen between -25°C to -15°C • Protected from light • Do not store on dry ice or below -40°C • Shelf life is 6 months + 30 days further at refrigerated state
Thawed, unpunctured vials	• Thawed and stored at +2°C to +8°C for up to 30 days, or at +8°C to +25°C for up to 12 hours • During storage, vials should be protected from light • Do not refreeze thawed vials
Thawed, punctured vials	• Stored between +2°C to below +25°C and used within 6 hours from the time of first puncture • During storage, vials should be protected from light

Standard storage and handling practices must also be observed in all clinics including:

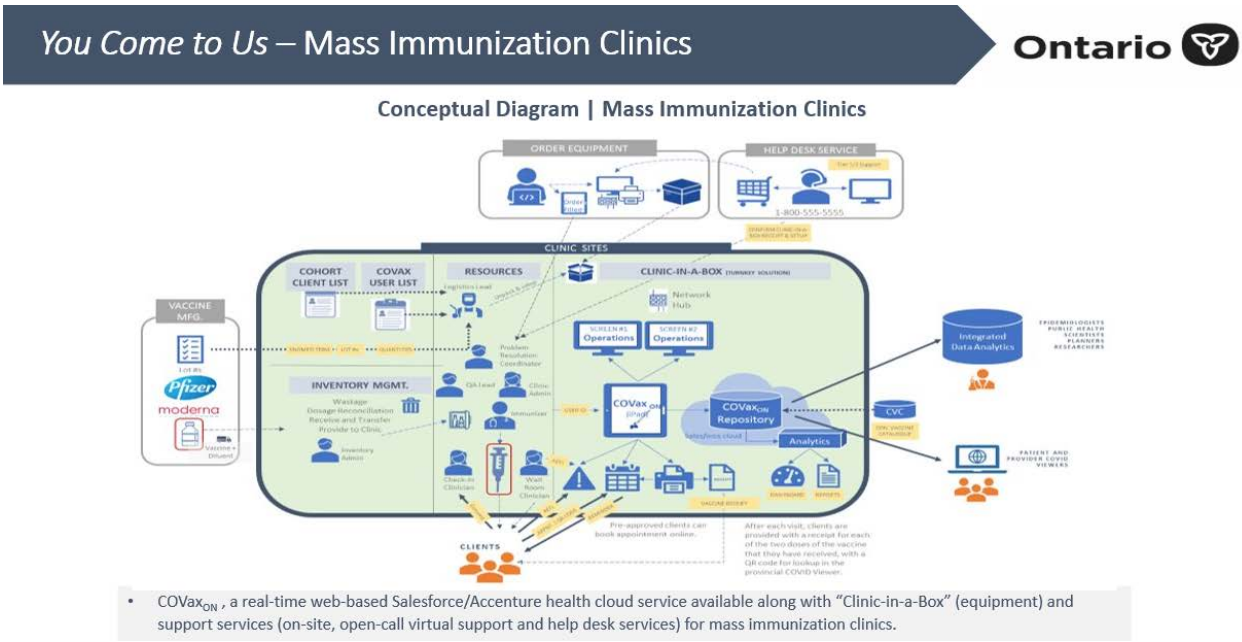
- Being stored in a hard-sided cooler
- Once vaccine is thawed, it is maintained between 2-8°C at all times

- Temperature of the cooler needs to be recorded before leaving health unit office, upon arrival at clinic location, every hour during the clinic, before leaving the clinic location and upon arrival back at the health unit

Vaccines that have not maintained cold chain cannot be used until a cold chain investigation is completed to determine if the vaccine is appropriate for use or not.

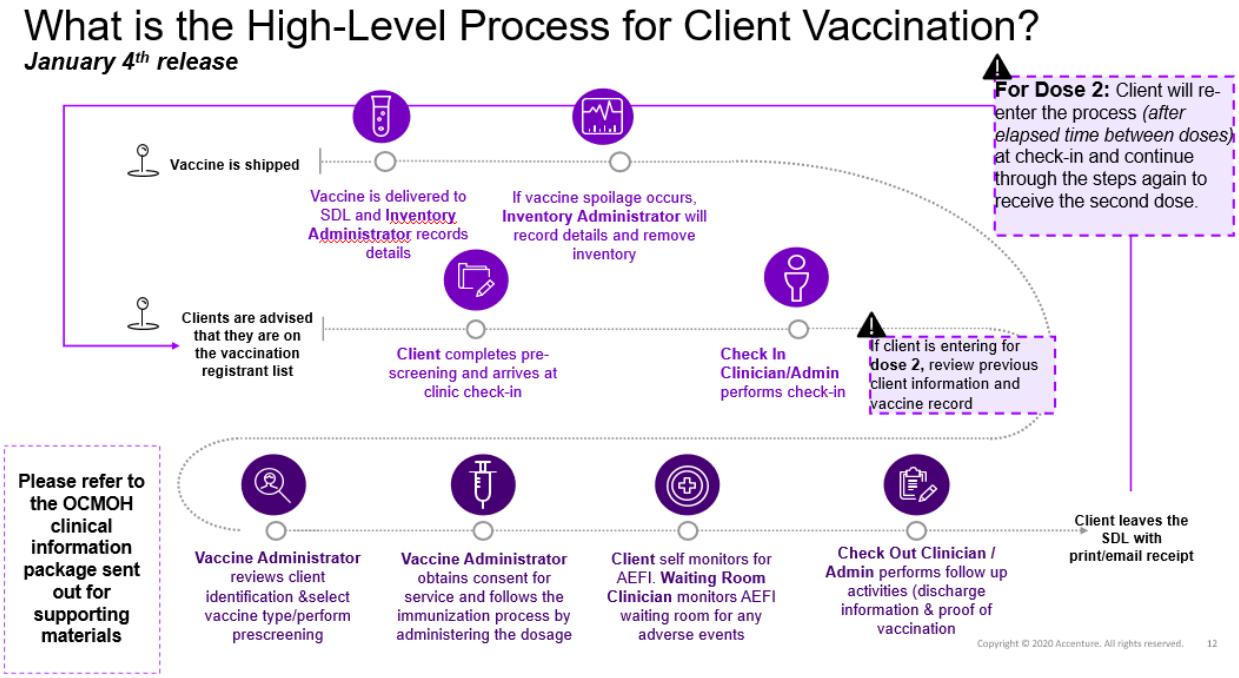
COVAX

COVAX is the IT solution for tracking all COVID-19 vaccine inventory and recording all administered doses of COVID-19 vaccines in Ontario. The COVAX solution will support the administration of all vaccine preparations (Pfizer, Moderna, others as licensed and available), in all settings including hospital-based clinics, mobile clinics and community clinics. It will also eventually be used for all doses administered by PCPs and pharmacists. The following provides an overview of the system's use for MICs:



COVAX provides real time administration data and inventory tracking for the province. Anytime COVAX cannot be used (e.g., no internet connection), paper records must be used and the data must be entered as soon as possible. Where the vaccination client lists has been preloaded prior to vaccination the data entry is quick. Where all the data elements need manual entry, it requires 2-3 minutes /record. Recording the immunization is a requirement of standard clinical

practice and the responsibility of the vaccinator. The following provides a process map of the client experience using the COVAX system:



COVAX Solution User Accounts

- Identify staff for specific roles in COVAX Solution (Inventory Managers; Check-In; Vaccinators; Check-Out; Bulk Data Uploaders; Dashboard).
- Request COVAX Solution user accounts, for each of the above, from the Ministry.
- Guide staff in the completion of setup and authentication of their respective USER accounts.
- Provide role-specific training (Live/video recordings; Job Aid documents; training accounts for role practice in COVAX Solution training environment).

Prioritized Client Lists

- Using Ministry-provided templates, create lists of prioritized Clients (i.e., those who will receive the vaccine):
  - For example, request LTCH fill out the template, providing information to populate the requested fields, on each of their staff. The LTCH then encrypts the file and sends it back to the local public health agency.
- Pre-load the information, collected using the templates, into the COVAX Solution. Having Client Profile information pre-loaded will decrease time at Check-In.

Scheduling of Prioritized Clients

- A scheduling component of the COVAX Solution is currently under development but is not available at present and may not be available until February 2021.
- Therefore, immunizers must use existing clinic scheduling processes for scheduling of clients.
- SMDHU has an alternate appointment booking system from Input Health that will be ready to be utilized when health unit based clinics with Moderna or other public health unit based vaccines are available.
- At present, there is no logic built into the COVAX Solution to prevent clients from receiving one vaccine for their initial dose, and a different vaccine for their second dose:
    - Creating processes to minimize this possibility (e.g., by offering only one type of vaccine at any given service delivery location will need to be developed in the interim).

CLINIC COMMUNICATIONS

During MICs, updated information may become available that needs to be quickly and clearly communicated to all clinic staff. A dedicated URL page will be shared with all staff working in clinics to ensure access to orientation documents and updated communications.

- At least 1 hour before the start of each clinic, the Clinic Manager will send a summary email to all Clinic Coordinators highlighting any changes or new information.
- Prior to the start of the clinic, the Clinic Coordinator will gather all clinic staff and share the contents of the email update with the group.
- Any questions or clarification needed will be directed back to the Clinic Manager by the Clinic Coordinator.
- Each Clinic site will be assigned a health unit-issued cell phone. The Clinic Coordinator will be responsible for bringing the cell phone with the clinic supplies to each clinic.
- As additional/revised information becomes available throughout the course of the clinics, the Clinic Manager will communicate with the Clinic Coordinators.
- As issues or need for clarification/information arise during clinics, the Clinic Coordinators will communicate back with the Clinic Manager.

At the end of each clinic, the Clinic Coordinator will email the COVID-19 Vaccine Clinic Summary form (see Appendix H) to the IP Clinic Manager. These will also be stored electronically.

External Communication

Media calls will all be received through the SMDHU Media Coordinators in Health Promotion & Communications team and directed to the most appropriate person for response. The MOH will be the primary spokesperson for the immunization campaign and will include updates in his weekly press conferences on COVID-19. All MIC Clinic Coordinators will receive media training in the event that media should arrive unannounced at a clinic location. Media will be discouraged in the immunization area as it can be distracting to clinic operations.

If a media outlet wants to interview people or take photos, they should connect with the MIC Clinic Coordinator.

Clients are permitted to take a photo or have a photo taken while getting their immunization provided the provider consents, there is no other clients in the photo and it is a photo not a video.

SMDHU Media Consents need to be completed anytime SMDHU or Health Promotion & Communication staff take photos to use for the health unit's own health promotion purposes.

Please see Communications section of this plan for the overall communications plan.

HUMAN RESOURCES (HR)

Factors that will be considered in SMDHU's HR Recruitment Strategy include:

- Expedited recruitment is required, meaning limited interview questions with the possibility of limited reference checks, if any, as their completion is time consuming
- Job Postings
- Soliciting volunteers, prior employees and retirees through a centralized data base in HR
- Consideration of using an external recruitment agency to supplement HR's recruitment efforts
- Using external staffing agencies when required
- Coordinating the use of external staff being requested or offered by other agencies
- If necessary, media ads to attract staff
- Role descriptions will need to be developed
- Qualifications, experience, skills and abilities need to be determined for each role

- Salary levels have to be determined, however there is no time for formal job evaluation to take place
- Limited staff orientation/onboarding is required
- Criminal Reference Checks consideration given the time needed to obtaining them
- Confirmation of any license requirements
- Letters of offer with probation
- Setting staff up on payroll and orientating them to electronic time sheets
- A Manager of Volunteers needs to be appointed with so many individuals offering to volunteer. Currently, offers to help are being collected by SMDHU through their website. Those interested can fill out an on-line form.

Please also see HR-related content within other sections of this plan.

CONTINGENCY PLANNING

Contingency planning is critical to ensure that the vaccination program is maintained, should elements of the primary plan face unforeseen challenges. Continuity of operations depends on identifying and managing those resources and situations most at risk of disrupting the program, such as staff absence, physical site security, IT systems and power supplies. A strong contingency plan considers these elements according to local public health risks and contexts so that the vaccine program continues to serve its region's residents in the manner best suited to them, despite unexpected challenges that may emerge.

Plans will be simple, well-communicated, and not reliant on a single person being present or available. If an interruption to vaccination is required to safeguard personnel at the delivery site, immediate risk to life and limb must be prioritized. At all times, vaccine stocks and supplies required for delivery should be safeguarded and accounted for, through the cooperation of health care partners where feasible. At all times interruptions to vaccination sites must be immediately communicated to the Ministry of Health's Emergency Operation Centre, and the local public health agency's IMS structure.

Risk Assessment and Hazard Identification

The SMDHU conducts annual Hazard Analysis and Vulnerability Assessments (HAVA) to identify risks, threats, and vulnerabilities that could potentially impede the delivery of public health services. The SMDHU Hazard Analysis and Vulnerability Assessment (HAVA) Plan contains identified hazards and local public health risks based on their probability, severity and potential impact to health unit infrastructure or operations. See Appendix I for most recent 2020

Hazard listing. SMDHU uses the HAVA to prioritize planning and has developed and implemented safeguards, controls and strategies to help mitigate potential consequences on service delivery, the health of the population and community.

Mass Vaccination Campaign Contingency Plans

Agency emergency/contingency plans and strategies have been developed to address local public health hazards. Contingency planning for the mass vaccination campaign strategy involves a proactive approach to potential issues before they arise. In addition to community-based and general local public health hazards, further brainstorming was conducted to determine possible problems, hazards and risks that could impede on SMDHU's ability to implement our local mass vaccine campaign and clinic operations. Of the pre-identified public health hazards, infectious diseases/medical emergencies, critical infrastructure failures, environmental and severe weather events were identified as having most significant and probable impacts on clinic operations and the vaccine delivery campaign. The following hazards have been identified as requiring contingency plans:

Identified potential hazards requiring contingency plans:

- HR Surge Capacity/Staff Shortages
- Health & Safety Hazards (including IPAC)
- Supply Chain Interruptions/Shortages
- Vaccine Safety and Security
- Critical Infrastructure Failures (Including Power Outages, Technology and Information Systems)
- Vaccine Uptake/Hesitancy (Trust, Conspiracy Theories, Anti-Vaccination Efforts)

Contingency plans have been developed to address these hazards and to ensure that control measures, safeguards and strategies are implemented to mitigate the risks.

Hazard: HR Surge Capacity and Staff Shortages

Potential hazards include: surge response and capacity demands, increased staff absenteeism/illness, health and safety, and psychosocial HR implications.

Contingency/Mitigation Strategies

(Refer to Clinic Operations, Scheduling and Appointment booking systems portion of the plan for additional contingencies and processes. For a list of community stakeholders and partners involved with supporting roll out of the COVID-19 Immunization program, and potential immunizers, refer to Engagement of Community Partners section of plan)

- Implement Reduction of Services and HR re-deployment strategies, in accordance with SMDHU Business Continuity Plan and COVID 19 Business Continuity and Resumption Strategy.
- Building surge capacity through re-deployment and recruitment and the leveraging of stakeholder support and volunteers, including web-based collection of offers for support.
- Skills development training for roles and functions.

- Purchasing additional licenses and technology to enable surge capacity.
- Scheduling and identifying potential back-up schedules/staff that can be deployed to work in clinics.
- Utilize scheduling system to schedule staff.
- Monitor and Report injuries/illness.
- Assigning Administrative Support Coordinators to make daily adjustments/cancellations as needed or as directed by the Clinic Manager (due to staff illness/absences, surge response needs, or as a result of service/clinic interruptions).
- Implement staff notification systems/process to notify scheduled staff and clients of cancellations.
- Clinics/Staff training on Health and Safety Risk and Measures.
- Implement early detection mechanisms for psychosocial identification and assessment processes (BC Plan).
- Provision of education and awareness training of clinic staff on health and safety, stress management coping and recognition strategies, in addition to the Employee Assistance Program (EAP), to support staff.

Hazard: Health & Safety

The following is a high-level list of mitigation strategies developed to ensure the health, safety and well-being of staff and clients, including blood borne exposures, injuries, and exposure to infectious diseases/environments.

(Additional measures and detail can be found within the Clinics Operations Health & Safety, IPAC, Screening, PPE and Security/Traffic & Line Management components of the plan). For additional contingency measures being implemented to control disease transmission in clinics, see Staff & Clinic Assumptions.

Contingency/Mitigation Measures:

- Ensure staff complete Daily COVID-19 Staff Screening survey, and only present to the clinic if they pass.
- Active screening of clients and staff for symptoms of illness by screeners prior to clients entering the clinics.
- Implementation of public health measures to decrease COVID-19 transmission in the clinic.
- Prioritized COVID-19 vaccination for immunizers.
- Monitoring and reporting of injuries.
- Health & safety training on the use of PPE and supplies and provision of appropriate PPE, equipment and supplies.
- All staff will work in accordance with SMDHUs Health and Safety policies.
- Daily Clinic IPAC/environmental cleaning measures implemented.
- Provision of cleaning supplies/equipment/Blood and Body Fluid Spills kits as MIC sites.
- Contracted 24/7 security provider available for MIC sites to address potential security threats due to limited vaccine supply.
- Implementation of security, traffic flow and line management measures.

Hazard: Supply Chain Interruptions and Shortages

Potential hazards include: limited access to supply chain, disruptions to service/supplies, supply shortage/wastage, and Inventory Management (insufficient inventory to meet surge/response needs).

Contingency/Mitigation Measures:

- Maintain inventory of vaccine supplies, monitor stock levels, and track/account for utilized supplies.
- On-going Surveillance & Situational Assessments to inform communication of needs for supplies to the province (vaccines will be delivered based on the assessments submitted by local health authorities and by the Ministry of Health.).
- Bulk order and storage to ensure availability when surge in vaccine stock levels are available.
- Reserved logistics storage sites, with controlled access and security (central inventory maintained in secured public health logistics/inventory room).
- Secure additional warehousing and supply storage capacity, utilizing SMDHU and partner warehousing sites.
- Inventory monitoring and requisition system for MIC sites.
- Assigned logistics staff (mobile teams) to ensure safe and timely delivery of vaccine and supplies from storage facility to clinics/administration sites, based daily clinic schedules and anticipated usage.
- Tap into existing localized donations management strategy, or request supplies/support from local, provincial/federal stakeholders request donations/supplies/resources, when necessary.
- Follow vaccine storage and handling, and manufacturers guidelines to avoid vaccine spoilage/wastage, utilizing Ministry of Health – COVID-19: Vaccine Storage and Handling Guidance – Pfizer-BioNTech and Moderna COVID-19 Vaccines.
- Scheduling appointments – reserved for priority group and administered in accordance with local vaccine roll-out strategy, and in correlation with vaccine availability and supply.
- Maximize vaccine supplies by uutilizing 1cc syringes when possible to allow maximum 6 doses to be drawn from each vial.
- Implement end of shift vaccine administration – in accordance with scheduled back-up priority groups to avoid wastage.

Hazard: Vaccine Safety and Security

Potential hazards include: vaccine security/handling, safeguarding of vaccine stocks and supplies.

Refer to Vaccine Security, Traffic Flow and Line Management, Distribution System (Delivery and Receiving) and Physical Security portions of plan for more details.

Vaccine Security at Main Storage Sites

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Hazard: Critical Infrastructure Failures/Disruption of Service

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Contingency/Mitigation Measures:

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Hazards: Vaccine Uptake/Hesitancy

Potential hazards include: uncertainty/mistrust, conspiracy theories, and anti-vaccination efforts.

For additional detail refer to Vaccine Strategy, SMDHU COVID-19 Vaccination Communications Plan within Communications portion of this plan.

Contingency/Mitigation Measures:

- Transparency: Reporting of AEFIs for COVID-19 vaccines (See AEFI Surveillance & Reporting processes).
- Reporting medical errors and adverse events.
- Implementation of active vaccine safety and surveillance.
- Engagement of vulnerable populations and providing heightened education/awareness.
- Increase awareness of the safety and efficacy of the COVID-19 vaccine.
- Encourage the uptake of individuals getting the COVID-19 vaccine.
- Reinforce continued public action of COVID-19 prevention measures.
- Address disinformation using multiple strategies to reduce vaccine hesitancy.
- Collaborate with key partners and stakeholders with key messages development and communications dissemination.
- Support to engage with populations in languages and ways that are most accessible (e.g., adaptation and translation of key messages and communications products).

VACCINE DISTRIBUTION IN PHASE 3

The manufacturers, Ministry of Health, as well as federal authorities at Health Canada, will continue to provide estimates of when COVID-19 vaccine will be available and in what quantities. Based on the most current and accurate information available, the Ministry of Health will provide such estimates to each local public health agency. Distribution of the COVID-19 vaccine to each local public health agency jurisdiction will be in alignment with each allocation phase and quantities available. Amounts to be allocated will follow principles for equitable allocation. Vaccines will be delivered based on the assessments submitted by local health authorities and by the Ministry of Health. Safe and timely delivery is key to this operation and will be conducted in part by contracted partners. Any change to the public health authority's assessment of the transportation, storage and security arrangements must be immediately

communicated to, and confirmed received by, the Ministry of Health's Emergency Operations Centre. It is anticipated that the Ontario Government Pharmacy along with local OPP authorities will deliver vaccine to local public health agencies.

Distribution System (Delivery and Receiving)

The manufacturers, Ministry of Health as well as federal authorities at Health Canada will provide early estimates of when COVID-19 vaccine will be available and in what quantities. Due to the storage conditions required for the Pfizer vaccine, it will continue to be allocated to the hospital sites, and public health will work collaboratively with the hospital sites to utilize this vaccine. When Moderna and other less storage restrictive vaccine are available, it is anticipated that the Ontario Government Pharmacy along with local OPP authorities will deliver vaccine to local public health units. With an established supply chain for the Pfizer vaccine, second doses do not need to be held back at this time, however appointments cannot be booked unless vaccine allocation is available for them. It is anticipated that vaccine for second doses of Moderna vaccine will need to be allocated at the same time as the first dose quantities to ensure that there is sufficient quantity available for the second dose at the appropriate interval until an established supply chain is known.

In collaboration with local partners, SMDHU will ensure they have the space, expertise and staff to receive, store and handle the vaccine per current Ministry of Health Vaccine Storage and Handling Protocol. Pfizer vaccine storage continues to require ULT freezers, therefore RVH will continue to store this product. SMDHU has received a -20◦C freezer from the province, and it is ready to receive Moderna vaccine when it is available. All vaccines, whether stored at ULT or -20◦C, require monitoring and documenting maximum, minimum and current temperatures at least twice daily in accordance with guidelines and standards issued by the Ministry of Health or other industry or government agencies.

Once provincial guidance allows for distribution of vaccine to providers outside of hospitals and public health, SMDHU will leverage our existing vaccine distribution systems with our HCPs to ensure proper delivery and storage of these vaccines.

There is significant storage capacity for vaccines within the region. SMDHU inspects 280-300 fridges that hold publicly funded vaccine each year. There are also 165 pharmacies that are qualified for the annual flu program. In addition to RVH's ULT freezer, SMDHU's -20°C freezer will allow us to store the Moderna vaccine, which requires long-term storage of -15°C to -25°C. Muskoka Algonquin Health Care currently has a freezer to store Pfizer/BioNTech vaccine and is in the process of confirming the requirements.

Strict attention must be paid to maintaining cold chain requirements when vaccine is being transported, distributed and stored. 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 Ministry of Health Vaccine Storage and Handling Protocol outlines roles, responsibilities, and processes for current storage and handling. The resource for Vaccine Storage and Handling Protocol, 2018 is followed by all HCPs who store and handle publicly funded vaccine. Additional Storage and Handling Protocols specific to COVID-19 vaccines have also been provided by the Ministry, which all providers will be required to follow for these vaccines.

For further information on the responsibilities for storing and handling of specific vaccines, consult the manufacturer and government guidelines.

Physical Security

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SURVEILLANCE AND REPORTING

Simcoe Muskoka COVID-19 Vaccination Surveillance Plan

The COVID-19 Vaccination Surveillance Plan is one component of a larger SMDHU COVID-19 Surveillance Plan, important for surveillance and assessment and to inform local planning and adjustments to the vaccination program.

Transparency in reporting on vaccine distribution, uptake by prioritized populations, and progress towards targets, with attention to equity, is critical for maintaining public trust and confidence in the process.

Data management systems (Case and Contact Management (CCM), COVAX) should easily support the generation of information required for reporting requirements. Report generation for COVAX is still in the early stages, and we will continue to work with the Ministry of Health to provide feedback regarding local reporting requirements. In the event that information can be entered into COVAX but reporting functionality remains unavailable, other means of data collection will be employed. As a contingency, SMDHU will employ our vaccine inventory management (VIM) spreadsheets. VIM has been used previously when MICs have been required.

SMDHU has already created a section on our HealthSTATS COVID-19 page specific to COVID-19 immunizations. The following initial set of indicators have been selected:

- Total # of doses administered (cumulative).
- Doses administered the previous day.
- Immunizations by priority group. Currently includes LTCH and Rhome staff, essential caregivers and residents along with hospital staff. Numbers and percentages receiving dose #1 and dose #2. Future priority groups will be included.
- Cumulative number of individuals immunized by day, by dose #1 and dose #2.

- Priority groups immunized with dose #1 and dose #2 by geography (County of Simcoe and District of Muskoka). As more immunizations are administered, we will also report on immunization rates by LHIN sub-region and/or local municipalities.

As the local vaccine roll-out continues, the intention is to revise and include additional data.

Goals of the Vaccination Surveillance Plan

To inform vaccination strategies during each phase of roll out by monitoring and reporting out on the following five key areas:

- Vaccine inventory, distribution and wastage. Reporting of local vaccine inventory requires Ministry of Health approval.
- Vaccine administration and coverage:
    - by priority populations targeted in Phase 1 and Phase 2:
        - dose administration and coverage by facility (e.g., LTCH, RHome) and resident vs staff;
    - for the overall population (Phase 3);
    - among socio-demographic groups (e.g., race, occupation, language, country of birth, age and gender);
    - by geographical areas (e.g., municipalities); and
    - accounting for vaccine dosage/scheduling.
- Barriers to vaccine uptake:
    - barriers to uptake and reasons for vaccine refusal or vaccine hesitancy.
- Public awareness/opinion/beliefs on COVID-19 vaccination.
- AEFI.

Reporting Plan

Information collected under the surveillance plan will be reported internally and externally in a timely fashion using appropriate reporting tools, including SMDHU's weekly COVID-19 epidemiological surveillance report, weekly media scrums with SMDHU's MOH, the HealthSTATS COVID-19 webpage and the SMDHU COVID-19 Case Explorer.

Data Sources

SMDHU will need to develop or implement data collection tools and processes to collect and report data. Current or proposed local data sources for surveillance reporting include:

1. COVAX-ON: Given the limited reporting functionality in COVAX-ON, Public Health Ontario (PHO) is able to support immunization data requests for emergent outbreak management on a case-by-case basis. 3 reports are currently available:
    a. Dose Administration by Reason: This report provides counts of doses administered by reason for immunization (e.g., role)

b. Summary Client and Dose Administration Report: This report does not contain personal health information data and may be used by organization executives as well as staff to support day-to-day operation. This is the most detailed information we have for each dose administered but there is no ability to link back to the client (e.g., no personal health information)
c. Vaccine Inventory Report: This report will be used to support day-to-day operation by organizations (Hospitals, LTCH, Rhomes, public health units, etc.). This report does not contain personal health information data so it can be used by Inventory support staff as well as organization executives.

2. Case and Contact Management system: # of AEFIs
3. Local booking systems for appointments. For example, The Ottawa Hospital's Booking System includes a Dashboard for the Ottawa Hospital's clinic bookings, including:
   - Facility name of client (using a free text field that is very laborious to report on)
   - Confirmation of 1st vs 2nd dose appointments
4. Population data for use in planning clinics and estimating vaccination coverage rates:
   - Bed census counts of LTCHs and RHomes (acquired from the LHIN)
   - Number of LTCH and RHome residents and staff (acquired directly from these facilities)
   - Population estimate data (Ministry population estimate and projection data)
   - Other priority population data, e.g., ages 70+ in community (not in LTCH/RHome), rurality, neighbourhood income quintile, those with chronic conditions, immunocompromised, persons with medical conditions associated with frailty (IC/ES)
5. Survey data: To collect public opinion/awareness of the COVID-19 vaccine and some reasons or barriers for vaccine hesitancy and refusal. Questions were asked in Simcoe Muskoka in the fall of 2020 and will be repeated in the spring of 2021 via the COVID-19 Impact Survey (administered by York University on behalf of SMDHU).

Further provincial and local work to advocate for data elements and functionalities in COVAX that local public health units are not able to extract and report on, as well as for collection of socio-demographic client data and other population health data is essential to inform this response.

Social Determinants of Health Collection and Reporting

Purpose: To assess vaccine uptake for populations at risk or with higher burden of COVID-19. A similar approach proposed below has been taken to assess the burden of COVID-19 morbidity and mortality in Simcoe Muskoka.

Client based Socio-Demographic Data Collection:

At the COVID-19 Vaccine Operations call on February 10th, the Ministry indicated that the addition of SDOH variables into the COVAX system is imminent. The variables will mirror those that are currently listed in CCM. However, the date of availability is unknown.

In addition to age and gender, Simcoe Muskoka is interested in collecting the following socio-demographic indicators from clients (excluding LTCH or RHome residents):

- Certain current provincial socio-demographic indicators collected as part of COVID case management:
    - Ethno-racial identity
    - Language
- Consideration will also be given to:
    - Indigenous self-identification, based on local collaboration towards such an indicator for Simcoe Muskoka COVID-19 cases to date
    - Occupation
    - Other

It has been recommended in the Public Health Playbook that some socio-demographic indicators be excluded (e.g., income) due to expected low response, and since other proxies of these can be used to inform uptake and planning.

The preferred method for collection of sociodemographic data would be via COVAX. However, if this does not proceed or is significantly delayed, then SMDHU would pursue an alternative approach; we have asked the Ministry if there would be the potential for us to customize the emailed proof of immunization receipt that is sent to people after receiving vaccination, in order to include a link to a survey for them to complete, and the Ministry is exploring.

Geographical Mapping of Vaccine Uptake

It is important to collect accurate geographical information (address or at a minimum postal code), to assess geographical (e.g., by DA, city/town, municipality or LHIN sub-region) coverage of vaccine uptake in the population.

Vaccine safety surveillance

AEFI Surveillance:

Reporting of AEFIs for COVID-19 vaccines will follow the same procedure as AEFI reporting for all other vaccines, using the Ontario AEFI reporting form for initial reports of AEFIs and iPHIS for case management, until COVID-19 AEFI reporting functionality is built into the CCM system and eventually COVAX. 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.

Key COVID-19 AEFI Surveillance Resources:

- Infectious Disease Protocol, Appendix B (*updated December 2020*)
- Ontario AEFI Reporting Form (*updated December 2020*)
- COVID-19 CCM Data Entry Guide: Adverse Events Following Immunization (AEFIs) *(Jan 22, 2020).*
- iPHIS AEFI User Guide *(updated December 2020)*
- Enhanced Reporting Form for Events Managed as Anaphylaxis
- Adverse Events of Special Interest (AESI) for COVID-19 Vaccine Surveillance *(created December 2020)*

Active Vaccine Safety Surveillance:

Ontario will be conducting active vaccine safety surveillance for COVID-19 vaccines through the Canadian National Vaccine Safety Network (CANVAS) beginning in late January. CANVAS conducts active vaccine safety surveillance after implementation of new vaccine programs and will be used by multiple Canadian provinces to gather safety information on COVID-19 vaccines. Individuals who have their consent to receive electronic communication (e.g., email) about research studies documented in the COVAX system will receive an email providing information about CANVAS. Clients who consent to participate in CANVAS will complete online questionnaires following vaccination to elicit information about symptoms as well as medically attended events that require reporting as AEFIs. Any AEFIs identified by CANVAS will be referred to local public health agencies for further investigation and entry into the provincial surveillance system. PHO will assist CANVAS in referring AEFI reports to the correct local public health agency.

Clinical Advice on Re-Immunization Following Complex AEFIs:

Lastly, the Special Immunization Clinic (SIC) Network, a Canadian network of paediatric and adult infectious disease specialists and allergists with expertise in the assessment and management of patients who have experienced a complex AEFI has recently expanded to include additional adult sites in Ottawa and Toronto, including The Ottawa Hospital, St. Michael's Hospital and University Health Network.

COMMUNICATIONS

The roll out of the COVID-19 vaccines will be one of the largest and most rapid mass vaccination programs in history. To ensure a successful roll out, communications and engagement activities will aim to be proactive, clear, concise and timely to inform and assure the public of what action is being taken to administer the vaccines. It's important to ensure clear communication and education about the safety, efficacy and availability of the vaccines. Challenges to consider may include the balancing of perceptions about the vaccines, the ability

to impact or change behaviour, as well as ensuring important logistical information is communicated in a clear and timely way. With many partners involved, it is also important to centralize communications to minimize confusion and establish one go-to source for information.

SMDHU COVID-19 Vaccination Communications Plan

SMDHU is creating a COVID-19 Vaccination Communications Plan that is chunked out by phase (refer to Appendix K for the Phase 1 plan). Its overall goal is to provide the public with accurate, credible and reassuring information about the COVID-19 vaccine. The plan includes the following objectives:

1. Increase awareness of the availability and process for getting the COVID-19 vaccine.
2. Increase awareness of the safety and efficacy of the COVID-19 vaccine.
3. Encourage the uptake of individuals getting the COVID-19 vaccine.
4. Reinforce continued public action of COVID-19 prevention measures.
5. Address disinformation using multiple strategies to reduce vaccine hesitancy.
6. Use crisis communication principles.
7. Collaborate with key partners and stakeholders with key messages development and communications dissemination.

To help inform the development of concepts and key messages to meet some of these objectives, SMDHU is exploring vaccine hesitancy to understand where vaccine confidence may lowest in Simcoe Muskoka and for what reasons. Further, it will identify strategies for increasing vaccine confidence, and will engage community partners and leaders to help shape and disseminate messaging to vaccine hesitant groups.

For a detailed description of SMDHU vaccination communication activities, please see Appendix K for the SMDHU COVID-19 Vaccination Communications Plan.

Communication Modes and Media Platforms

SMDHU communication platforms include:

- SMDHU websites
- social media and video sharing platforms (e.g., Twitter, Facebook, Instagram, YouTube)
- local print and digital newspapers
- radio
- local television

- press releases and press conferences, including joint press releases and press conferences with partners, such as hospitals as needed
- videos (key spokespersons, significant vaccine events posted to SMDHU website)
- special MOH statements to specific audiences (distributed via appropriate partner channels and/or via SMDHU website)
- weekly partner updates targeted at community partners (posted to website)
- HealthFAXes (for HCP audience)

Communications and Community Engagement Considerations

The following considerations will aid in successful communications and community engagement.

Media Relations

- Have ensured a consistent and trusted spokesperson (or very small number of spokespeople with specific areas of responsibility). The MOH for SMDHU is the primary spokesperson for our campaign, with the AMOHs as backup/additional spokespersons.
- Be responsive to media partners and are the first to communicate new developments in our area or in lockstep with the province.
- Clarify possible instances of misinformation.
- Hold regular media/technical briefings with MOH and AMOH to leverage our media partners as a channel to the public. The MOH for SMDHU holds a weekly press conference on COVID-19, as well as when needed, and includes updates on the vaccination campaign within his report.

Tone and Accessibility

- Tone is empathetic, given some people may be hesitant of the new vaccine.
- Will link to websites that have translated information in other languages available.
- Will communicate competence and expertise, conveyed through MOH and AMOH spokesperson(s).
- Will communicate with honesty and openness (i.e., what we know, when we intend to get more information).
- Will ensure web design and information meets accessibility standards under the Accessibility for Ontarians with Disabilities Act (AODA).
- Utilize clear, concise communication, and aiming for a Grade 5-6 reading level for all communications.

FINANCE

Boards of Health are 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 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 Ministry of Health.

COVID-19 costs are tracked separately by the Ministry of Health through special reporting of both CCM cost estimates as well as global extraordinary costs associated with the COVID-19 response. The Ministry of Health has informed health units that the health unit is expected to report COVID-19 immunization costs separate from COVID-19 CCM costs. SMDHU has established a unique expense code for COVID-19 Immunization and a separate pay code within the KRONOS timecard system to track all salary costs.

Local public health agencies will report COVID-19 Immunization costs when the Ministry of Health invites health units to do so.

Costs tracked will include but are not limited to:

- Staff costs in FTEs and dollar value:
    - a separate time code (COVID-19 Immunization) will be created within SMDHU HR pay roll system – KRONOS;
    - Staff involved in the COVID-19 immunization planning and operations will code their time with the COVID-19 immunization code; and
    - Overtime will be tracked separately (based on reporting of extraordinary costs).
- Materials and Supplies / Other Operating Costs in dollar value:
    - A separate project code (COVID-19 Immunizations) will be created within the SMDHU finance enterprise program; Microsoft Dynamics; NAV;
    - Costs associated with the COVID-19 Immunization campaign will be coded using the separate project code; and
    - Subcategories to track may include but are not limited to (based on reporting of extraordinary costs in 2020): Travel & Accommodation, Supplies & Equipment, Purchased Services, Communications.

Post campaign economic evaluation can be completed by assessing and comparing metrics such as cost per dose, cost per clinic/delivery method, and other economic metrics.

EVALUATION APPROACHES

An evaluation plan will be developed that considers both process and outcome evaluation questions, with an emphasis on implementation and real-time process improvements.

Stakeholder perspectives to consider include clients, employees, volunteers and partner agencies.

SMDHU's evaluation objectives are:

- Have we achieved our goal of immunizing the target populations in each of the three phases of the vaccination program in Simcoe Muskoka?
- Did we work collaboratively with our community partners to plan and implement the mass immunization program in Simcoe Muskoka?
- Did we engage with the First Nations, Inuit and Metis people and other identified higher risk populations in Simcoe Muskoka in a meaningful and appropriate manner in the mass immunization program?
- Did we deliver the mass immunization program in an effective, equitable and ethical way?
- Did we communicate with the general public in a way that reduced vaccine hesitancy and increased the rate of uptake of immunization?

A variety of evaluative processes will be used:

Data Collection Method	Sources	Timeline
Document Review	• Review of clinic data collection tools and provincial data sources (e.g., COVAX) • Review of information reported at daily debriefings by staff after each clinic • Review of client evaluations conducted during the waiting period at clinics or online after the clinic • Review of Serious Event Forms and Incident Reports • Review of vaccine wastage	At the end of each phase of mass immunization program
Surveys	Survey of: o Clients o Staff o Volunteers o Community Partners	Clients – ongoing, collected at time of immunization

Data for evaluation will be collected and analyzed in a timely and ongoing manner so that adjustments/modifications can be made to the program to ensure effective delivery throughout.

A written summary report including the processes used in running the clinics, quantitative summary data (e.g., numbers of clinics, numbers vaccinated, numbers of adverse events), qualitative data, evaluation outcomes and lessons learned will support future clinic planning.

The following example evaluation plan from the Public Health Playbook will also be of value to SMDHU as we further develop our own evaluation plan:

Areas	Sub-Areas	Evaluation Questions	Examples of Sub-questions (not an exhaustive list)	Data Sources
1. Priority populations/ Equity	Planning, communication, implementation	How equitable was the immunization campaign?	a) How equitable was the process of identifying priority populations who are more severely impacted by COVID-19 (e.g., health, job loss, economic impact, etc.)? Was it equitable, evidence-based and applied consistently? b) What was the uptake of the vaccine in the priority populations? What were the demographics of priority populations who received the vaccine? Did they receive it in a timely manner (e.g., number of people who took single dose and double dose)? c) What factors contributed to vaccine hesitancy in the priority populations and what was done to address these factors (including building on community partnership, influential communication strategy, etc.)? d) What was done to make vaccines accessible for the priority populations (e.g., access to booking system, vaccination location, AODA accessibility, translation services, etc.)?	Surveys of: • Priority populations • Clinic clients • Immunization planning and/or implementation team COVAX-ON
2. Outcome - Vaccine uptake in general population	Planning, communication	What was the uptake of the vaccine in the general population and what factors influenced and inhibited the uptake of the vaccine?	a) What was the population's awareness and knowledge about the vaccine and their intentions regarding vaccination? b) What was the uptake of the vaccine in the general population (e.g., number of people who took single dose and double dose)? What were the demographics of the general population who took the vaccine? c) How did the vaccination coverage rates affect disease transmission (number of days to herd immunity), severity of illness, number of hospitalizations, number of Intensive Care Unit- beds occupied, etc.? d) What were the barriers to vaccination for general population (e.g., access to booking system, vaccination location, translation services, childcare, etc.)? e) How well did we address the barriers to vaccination for general population (e.g., communication, transportation, etc.)? f) What are the positive influencers/change agents to vaccination?	Surveys of: • General & targeted populations • Clinic clients • Immunization planning and/or implementation team COVAX-ON Epidemiology and Data Analytics

Areas	Sub-Areas	Evaluation Questions	Examples of Sub-questions (not an exhaustive list)	Data Sources
3. Outcome - Vaccine hesitancy in general population	Planning, communication	What was the vaccine hesitancy level in the general population and what factors contributed to the vaccine hesitancy?	a) How many people were vaccine hesitant? What were their characteristics? b) What factors contributed to vaccine hesitancy in the general population? c) f) What was done to address vaccine hesitancy (including building on community partnership, improving the communication strategy, addressing public's perception of safety and its impact on their decision to vaccinate etc.) and what were the outcomes of those interventions?	Surveys of: • General and targeted populations • Immunization planning and/or implementation team
4. Implementation - vaccine administration at the various clinic settings (e.g., pharmacies, MD offices, traditional Mass Immunization Clinic (MIC), mobile units, etc.)	Planning, communication, implementation	What was the effectiveness of the vaccine administration process? Were vaccination targets met (e.g., wait times, timeliness of services, coverage rates)?	a) How effective was the appointment mechanism for the vaccination? b) How effective was the use of various clinic settings (e.g., pharmacies, MD offices, MICs, mobile units, etc.) for administering the vaccines? How accessible were they (e.g., close to transit/availability of parking)? c) How effective was the clinics' design/layout, set-up and space usage? d) How efficient was the execution/vaccine administration (e.g., wait times, timeliness of services, coverage rates, ability to meet minimum/maximum vaccination rate thresholds)? e) What was the frequency, intensity and characteristics (including types of vaccines) of the AEFI? Were communication and implementation plans adjusted accordingly? f) How efficient and effective was the staffing model for the clinics (e.g., was there enough staff to meet needs)? g) How well were the roles and responsibilities of the clinic management and staff implemented for the clinics, including support functions such as security, housekeeping, etc.,? h) How effective was the online and just-in-time trainings for the clinics staff? i) How effective was the use of technology and information systems to facilitate the administration of the vaccine (e.g., provincial IT system for documenting, reporting and scheduling)? j) Were there sufficient IT supports and resources available for the clinics? k) Were best practices for IPAC and Occupational Health and Safety (OHS) followed at the clinics? l) How effective was the vaccine and supplies management and distribution (e.g., delivery and receiving, storage and handling, cold chain and wastage, allocation, inventory management, etc.)? m) How effective was the internal communication in keeping clinics staff, management, and suppliers informed about clinics operations? n) How effective was the external communication (e.g., general communication about vaccine and coverage to the public, specific pre-vaccine and post-vaccine communication for the clients)?	Surveys of: • General & targeted populations • Clinic clients • Immunization planning and/or implementation team • Support teams (IT, HR, Security, Procurement, Communications) COVAX-ON data (including AEFI data) Epidemiology and Data Analytics HR, Procurement, and Communications data IPAC and OHS guidelines and data

Areas	Sub-Areas	Evaluation Questions	a) Examples of Sub-questions (not an exhaustive list)	Data sources
5. Interjurisdictional collaboration	Planning, communication	What was the effectiveness and efficiency of the interjurisdictional collaboration?	b) How efficiently do jurisdictions work together in terms of communication, roles and responsibilities, direction, and how did it affect the following systems: supply, distribution, storage and transportation, information and tracking, financial, and workforce systems?	Surveys of: • Immunization planning and/or implementation team at Federal, Provincial, and Local levels • Support teams (IT, HR, Procurement, Communications) COVAX-ON data

ADDITIONAL INFORMATION

SMDHU Resources Referenced Within the COVID-19 Simcoe-Muskoka Vaccination Campaign Plan

Reports/Documents:

Emergency Management Hazard Identification Risk Assessment (HIRA)

Webpages:

SMDHU – COVID-19 Vaccination Campaign Information Page

SMDHU - HealthSTATS (Local COVID-19 vaccination data)

SMDHU – COVID-19 Monitoring Dashboard

SMDHU – COVID-19 Offers of Assistance

SMDHU - HealthFAXes (Includes vaccination direction to local HCPs)

APPENDIX A: SMDHU/RVH PFIZER SPERLING CLINIC IMS COMMITTEE TERMS OF REFERENCE

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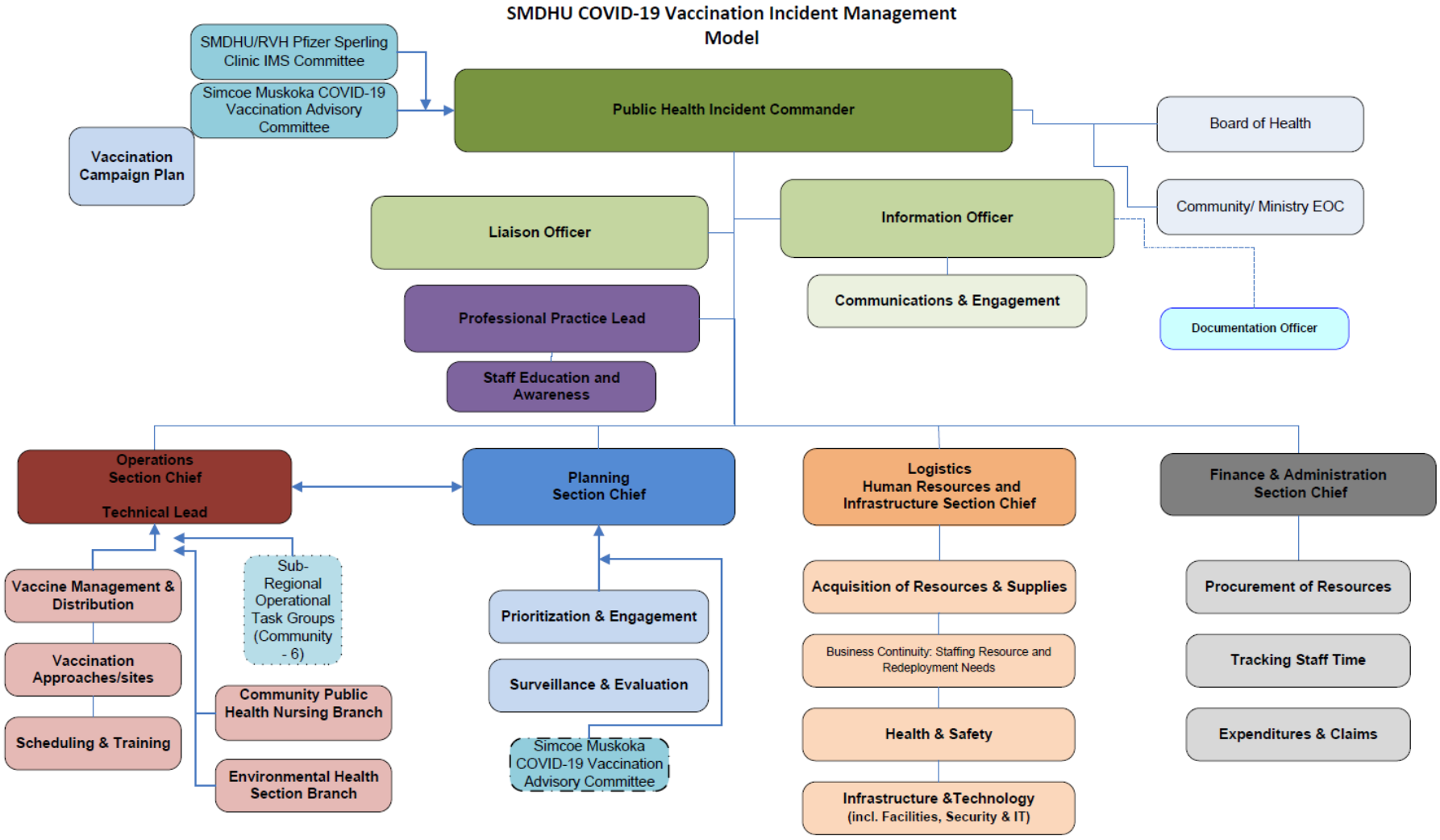
APPENDIX B: SMDHU COVID-19 VACCINATION IMS STRUCTURE (DRAFT)



APPENDIX C: REGIONAL COMMUNITY COVID-19 VACCINE CLINIC TASK GROUP MEMBERSHIP

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APPENDIX D: COVID-19 VACCINATION REGIONAL PLAN TEMPLATE (DRAFT)

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APPENDIX E: COMMUNITY HUB & CLINIC SITE OPTIONS

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APPENDIX F: CLINIC SUPPLY LIST

Clinic Supply List

Bin Contents	2 Nurses
Sharps Containers	2
Small bottles of water	2
Bandaids - Latex Free	1 box
Cotton Balls	1 bag
Alcohol Swabs	2 boxes
Hand sanitizer	3
Gloves - non latex	4 pair
Optim Wipes (disinfect clinic surfaces)	1 canister of each
Lysol Wipes (disinfect computer key board)	1 canister of each
Equip Wipes	A supply
Paper bags	3 bags
Tissue	1 box
Paper towels	1 roll
Large Drape Sheets	3
Small Drape Sheets	3
Safety Needles 25 G - 1 inch	200 (2 boxes)
Safety Needles 25 G - 1 1/2 inch	100 (1 box)
Emergency Bag	1
Internet Hub	1
Power Bar and Extension Cord	1
Emergency Bag Contents	**Total #**
Contents of Emergency Bags slip (in front pouch)	1
Emergency Bag Inspection Sheet	1
3 Blood Pressure Cuffs - extra large adult	1
- adult	1
- child	1
Blood Pressure Gauge (if separate from cuff)	1
Stethoscope	1
Pocket Mask	1
Scissors	1
SMDHU Mgmt of Anaphylaxis Quick Ref Sheet	1
Anaphylaxis Treatment Worksheets	2 (in plastic sleeves)
Aqueous Epinephrine Kit (in clear plastic hard case)	
Aqueous Epinephrine Kit Contents	**Total #**
Quick Reference Dosing Chart	1
Epinephrine Product Monograph	1
Alcohol Swabs	3
Cotton Balls	6
Ampoules of Aquesous Epinephrine	4

1cc syringe with 25G 1" needle	3
Body Fluid Clean Up Kit	**Total #**
Steps to Clean and Disinfect Body Fluids - ACCEL WIPES	
Ear loop masks	20
Disposable gowns	3
Sm and Med gloves (in ziploc bags with sizes on a label on the baggie)	
Plastic garbage bags	5
Administrative Items	Total #
Fact Sheets	A supply
Consent Forms	A supply
After Care Tear pads	Per nurse
Stapler/Paperclips/Elastics	A supply
Black Pens/Red Pens	A supply
Canadian Immunization Guide	(Available On-Line Only)
Clinic Document Portfolio Contents	**Total #**
Tab 1 - Health & Safety	
Agency Health & Safety Policy - HS0101	1
Staff Exposure to Blood and Body Fluids Policy - HS0102	1
Slips, Trips and Falls Policy - HS0104	1
Injury on Duty Policy HS0105	1
Health & Safety Manual - Oct 2010	1
Potential or Exisitng Unsafe Work Condition Form	5
Near Miss Form	5
Employee Incident Report Form A	5
Workplace Violence Incident Report Form	5
Tab 2 - Agency Policies	
Medication Error Policy - LG0103	1
Medication Error Forms	5
AEFI Forms	5
Reports to Children's Aid Society Policy - LG0102	1
CAS Report Form	3
Tab 3 - Directives and Product Monographs	
Anaphylaxis Directive	
Pfizer BioNTech Directive	
Moderna Directive	
Pfizer BioNTech Product Monograph	
Moderna Product Monograph	

APPENDIX G: ANCILLARY SUPPLY ORDER FORM

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APPENDIX H: COVID-19 VACCINE CLINIC SUMMARY FORM

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APPENDIX I: SMDHU HAZARD ASSESSMENT AND VULNERABILITY ANALYSIS - 2020

Hazard Assessment and Vulnerability Analysis (HAVA)

Emergency Management Program

Hazard and Vulnerability Assessment Tool

	PROBABILITY'	Public Health Consequences			RISK VULNERABILITY
		HUMAN IMPACT	COMMUNITY/ ENVIRONMENTAL IMPACT	ORGANIZATION/ BUSINESS IMPACT	
	Likelihood this will occur	Possibility of dealth or injury	Physical losses and damages	Interuption of services	
Public Health Hazard	1. No incidents in last 15 years 2. Last incident 5-15 years ago 3. One incident in last 5 years 4. Multiple incidents in last 5 years	1 = No/Limited Impact 2 = Low/Minor Impact 3 = Moderate/Substanial Impact 4 = High/Extensive Impact	1 = No/Limited Impact 2 = Low/Minor Impact 3 = Moderate/Substanial Impact 4 = High/Extensive Impact	1 = No/Limited Impact 2 = Low/Minor Impact 3 = Moderate/Substanial Impact 4 = High/Extensive Impact	Score Total
Infectious Diseases	4	4	4	4	16
Food Related Hazards	4	4	4	4	16
Water Related Hazards	4	4	4	3	15
Bioterrist Event	2	4	4	4	14
Mass Gatherings	4	4	3	3	14
Opioids Overdose Outbreaks	4	4	3	3	14
Zoonotic and Vector-Borne Disease	4	3	3	3	13
Severe Weather	4	3	3	3	13
Hazardous Material Incidents	4	3	3	3	13
Environmental	4	3	3	3	13
Technological and Critical Infrastr	4	3	3	3	13
Floods	4	3	3	3	13
Cyber Attack	4	1	3	4	12

APPENDIX J: SMDHU POWER OUTAGE CONTINGENCY PLANS FOR VACCINE STORAGE & HANDLING

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APPENDIX K: SMDHU COMMUNICATIONS PLAN – COVID-19 VACCINE

Last Revised: February 17, 2021

Communications Plan – COVID-19 Vaccine PHASE 1

Communication goal: Provide the public with accurate, credible and reassuring information about the COVID-19 vaccine, including prioritization and roll out of vaccination campaign during PHASE 1.

Objectives:

- Increase awareness of the safety and efficacy of the COVID-19 vaccine
- Reinforce continued public action of COVID-19 prevention measures
- Manage public expectations as priority populations are announced and vaccine supply is increased
- Address vaccine disinformation and misinformation
- Increase vaccine confidence
- Use crisis communication principles
- Collaborate with key partners and stakeholders to amplify messages and ensure consistent communications

Timeline:
December 2020 – April 31, 2021

Budget:
TBD

Audiences:

Priority groups for vaccine:

- Long-term care home (LTCH) staff & essential caregivers
- Retirement home (Rhome) staff & essential caregivers
- High risk hospital staff
- Highest Priority health care workers, followed by Very High Priority health care works, in accordance with the Ministry of Health's Guidance on Health Care Worker Prioritization.

- Indigenous adults in northern remote and higher risk communities (including on-reserve and urban communities)
- Adults 80 years of age and older.
- Staff, residents and caregivers in retirement homes and other congregate care settings for seniors (i.e. assisted living)
- Health care workers in the High Priority level, and in accordance with the Ministry of Health's Guidance on Health Care Worker Prioritization
- All Indigenous adults
- Adult recipients of chronic home care

External:

- Partners and stakeholders (Acute care, LTCH, Rhomes, Municipalities, Indigenous)

Internal:

- Staff
- Board of Health

Background information:

SMDHU's COVID-19 Vaccination Campaign is a phased approach, with various models of vaccine delivery required. This vaccination plan is a monumental task that will require the combined efforts of many community partners. To meet the goal of vaccinating 75% of the vaccine-eligible population, Simcoe Muskoka as a community must immunize 372,182 individuals twice, as both products currently authorized for use (Pfizer and Moderna) require two doses. In order to do so, we are building on our existing immunization infrastructure and consider new and innovative means of vaccinating.

Work is guided by a number of committees, including the Simcoe Muskoka COVID-19 Vaccination Campaign Advisory Committee that has been created to advise on the planning and coordination. Membership is based on representation from the six local Ontario Health Team (OHT)/planning regions (Couchiching, Muskoka and Area, South Georgian Bay, Barrie and Area, North Simcoe, and South Simcoe), and sectors that include hospitals, primary care, First Nations communities, municipalities, the Local Health Integrated Network and the Central Region of Ontario Health.

A group of partners in each community has been pulled together to form a regional COVID-19 Vaccine Task group. Building off of existing regional healthcare planning structures, partners from various sectors including public health, primary care, hospitals, municipalities and other community partners have been engaged in assisting with this planning. Each group is working together to

come up with a regional plan for the rollout of the COVID-19 vaccine to their community, with the goal of having the plan submitted by February 19th and community clinics ready to open March 1st. Each region has identified central COVID-19 Community Clinic locations, and where mobile/outreach clinics will also be required. Innovative approaches are being integrated based on community needs, resources available in those communities & what will work best in each community (e.g., drive-thru clinics).

Considerations for Planning:

- Due to a great degree of uncertainty regarding local vaccine supply and changing provincial guidance about priority populations in Phase 1 this plan is considered an evergreen document and will be updated to reflect change in priority populations, communications activities and timelines.
- As per recommendations for the Ontario government communications team it is agreed that during Phase 1 key messages to the public will be based on the requirement to adhere to public health prevention efforts, while maintain expectations about vaccine supply and roll out to priority populations.
- As there is a variety of priority populations the creation of additional communications plans will provide depth of details required to reflect the engagement, planning and associated tasks. In Phase 1 additional communication plans have/may be created for First Nation and rural and Urban Indigenous populations, adults over the age of 80 as well as others as yet to be determined.
- The principles of crisis communication will be used to ensure ongoing transparency, timeliness of messages, continue to build trust in our agency and prevent the spread of misinformation.
- The 5-Cs of vaccine hesitancy will be applied when communicating to priority populations regarding vaccine uptake. The 5 C's include: community-centred, confidence, complacency, convenience and cultural safety.
    - Note that although collective responsibility is usually promoted it doesn't resonate with vaccine hesitant individuals around the COVID-19 vaccine because their own personal safety is paramount over collective responsibility.
- Hazards – need to address disinformation using multiple strategies to reduce vaccine hesitancy. The difference between misinformation and disinformation is: "When someone deliberately creates or shares false or misleading content, and they intend to cause harm, that's disinformation. When they do so unwittingly and don't intend harm, it's misinformation." https://www.bmj.com/content/372/bmj.n26
- While the vaccine(s) offers protection against COVID-19, there is no data yet on prevention of transmission. We need to be careful about how we speak about protecting others due to this.

Key messages concepts:

For general messaging while majority of population waits to become vaccine eligible:

- The province has determined a three-phased approach to vaccination based on risk and availability of vaccine, beginning with high risk populations. We are currently in Phase 1.
- Until a vaccine is widely available and a large percentage of the population becomes immune to COVID-19, we all have to continue to follow public health measures and rules for our region and continue to take everyday actions to help stop the spread of the virus.
- It takes time for a vaccine to develop its protective effects (ie. a month or longer).
- We are still experiencing high COVID-19 infection rates, which has placed intense strain on our hospitals and health systems, as well as the health workers that have been on the front lines of this crisis for many months.
- It is important that everyone, including those who been immunized, continue to physical distance, wear a mask when we can't, and wash/sanitize our hands frequently.
- As we have seen over the last two months Ontario's vaccine supply will roll out to local areas in stages. As vaccine doses are limited we continue to focus on local residents based on high risk priority.
- At this time vaccination appointments are focused on the priority groups.

For messaging to prioritized groups:

- We recognize that the decision to get immunized is a personal one, but we strongly encourage you to take this opportunity to protect yourself.
- We will reach out to identified populations to prepare them for upcoming vaccine clinics as more information on timing of first dose and appointment booking procedures becomes available.
- Vaccination against COVID-19 is safe, effective and the best way to protect you from serious illness.
- Plans are in place to offer scheduled appointments for COVID-19 in community clinics in Simcoe Muskoka municipalities in March, depending upon the arrival of the vaccine.

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