COVID-19 Vaccination Plan

Marion County

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Marion County Health and Human Services |Draft |Last Revised: 1/29/2021

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Introduction

Since the start of the SARS-CoV-2 (COVID-19) pandemic in Marion County in early March, Marion County Health and Human Services (MCHHS) Department Operations Center (DOC) has worked to develop a robust emergency coordination and response system in conjunction with MCHHS and county staff, the Marion County Board of Commissioners, community stakeholders, and state partners. While the imminent release of a COVID-19 vaccine is anticipated to bring much needed support to local public health in controlling and curbing the impact of the virus, continued social distancing, contact tracing, and testing will need to continue until vaccine uptake reaches a level high enough to mitigate transmission and bolster herd immunity. Guided by the principles of health equity, MCHHS will continue to work with community partners to build health systems conducive to community uptake of vaccine to reduce COVID-19 prevalence and disease burden. Decisions made regarding vaccine distribution and allocation will be driven by the latest data regarding COVID-19 transmission.

The Marion County COVID-19 Vaccination Plan is modeled after the CDC COVID-19 Vaccination Program Interim Playbook for Jurisdictions with additional guidance from the Oregon Health Authority (OHA) COVID-19 Vaccination Plan. This plan provides an overview of the planning process MCHHS will undertake in response to the three vaccine program implementation phases outlined by the CDC. This document will also outline vaccine planning infrastructure both internally and in conjunction with community partners, the phased approach to COVID-19 vaccination, outline critical and priority populations, provider enrollment support, vaccine distribution and administration infrastructure, vaccine allocation, and program communication.

The goal of the Marion County COVID-19 Vaccination Plan is to provide a framework for coordination across county and state partners, with the goal of reducing and eliminating the disproportionate impacts of COVID-19 and preventing community transmission within Marion County. The plan is intended to be a living document and is subject to revision based on community and stakeholder feedback and additional guidance released by the CDC and OHA. The continuously evolving nature of the COVID-19 pandemic requires continued adaptation in response to new information, best practices, and feedback gained from implementation of the plan.

Health Equity in Vaccine Allocation

The MCHHS COVID-19 vaccine allocation and distribution framework is based on a foundation of health equity, driven by data collected over the course of the pandemic and revealing disproportionate impacts in certain populations within Marion County. Allocation decisions must also be guided by foundational principles to reduce severe morbidity, mortality, and negative societal impact due to COVID-19.

MCHHS has adopted Oregon Health Authority's definition of health equity, which states that: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Health Equity Lens

In addition to utilizing health equity as a guiding principle for vaccine planning, MCHHS will adopt a health equity lens to inform prioritization of vaccine while supply remains limited in Phase 1 and early Phase 2. The health equity lens is intended to guide allocation decisions by providing decision makers with a list of questions to consider when determining priority. The adoption of a health equity lens will be based on internal as well as external stakeholder and community partner input. MCHHS has adopted the equity questions outlined in the Oregon Department of Education equity framework, which may be used as a framework to make resource allocation decisions and evaluate strategic investments. These questions include:

1. Who are the racial/ethnic and underserved groups affected? What is the potential impact of the resource allocation and strategic investment to these groups?
2. Does the decision being made ignore or worsen existing disparities or produce other unintended consequences? What is the impact on eliminating the opportunity gap?
3. How does the investment or resource allocation advance the goal?
4. What are the barriers to more equitable outcomes? (e.g. mandated, political, emotional, financial, programmatic or managerial)
5. How have you intentionally involved stakeholders who are also members of the communities affected by the strategic investment or resource allocation? How do you validate your assessment in (1), (2) and (3)?
6. How will you modify or enhance your strategies to ensure each individual and communities' individual and cultural needs are met?
7. How are you collecting data on race, ethnicity, and native language?
8. What is your commitment to professional learning for equity? What resources are you allocating for training in cultural responsive instruction?

MCHHS will continue to refine its equity framework in conjunction with community partners and stakeholders. In addition, MCHHS will utilize ethical considerations outlined by the Advisory Committee on Immunization Practices (ACIP) and the CDC to inform county allocation and prioritization decisions. The MCHHS DOC has also identified staff to act as health equity technical advisors and lead health equity review of planning documents and COVID-19 operations.

Disproportionate Effects of COVID-19 in Marion County

Marion County statistics regarding incidence and mortality rates by race and ethnicity echo overarching state level trends highlighting the disparate impacts of COVID-19. These differences reflect an inequitable burden of disease among communities of color, as COVID-19 transmission is impacted by

social vulnerabilities that include access to testing, adequate space and resources to self isolate, access to healthcare, and ability to physically distance.

Data on COVID-19 within Marion County show that American Indian/Alaskan Native, Native Hawaiian or Pacific Islander, and individuals who identified as multiracial experienced a disproportionate burden of morbidity and mortality when compared to other groups. When stratified by ethnicity, the Hispanic or Latinx community also shows elevated morbidity when compared to non-Hispanic or Latinx.

Incidence and mortality rates by gender show that individuals who identified as female carry a higher disease burden than males, while males account for a higher proportion of mortality.

The following tables derived from Marion County epidemiological data are based on Opera data current as of November 2, 2020 and depict rates per 100,000. Population estimates used for gender are based on 2019 estimates for Marion County. Data used for race/ethnicity is based on population values used in the ACS 2018 5-year estimates.

COVID-19 Cases by Race/Ethnicity

	Incidence Rate	Mortality Rate
African American/Black	962	0
American Indian or Alaskan Native	5,700	0
Asian	977	0
Native Hawaiian or Pacific Islander	5,882	82
Other/Multiracial	4,530	23
White	977	34
Hispanic or Latinx	3,315	20
Non-Hispanic or Latinx	977	34

COVID-19 Cases by Gender

	Incidence Rate per 100,000	Mortality Rate per 100,000
Female	943	15
Male	851	17
Non-Binary	0	0
Unknown	4	0
Marion County	1,798	32

Stratification of incidence and mortality rates by zip code indicate spatial disparities in the impacts of COVID-19, likely driven by social determinants of health. Zip codes with higher incidence and mortality rates include Gervais, Hubbard, Woodburn, and Northeast Salem. Population estimates for zip code areas are derived from the 2018 ACS 5-year estimates.

Zip Code Area	Description	Incidence Rate	Mortality Rate
97002	Aurora	966	17
97020	Donald	699	78
97026	Gervais	3,136	22
97032	Hubbard	2,202	0
97071	Woodburn	4,077	109
97137	St Paul	725	0
97301	Central Salem	1,715	20
97302	South Salem	766	18
97303	Keizer	1,292	27
97305	NE Salem, Brooks	2,246	7
97306	South Salem, Sunnyside	899	68
97317	SE Salem	1,550	29
97325	Aumsville	792	0
97342-46	Detroit & Gates	95	0
97352	Jefferson	381	15
97358	Lyons	37	0
97362	Mt Angel	1,662	46
97375	Scotts Mills	942	0
97381	Silverton	1,005	6
97383	Stayton	894	10
97385	Sublimity	874	28
97392	Turner	645	15

Furthermore, following state and national trends, the majority of deaths due to COVID-19 within Marion County are among individuals aged 78 and over. Mortality within this age group is five times more likely compared to other age groups, with individuals aged 65 and older experiencing elevated risk of severe morbidity and mortality overall. The table below is derived from Marion County data and shows incidence and mortality rate by age.

Age Group	Cases	Deaths	Incidence Rate (per 100,000)	Mortality Rate (per 100,000)
0 to 9	238	0	526	0
10 to 19	641	0	1,307	0
20 to 29	1,339	0	2,852	0
30 to 39	1,240	0	2,722	0
40 to 49	1,159	1	2,666	2
50 to 59	866	9	2,147	22
60 to 69	492	14	1,230	35
70 to 79	320	31	1,296	126
80 and older	234	60	1,883	483

Congregate Care Settings and Other Vulnerable Groups

Marion County has the highest number of agricultural facilities in the state as well as a high concentration of long term care and correctional facilities, increasing the potential for large outbreaks in congregate settings and migrant farm worker populations. Marion County contains five correctional institutions as well as Oregon State Hospital, all of which have experienced significant outbreaks throughout the course of the pandemic. This poses unique challenges for Marion County in planning for COVID-19 vaccine allocation and distribution, as migrant and seasonal farm worker populations are transient and tend to fluctuate based on seasonal demand. Additionally, populations in congregate care settings are disproportionately impacted by COVID-19 due to the high risk of transmission. Migrant and seasonal farmworker populations will require specific interventions and targeted messaging to ensure access to vaccine.

Individuals with intellectual and developmental disabilities (IDD) as well as individuals residing in group and foster homes also constitute a group experiencing disproportionate impacts of COVID-19 within Marion County. Many IDD individuals are transient and continuum of care in tracking vaccine uptake for this population must be considered in planning. Individuals experiencing homelessness and individuals with disabilities may also experience barriers to accessing vaccination services.

COVID-19 Vaccine Preparedness Planning and Organization

Following the release of the CDC COVID-19 Vaccination Program Interim Playbook for Jurisdictions, MCHHS planned a series of tabletop exercises with DOC staff, external stakeholders and community partners, and the Marion County Board of Commissioners. The series of exercises focused on Marion County's medical countermeasures capacity and planning for COVID-19 vaccine distribution and allocation, with a focus on building partnerships to expand vaccine infrastructure, prioritization and decision making in allocation of vaccine, and the use of Points of Distribution (POD) in vaccine administration.

Following the series of exercises, an after-action report (AAR) was developed to outline key decisions made in the planning and allocation process, identify gaps, and define roles in the MCHHS DOC related to vaccine planning. The series of exercises resulted in a delineation of roles for DOC personnel as they relate to ongoing vaccine planning, as well as an overview of work.

Exercises developed for community partners and stakeholders identified several key themes, needs, and suggestions for vaccine planning. They include:

- Working with local community based organizations (CBOs) to develop communications materials and identify trusted spokespersons to reach communities
- The need to develop a robust communication plan around COVID-19 vaccine allocation, access, and enlisting support from community partners to help inform and educate the public
- Coordination across agencies for vaccine prioritization
- Coordination regarding POD sites and the registration process
- Consistent outreach to providers for individuals experiencing homelessness
- Holding listening sessions for various community groups to gauge concerns and provide feedback
- Implement a system for dose tracking and reminders, including an app-based system, case management, and automated reminders
- Ensure that an equity lens is applied in decision making and setting strategies for vaccine allocation
- Host training on PODs

Engaging Community Partners

To address these needs, MCHHS will continue to engage community partners throughout the planning process and build communication pathways across collaborating agencies. MCHHS will participate in OHA's Oregon CARES Influenza Project to build vaccine distribution infrastructure capacity. In coordination with OHA, CARES influenza vaccine will be pushed to EMS and partnering agencies to support vaccination events, build capacity for closed PODs, and practice requisition of vaccine from the state. In supporting this project, Marion County will also benefit from reduced influenza transmission and decrease healthcare system burden.

The MCHHS Liaison hosts biweekly calls with community partners to provide updates on the COVID-19 response, communicate new guidance and best practices, and respond to questions posed by community partners. MCHHS will incorporate COVID-19 vaccine planning efforts and updates into its biweekly partner calls.

Additionally, the MCHHS DOC will form a COVID-19 Vaccine Planning Committee and host separate partner calls for hospitals and community partners directly involved in COVID-19 vaccine planning, distribution, and administration efforts throughout Marion County. The target audience for these calls includes EMS, healthcare, and CBO partners, with representation from MCHHS staff involved in vaccine planning and provision of services to IDD and behavioral health. These calls will be held twice weekly or as often as needed once vaccine has been allocated. Partners will have the opportunity to discuss

planning and response efforts, provide feedback, and discuss issues related to COVID-19 vaccine. The goal of the Vaccine Planning Committee will be to follow a participatory model, with representation from diverse stakeholders serving communities most impacted by COVID-19. The Committee will engage in identifying strategies to reach vulnerable and priority populations identified to receive vaccine.

The MCHHS DOC leadership also participates in weekly vaccine planning Health Administrator and LPHA and Tribes calls hosted by OHA to receive timely response updates and information.

Push Partner Registry

The Push Partner Registry (PPR) form contains information for agencies and partners who are willing to volunteer to receive vaccine and host closed Points of Distribution (PODs) for agency staff and their families, clients, and residents. If utilized, MCHHS will act as a flow-through entity to distribute vaccine acquired from the state to partners established under the registry. The PPR form will also be used to collect critical information regarding partner readiness to administer vaccine, including number of clients served, access to ALERT IIS, and providers eligible to administer vaccine. Push partners must have an eligible provider onsite to administer vaccine.

Key Partnerships

MCHHS will engage the following partners to identify and plan for vulnerable populations and build infrastructure for COVID-19 vaccine. The list includes both internal county partners vital to vaccine planning as well as external partners serving critical and disproportionately impacted populations. Partners will be engaged throughout the planning process prior to and after release of vaccine. Continuous engagement will be needed to ensure that access to vaccine is established as supply increases.

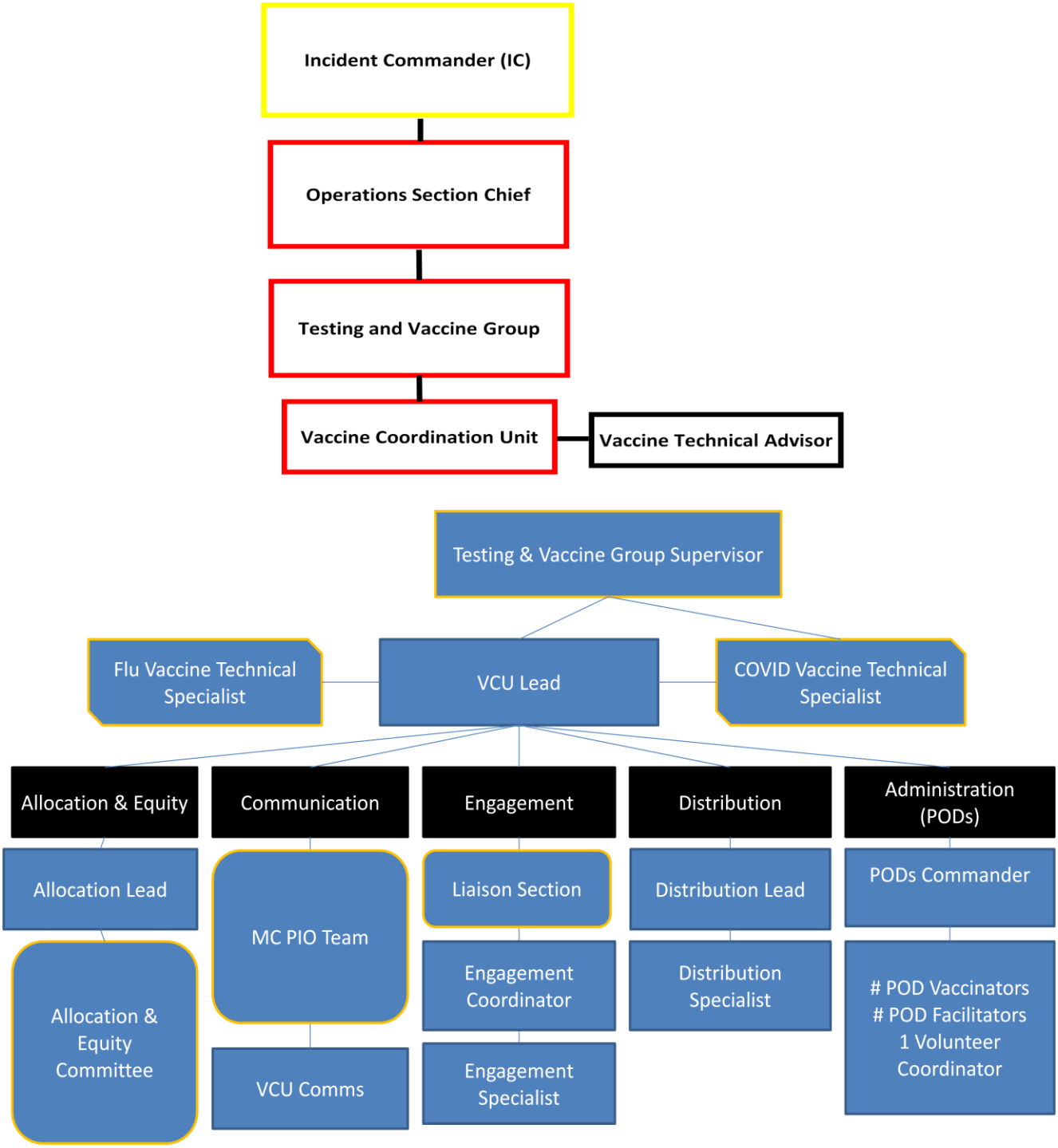
Internal Partners		
Key Partner	**Critical Population Served**	**Engagement Strategy**
MCHHS Behavioral Health Division	Individuals with acute and chronic behavioral health needs. Includes Assertive Community Treatment (ACT) staff, crisis screeners, Horizon House, Stepping Stones, Her Place, and behavioral health nurses who provide injections	Include staff representatives in DOC planning work and the Vaccine Planning Committee
MCHHS Residential and Support Services	Individuals with mental health and substance use disorders requiring housing support	Include staff representatives in DOC planning work and the Vaccine Planning Committee
MCHHS Intellectual and Developmental Disabilities Services	Individuals with intellectual and developmental disabilities, case management	Include staff representatives in DOC planning work and the Vaccine Planning Committee
LEAD Navigators	Unsheltered individuals and individuals experiencing homelessness	Include staff representatives in DOC planning work and the Vaccine Planning Committee
Marion County Emergency Management	All	Engage for support with PPE and resource needs acquired through

		the state or Ops Center
Marion County Sheriff's Office	Individuals who are incarcerated, Marion County Jail, law enforcement	Engage representatives for input in DOC planning work and the Vaccine Planning Committee

External Partners		
Key Partner	**Critical Population Served**	**Engagement Strategy**
Pharmacies	All	Engage in public health Pharmacy MOU and Push Partner Registry
Hospitals	All	Engage in planning considerations for central distribution. Include representatives in DOC planning work and the Vaccine Planning Committee.
Long Term Care Facilities (LTCF)	Long term care and skilled nursing staff and residents, people living and working in congregate care settings	Provide ongoing communication to LTCFs via ClickSend regarding vaccine updates and participation in the CDC's Pharmacy Partnership for LTC Program for COVID-19 Vaccine. Provide ongoing support for PPE needs through MCHHS DOC
Emergency Medical Services (EMS)	All	Modify existing contracts established through COVID-19 testing to include vaccine administration. Include representatives in DOC planning work and the Vaccine Planning Committee
Homeless Service Providers	Individuals experiencing homelessness and may lack access to healthcare	Participate in community calls for homeless service providers. Include representatives in DOC planning work and the Vaccine Planning Committee
Community Based Organizations (CBO)	All	Leverage CBO contracts and grants to expand access to vaccination services for priority and vulnerable populations. Include representatives in DOC planning work and the Vaccine Planning Committee
Coordinated Care Organizations (CCO)	All	Leverage relationship with local CCO to set priorities and expand access to vaccination services for priority and vulnerable populations. Include representatives in DOC planning work and the Vaccine Planning Committee
Employers of essential workers	Essential and critical infrastructure workers	Work with employers to provide communication to workers eligible to receive vaccine in closed POD settings

MCHHS Organizational Structure and DOC Roles

The MCHHS DOC has established an internal emergency response and coordination structure to support planning and operations for COVID-19 vaccine distribution. The DOC roles and relevant responsibilities related to vaccine planning are detailed below. Responsibilities may shift and evolve as more information is provided and needs arise.



DOC Section/Position	Role in COVID-19 Vaccine Planning
Incident Commander	Responsible for overseeing all DOC activities and providing strategic direction for vaccine planning, working with partners and county leadership to establish and support systems for vaccine distribution and administration
Public Information Officer (PIO)	Responsible for coordinating, drafting, and revising the COVID-19 vaccine communications strategy, developing talking points and social media posts for various audiences, and liaising with media. Coordinates with OHA Risk Communications to tailor messaging and participates in weekly PIO calls hosted by OHA
Liaison Officer	Works with community partners and external organizations to provide information regarding COVID-19 vaccine, hosts community calls and listening sessions, and works with CBOs to allocate grants
Safety Officer	Develops safety plans and guidance related to COVID-19 vaccine operations, including ways to reduce risk of COVID-19 transmission during closed POD events
Contracts	Develops, amends, and finalizes contracts related to COVID-19 vaccine distribution and administration with partners and CBOs
Logistics Section	Procures equipment for vaccine storage and handling, researches suppliers for equipment, and allocates staff to support DOC operations
Planning Section	Provides situational awareness; compiles and produces visual presentations of vaccine related data, including mapping of vulnerable and priority populations, vaccine uptake, and disease transmission indicators
Operations Section	Responsible for overseeing and providing technical support to all groups related to COVID-19 operations, including the Testing and Vaccine Coordination Unit. Provides strategic direction and assigns work based on input from Incident Command
Health Equity Technical Advisors	Provide technical assistance regarding health equity considerations in vaccine planning, review vaccine planning documents using a health equity lens

Testing and Vaccine Group

Overseen by the Operations Section Chief, the Testing and Vaccine Group includes staff with experience in coordinating the response to H1N1 vaccine and POD planning. Staff will oversee and share resources acquired through establishing infrastructure for COVID-19 testing with the Vaccine Coordination Unit.

Vaccine Coordination Unit

The Vaccine Coordination Unit (VCU) will be responsible for carrying out activities established by Incident Command and the Operations Section Chief, including tracking Push Partners and agency specific information related to COVID-19 vaccine distribution, coordinating with partner agencies to host PODs, tracking vaccine supply and uptake, reporting vaccine data and program outcomes to Incident Command, and carrying out the COVID-19 Vaccination Plan. The VCU is supervised by the MCHHS immunizations coordinator and includes staff responsible for activities related to both influenza and COVID-19 vaccine. The MCHHS Public Health Nurse Program Manager for Clinical Preventive Services will provide guidance and technical assistance to the VCU regarding immunization program elements. The Liaison, PIO, and Allocation Lead will coordinate closely with VCU to coordinate communication and partner outreach activities. The Distribution and Administration branches of the VCU will coordinate local oversight of vaccine and assist with distribution infrastructure, including allocation to critical populations and developing delivery mechanisms. The VCU will monitor the vaccine distribution infrastructure to assess capacity and address gaps in coordination with OHA.

Vaccine Allocation Strategy

Allocation of vaccine in Marion County will follow the phased approach outlined by the CDC and is contingent on availability of supply allotted to jurisdictions. MCHHS will prioritize establishing a vaccine data tracking process to ensure that individuals vaccinated complete their series, modify contracts with EMS partners in preparation for Phase 1, and coordinate with local hospitals to build infrastructure for distribution. Each phase will target different priority groups, engage key partners, and employ different vaccination strategies. The allocation framework can be adjusted to accommodate different supply levels. The three phases outlined by the CDC include:

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

Phase 1

Limited supply allotted to Marion County during Phase 1 will require highly targeted administration to groups recommended to receive FDA approved vaccine first. Recommendations for which groups will be prioritized in Phase 1 will be based on ACIP recommendations, the OHA allocation framework, input from county leadership and community partners, and health equity principles. MCHHS will use a staged approach to identify vaccination sites, identify and recruit providers, and track partners participating in the Push Partner Registry. Final allocation decisions will be guided by the Marion County Board of Commissioners.

An estimated statewide total of 197,000 doses are reported to be available by the end of December 2020, enough to immunize 100,000 people. This number encompasses both Pfizer/BioNTech and Moderna vaccine. First shipments will only be distributed to three hospitals across Region 2 capable of ultra-cold storage, with broader distribution beginning in January. County allocations are based on total population size, population size of groups prioritized for each phase, and ability to receive vaccine. Total vaccine availability will be contingent on federal allocations and will prioritize populations identified in

Phase 1A, Groups 1-4. If vaccine is received onsite, MCHHS will administer doses within 24 hours of receipt.

Groups Vaccinated During Phase 1

The tables below list possible groups that have been identified for Phase 1A, Phase 1B, and Phase 1C vaccine allocation based on availability of vaccine. Data for essential and critical infrastructure workers by occupation include estimated county level population sizes by occupation, in addition to incidence and mortality rates per 10,000 by group.

Phase 1A will prioritize LTCF staff and residents and healthcare personnel in hospital settings, including key staff required for essential facility functions. This phase includes personal support workers and workers providing in-home care to IDD, behavioral health, and individuals with disabilities. Phase 1B will prioritize other essential workers. Phase 1C will include any healthcare non-healthcare essential and critical infrastructure workers not vaccinated in Phase 1A and 1B, as well as people with underlying medical conditions. Priorities for Phase 1B and 1C may shift based on vaccine availability and decisions made in coordination with county community and healthcare partners. OHA has opened vaccine eligibility to all individuals included in Phase 1A, Groups 1-4. Beginning January 25, Oregon will shift to Phase 1B of vaccine distribution, which includes childcare, early learning providers, and K-12 educators and staff. Beginning February 8th, vaccination of individuals aged 65 and older will follow a phased rollout with eligibility for individuals aged 80 and over. Vaccination of the 65 and older age group will expand in subsequent weeks to those meeting eligibility criteria. Due to limited vaccine supply, it is estimated that it will take 12-15 weeks to vaccinate Groups 1-5 of Phase 1B.

Further refinement of priority groups may be conducted based on final allocation and availability of doses. Changes to the prioritization framework may be necessary based on vaccine efficacy among groups, current outbreak data, and further guidance provided by the CDC and OHA. The Oregon COVID-19 Vaccine Advisory Committee sets priority groups for the state. As the local public health authority, the Marion County Board of Commissioners will determine final allocations for vaccine received by MCHHS. The Marion County Vaccine Planning Committee will identify strategies to reach vulnerable populations prioritized for vaccine.

Phase 1A			
Group 1	**Group 2**	**Group 3**	**Group 4**
All paid and unpaid healthcare personnel serving in hospitals, freestanding emergency departments, or urgent care clinics with direct or indirect exposure to patients or infectious materials	**Other LTCF and congregate care facility staff with direct or indirect exposure to patients or infectious materials; all LTCF residents**	**Home care, personal support, in-home nursing, and in home support paid and unpaid healthcare personnel with direct or indirect exposure to patients or infectious materials**	**All other paid and unpaid healthcare personnel with potential for direct or indirect exposure to residents or infectious materials serving in outpatient settings**
All residents and all paid or unpaid staff serving in SNFs or memory care facilities with direct or indirect exposure to patients or infectious materials	**All residents and all paid and unpaid staff working in adult foster homes, including behavioral health foster homes and residential treatment**	**Parents, foster parents, and other caregivers of medically fragile children or adults living at home**	**Healthcare personnel serving in ambulatory surgery centers and outpatient infusion centers**
All healthcare personnel serving at Tribal Health Programs with direct or indirect exposure to patients or infectious materials	**Residents who meet FDA age criteria for vaccine eligibility and staff working in group homes for children or adults with IDD with direct or indirect exposure to patients or infectious materials**	**All paid and unpaid healthcare personnel working in freestanding birth centers or providing in home midwifery services**	**Healthcare personnel providing out-patient physical, oral health, addiction, mental health; veterinary care; laboratory, pharmacy, phlebotomy services**
Traditional health workers and interpreters working in the above settings	**All paid and unpaid healthcare personnel serving in hospice programs with direct or indirect exposure to patients or infectious materials**	**All paid and unpaid healthcare personnel providing day treatment services**	**Healthcare personnel providing chiropractic, massage services, and acupuncture**
EMS and first responders	**Mobile crisis care**; includes county employees providing direct care or community services (ACT Team, mobile crisis team, nurses providing medication dosing)	**All paid and unpaid healthcare personnel providing dialysis services**	**School nurses, school-based health center healthcare personnel, and student health center healthcare personnel**
	Secure transport and transport custody providers serving patients in behavioral health programs	**All paid and unpaid healthcare personnel providing dialysis services**	**Healthcare personnel providing direct services, including testing in public health, emergency response, community pharmacy, and community based organization settings**

	All residents and all paid and unpaid staff working in congregate housing with direct or indirect exposure to patients or infectious materials	**All paid and unpaid healthcare personnel providing medication assisted treatment services (MAT)**	**Healthcare personnel providing services with blood donation organizations**
	All paid and unpaid staff working in the Oregon Department of Corrections (DOC) facilities; Oregon Youth Authority facilities, community residential programs, and the county jail system; includes transport personnel	**Non emergency medical transport personnel**	**Other direct care personnel providing direct services to people with IDD and other high risk groups**
	Traditional healthcare workers and health care interpreters working in any of the above settings	**Traditional healthcare workers, health care interpreters, and healthcare personnel providing culturally specific healthcare services not captured in earlier groups**	**Healthcare personnel serving in other public health or early learning settings, including WIC, Head Start, and Home Visiting services**
			Medical/legal death investigators and death care workers
			Traditional healthcare workers, health care interpreters, and healthcare personnel providing culturally specific healthcare services in any of these settings

Phase 1B		
All healthcare workers and groups included in Phase 1A not yet vaccinated	**Group 1 – Childcare, preschool, and K-12 school and school district staff**	**Group 2 – *Eligible beginning February 7, 2021* People 80 years of age and older**
Group 3 – *Eligible beginning week of February 14, 2021* People 75 years of age and older	**Group 4 – *Eligible beginning week of February 21, 2021* People 70 years of age and older**	**Group 5 – *Eligible beginning week of February 28, 2021* People 65 years of age and older**
Staff and individuals in custody in prisons, jails, and detention centers	**People with intellectual, developmental, and other disabilities not living in congregate care settings who meet FDA age criteria for vaccine eligibility not vaccinated in Phase 1A.**	**Food processing workers; migrant and seasonal farm workers**

People aged 16-64 with underlying health conditions that increase the risk of severe COVID-19 illness	**People from BIPOC communities; racial and ethnic minorities disproportionately impacted by COVID-19**	**Other essential workers in high risk settings**
	Phase 1C	
People with underlying health conditions that increase the risk of severe COVID-19 illness not vaccinated in Phase 1B	**People aged over 65 not vaccinated in Phase 1B**	**All other healthcare and essential workers not vaccinated in Phase 1A and 1B**
People experiencing homelessness or living in congregate shelters	**People from BIPOC communities; people from racial and ethnic minorities disproportionately impacted by COVID-19**	**People living in multigenerational households**

***Bold** indicates priorities also set by OHA. Non-bold text indicates further refinement by MCHHS.

Essential and Critical Infrastructure by Occupation

Facility	Population Estimate in Marion County	Cases	Deaths	Incidence Rate (per 10,000)	Mortality Rate (per 10,000)
Farmworkers	14,166	299	2	211	1
Food Processing	3,948	165	0	418	0
Marion County Correctional	145	3	0	207	0
Fire Responders & EMS	1,131	30	0	265	0
Healthcare Workers	8,973	202	0	225	0
LTCF Workers	2,428	525	1	2,162	4
LTCF Residents	3,614	672	122	1,859	338

Farmworkers include nursery workers but not cannery workers. Population estimate is from the 2017 Census of Agriculture for Marion County and the State of Oregon Employment Department. Case numbers may be under-counted. LTCF cases and deaths are derived from Marion County estimates. LTCF worker estimates may be undercounted. Population estimates for healthcare workers are derived from the OHA 8120 Workforce Report; Client: revision 9/2015. Cases among this cohort may overlap with cases among LTCF workers.

CDC Pharmacy Partnership for Long Term Care (LTC) and Direct Allocation to Pharmacies

LTCFs choosing to enroll in the CDC's Pharmacy Partnership Program will receive on-site vaccination for LTCF staff and residents during Phase 1A. Any staff or residents not vaccinated in Phase 1A will be vaccinated during Phase 1B. MCHHS issued a message to LTCFs and SNFs through ClickSend during the enrollment period in late October encouraging facilities to register. The program will provide on-site clinic scheduling, vaccine supplies, cold-chain management, and mandatory data reporting for facilities that choose to sign up for the program with Walgreens or CVS. MCHHS will assist in facilitation of the program for LTCFs within its jurisdiction and form relationships with smaller, non-retail chain

pharmacies via its Push Partner Registry. Pharmacy partners will be required to report data regarding number of doses by store location, supply on hand and number of doses administered. In addition, MCHHS will reach out to facilities in the county not yet registered for the program to assess needs, inquire about alternate plans, and provide technical assistance. Depending on capacity, assistance may include vaccination of staff and residents for facilities not enrolled in the federal pharmacy partnership program.

Strategy for Phase 1

MCHHS will map populations prioritized for Phase 1 to determine key locations for points of distribution. Other populations at increased risk of severe illness from COVID-19 will be mapped using ArcGIS to determine possible locations for expanding vaccine access and implementing mobile vaccination sites or closed PODs. MCHHS will maintain local oversight of vaccine administration to ensure that priority populations are reached during Phase 1, including redistribution of vaccine to enrolled providers in order to reach target groups.

The process for acquiring vaccine during Phase 1 will rely on a push model from the state. Because approved Pfizer vaccine must be maintained under ultra-cold (-70C) conditions, it will be distributed using a regional hub model with minimum dose allocations of 975. MCHHS will work with the Marion County Board of Commissioners, OHA, and local hospitals to allocate doses to critical populations and establish closed PODs or mobile vaccination clinics to reach priority groups, including LTCFs and group homes for adults with IDD not enrolled in the federal pharmacy program. In addition, MCHHS will initiate planning to reach individuals 65 years of age and older prioritized for Phase 1B, including collaboration with community partners regarding outreach strategies, access considerations, and ways to address barriers. MCHHS will work to redistribute vaccine to enrolled providers and assess access, vaccine uptake of Phase 1A groups, and identify gaps.

Phase 2

Phase 2 will include a significant increase in vaccine supply availability, and should allow for expanded access to vaccine for high risk and priority populations not able to receive vaccine under Phase 1. However, some priority populations identified for Phase 2 may receive vaccine during Phase 1 if vaccine supply is adequate to meet needs. Additional availability of vaccine will allow for more widespread vaccination of disproportionately impacted populations, including BIPOC communities, rural communities, individuals with disabilities, individuals experiencing homelessness, individuals with preexisting conditions, and individuals living in congregate care settings not vaccinated during Phase 1. This phase will prioritize continued uptake in high risk groups before expansion to the general population. MCHHS will prioritize access for zip codes known to be at higher risk for transmission based on epidemiological mapping completed during Phase 1.

Groups Vaccinated During Phase 2

The tables below show groups prioritized for vaccination during Phase 2 and population estimates of adults in Marion County with underlying medical conditions.

Phase 2	
Remainder of Phase 1 groups not vaccinated in Phase 1	People living in congregate settings not vaccinated during Phase 1, including university students
People with underlying medical conditions that increase risk of severe illness from COVID-19 not vaccinated in Phase 1	**People from racial and ethnic minorities disproportionately impacted by COVID-19 not vaccinated in Phase 1**
People aged 65 or older not vaccinated in Phase 1	**People living in tribal communities not vaccinated in Phase 1**
People living in rural areas	**People experiencing homelessness or living in congregate shelters**
People with low healthcare access and under- or uninsured	**General population**

***Bold** indicates priorities also set by OHA. Non-bold text indicates further refinement by MCHHS.

Estimates of the prevalance and number of adults in Marion County with underlying medical conditions that increase the risk of a severe COVID-19 illness

Data Source	Medical Condition	Prevalance (%)	Est. Number of Adults
Adults 18 and older (BRFSS)	Any	52	137,340
	Cancer	9	22,222
	Chronic Kidney Disease	3	8,090
	COPD	8	20,470
	Diabetes	12	31,375
	Heart Disease	7	19,197
	Obesity	37	96,208
Medicare beneficiary (CMS)	Cancer	7	1,410
	Chronic Kidney Disease	21	4,408
	COPD	9	1,922
	Diabetes	25	5,212
	Heart Disease	40	8,436

Severe coronavirus disease: Illness requiring hospitalization, intensive care unit admission, mechanical ventilation, or resulting in death.
Number of adults: ACS 2018 est. of 261,436 adults (18 and older), Marion County, Oregon. Adults with multiple conditions are counted in the "Any" category.
BRFSS: Behavioral Risk Factor Surveillance System.
Sources: Estimated County-Level Prevalence of Selected Underlying Medical Conditions Associated with Increased Risk for Severe COVID-19 Illness — United States, 2018 MMWR Morb Mortal Wkly Rep 2020;69 [945-950]. Data from stacks.cdc.gov cdc_90519_DS1.xlsx. Downloaded 10/10/2020. Center for Medicare & Medicaid Services (CMS). The Medicare Chronic Conditions Dashboard: County Level, CMS Chronic Condition Data Warehouse. 2017. Downloaded 10/12/2020.

Strategy for Phase 2

MCHHS will expand PODs, community vaccination clinics, and mobile clinics to target high risk and priority populations that may be difficult to reach or have low vaccine uptake. Mass vaccination strategies, including drive through sites used for community testing events, will be employed to maximize vaccine reach during Phase 2. Vaccine uptake data will be tracked using ALERT, Oregon's immunization information system. If adequate levels of both vaccines are not available by Phase 2, cold chain constraints will require increased use of EMS partners to deliver vaccine to rural communities. Once both Moderna and Pfizer vaccine are available in sufficient quantities, MCHHS will work to expand access to vaccine in healthcare clinics, closed PODS, and mobile vaccination sites. Priority populations may change as epidemiological shifts occur due to vaccine uptake.

MCHHS will partner with hospitals, healthcare organizations, clinics, CBOs, EMS, schools, and faith based organizations throughout the county to inform programmatic work, promote vaccine uptake, and provide consistent messaging to build vaccine confidence and community trust. Data and reasons for vaccine hesitancy will also be assessed and used to tailor messaging.

Phase 3

As community vaccine uptake and supply levels increase to reach sufficient levels to meet demand, MCHHS will continue to promote completion of the vaccination series across all groups, including the general population considered to be low risk for severe disease from COVID-19.

Groups Vaccinated During Phase 3

Phase 3	
Remainder of Phase 1 and Phase 2 groups	**Other groups with low healthcare access not vaccinated in Phase 1 and Phase 2**
People aged 17 or younger once approved for vaccine eligibility	**General population**

***Bold** indicates priorities also set by OHA. Non-bold text indicates further refinement by MCHHS.

Strategy for Phase 3

Messaging will shift to promote completion of full vaccination for all groups, with targeted messaging for groups known to have low vaccine uptake from prior phases. MCHHS will shift its focus toward ongoing monitoring of vaccine uptake as providers expand access. Mobile vaccination clinics will be used to reach populations unable to receive vaccine from a provider. Gaps identified from implementation in prior phases will also be addressed.

Vaccine Distribution Strategy

MCHHS will work with local healthcare partners to determine capacity for COVID-19 vaccination, storage, and maintaining the cold chain. Capacity is determined by vaccination throughput and like testing capacity, must be increased to efficiently vaccinate priority populations during Phase 2 and 3. Using data collected through the Push Partner Registry and communication with partners, MCHHS will assess partner readiness based on the following parameters:

- Whether the site will serve as an open or closed POD

- Availability of eligible providers to administer vaccine
- Whether the site has access to ALERT IIS
- Number of personnel available to support vaccination
- Whether population served intersects with priority populations identified
- Method for vaccine administration (drive though, appointment-based, etc.)
- Vaccine storage capacity for refrigerated, frozen, and ultra-cold temperatures

MCHHS will support identified vaccination sites and providers through its DOC Operations section by providing support for personal protective equipment and COVID-19 testing supplies.

Inventory Management

Providers identified to receive COVID-19 vaccine will be required to report inventory to local jurisdictions and must enter data 24 hours after administering vaccine. MCHHS will track local vaccine inventory and requests for additional vaccine allocation. Providers will be required to complete the CDC Provider Agreement form and enroll with ALERT IIS prior to becoming a COVID-19 vaccine provider.

Provider Enrollment and MOUs with Local EMS

MCHHS will reach out to providers serving vulnerable and priority populations to increase vaccination capacity and recruit non-traditional providers to act as closed POD sites. These may include dental offices, schools, and universities. MCHHS will also partner with its local CCO to expand vaccine access and modify contracts with local EMS to include vaccine distribution. MCHHS will track enrolled providers through its Push Partner Registry and maintain up to date lists of provider types, populations served, and vaccination capacity. Messaging platforms for provider enrollment will include the biweekly partner calls, ClickSend announcements, and social media through the MCHHS Facebook page.

Provider types recruited for enrollment may differ depending on vaccine availability. If approved vaccine requires ultra-cold storage and handling conditions, only hospitals and providers with capacity to maintain ultra cold conditions would receive vaccine. In this scenario, MCHHS will rely on closed PODs to vaccinate priority populations during Phase 1.

If approved vaccine does not require ultra-cold conditions, hospitals and other healthcare providers will receive vaccine. MCHHS may also be allocated vaccine for redistribution to local providers. In both scenarios, MCHHS will use closed PODs to administer vaccine during Phase 1 and utilize EMS to provide mobile vaccination sites to priority populations.

The MCHHS Operations section will track ongoing provider PPE and vaccine supply needs, and monitor resource requests entered through Ops Center.

Closed Points of Distribution

MCHHS will develop and host training for providers acting as closed PODs, direct providers to template documents produced by OHA, and provide ongoing technical assistance to vaccination providers regarding POD management and vaccine handling and storage. In addition, MCHHS Vaccine Coordination Group will develop a map and schedule of local vaccination events. MCHHS will follow its

Medical Countermeasure Dispensing and Distribution Policy in the management of distribution planning and operations.

Communications Plan

MCHHS anticipates that the COVID-19 vaccination program will draw significant interest from stakeholders, local media, and the public. MCHHS PIO will develop a Communications Plan to communicate to the public regarding COVID-19 vaccine information, safety and efficacy, dose requirements, ways to access vaccine, and the county's response. In addition, MCHHS will work with CBOs and community partners to ensure communications materials are culturally appropriate and translated. Feedback regarding efficacy of communications materials will be gathered through Liaision community partner calls, the Vaccine Planning Committee, and communication with community partners. ALERT IIS data on vaccine uptake among priority populations will also be used to adjust messaging. MCHHS communications will align with CDC and OHA, but will be tailored to reach Marion County audiences and address communications barriers. Communications will be culturally responsive and translated to ensure accessibility.

MCHHS will publish information regarding vaccine types, dose requirements, priority populations, and efficacy on its COVID-19 webpage. Communications will be tailored based on vaccination phase, with key messages and audience shifting from healthcare providers, essential workers, and high risk priority populations to a general audience.

Direct communication will be employed during Phase 1 and 2 to disseminate information to healthcare providers, long term care facilities, and congregate care settings. Key partners in the Human Services and Behavioral Health Divisions will be consulted to ensure that messaging is tailored to reach individuals with disabilities and behavioral health needs.

Data Tracking and Monitoring

ALERT IIS will be used to track doses distributed and administered, including first and second doses. Vaccine uptake will be monitored and assessed on an ongoing basis to track county-level indicators and uptake among priority populations. Enrolled providers must report REAL-D data for every COVID-19 related encounter. MCHHS will track the following metrics to assess vaccine uptake in Marion County:

- Vaccine uptake by dose (first and second)
- Number of vaccine administered weekly
- Number of provider sites receiving vaccine
- Age
- Race and ethnicity
- Gender
- Priority populations including healthcare workers, essential workers, and high risk priority populations

Data will be compiled and reported on the Marion County Data Dashboard to promote program transparency. Weekly reports will also be compiled with the listed indicators and include vaccine uptake

by zip code. Data will be used to guide communications to priority populations, evaluate vaccine strategy, and provide feedback for ongoing operations. Data regarding reasons for vaccine refusal will also be tracked to tailor public messaging and address vaccine hesitancy.

References

1. COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations
2. OHA COVID-19 Vaccination Plan
3. Oregon's Phase 1a COVID-19 Vaccine Plan and Recommended Sequencing
4. The National Academies Press Framework for Equitable Allocation of COVID-19 Vaccine
5. Policy 200.10, SNS/Mass Medication Dispensing Plan