COVID-19 Vaccine Implementation Toolkit

January 2021

Information contained in this toolkit is subject to change based on the evolving provincial and national COVID response, as well as emerging evidence.

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Introduction

On December 7, 2020, the Ontario government announced it was ready to distribute COVID-19 vaccines as soon as they were received, beginning with vaccinating vulnerable populations and those who care for them (Premier, Newsroom, 2020). In the same news release, the province identified key populations to receive the vaccine first, one of which were adults in Indigenous communities, including remote communities where risk of transmission is high.

On December 11, 2020, an additional news release was disseminated from the Office of the Premier that further delineated 'Indigenous communities' into adults in First Nations, Métis and Inuit populations. Dissemination of COVID vaccines in Phase I are to include First Nation communities in northern Ontario and those in close proximity to grey and red zones. Phase II of the provincial distribution plan expands to include additional First Nation communities and urban Indigenous populations, including Métis and Inuit adults (Premier, Newsroom, 2020).

With approximately 85.5% of Indigenous Peoples in Ontario living off-reserve and in urban settings (MOHLTC, 2018), Aboriginal Health Access Centres (AHACs), Indigenous Community Health Centres (ICHCs), Indigenous Interprofessional Primary Care Teams (IIPCTs), and Indigenous Nurse Practitioner-Led Clinics (INPLCs) are in an opportune position to support vaccination strategies with reaching the urban Indigenous population. Moreover, many of these Indigenous-governed health agencies service on-reserve First Nation communities in various regions across northern Ontario.

AHACs, ICHCs, IIPCTs, and INPLCs are existing primary care agencies with not only capacity and experience delivering vaccination services, but they also have established trusting relationships with Indigenous communities.

Intent of Toolkit

This toolkit is designed to support Indigenous organizations with the planning and implementation of community level COVID-19 vaccination clinics, with assistance from mainstream organizations such as local public health units, primary care agencies, and/or hospital settings.

This tool will provide resources, checklists, and templates that Indigenous community agencies will be able to utilize, as needed, in the development of collaborative relationships, planning for communication to enhance vaccine confidence and acknowledge vaccine hesitancy, considerations for implementation of community level vaccine clinics, and recommendations for follow-up of clients after receiving the COVID-19 vaccine.

Each community agency is unique in the scope of services provided, degree of existing community partnerships, and way it outreaches and provides client, family, and community care. As such, advice and examples provided in this toolkit are meant to be adaptable to best serve community agency needs in response and planning for COVID-19 vaccination.

COVID-19 Vaccine Implementation Framework

The IPHCC COVID-19 Vaccine Implementation Framework (Image 1) outlines five steps for consideration in the planning, implementation, and evaluation of community level COVID-19 vaccination clinics.

5. Vaccination Administration After Care

- Develop a confirmation and reminder process for administration of second dose
- Provide after care instructions on potential side effects and recommended interventions.
- Implement a check-in process for vulnerable individuals for post vaccine administration.
- Explain importance of continuing to follow public health measures (i.e., wear a mask, practice physical distancing and hand hygiene)

1. Collaboration

- Advocate to sit on regional planning tables
- Explore collaborative models of implementation with vaccine distributors (i.e., hospitals, public health units)
- Identify opportunities for reciprocal resource sharing (e.g., COVAX training, donning/doffing of PPE for non-medical staffing)

4. Clinic Implementation

- Use vaccinator and recovery area models and expected vaccine numbers identified through the registry list, to support development of a vaccination capacity planning tool.
- Use the developed vaccination capacity planning tool to determine human capacity requirements (nursing, admin, screeners, security, crowd control, coordinators).
- Develop a clinic set-up blueprint to outline where the waiting, vaccination and recovery areas will be, along with the flow through plan.
- Have a response plan in place in the event of a serious adverse reaction.

2. Communication

- Leverage existing trusted relationships with health care providers to enhance vaccine confidence.
- Invite experts (infectious disease specialists, public health professionals) to virtual community information sessions to answer questions, address concerns.
- Survey individuals to learn of motivating and hesitancy factors to vaccine uptake. Leverage the motivating factors and address the hesitancy factors.

3. Determine Vaccine Numbers

- Develop a vaccine registry list, including a priority matrix.
- Develop and implement a process to populate registry list, leveraging the opportunity to provide health teaching to address concerns and enhance vaccine confidence at an individual level.

COVID-19 Vaccine Implementation Framework

Indigenous Primary Health Care Council January 2021

Step One: Collaboration

At the onset of planning community level COVID-19 Vaccine Clinics, it is important to identify who the vaccine distributors are within your local area, to comprehensively initiate the collaborative process. These may include hospitals, public health units (PHUs) and/or specific municipalities.

Collaboration with Public Health Units

Given the role PHUs play in general immunization and vaccine-preventable disease control, it is anticipated that as the province continues to move forward with extending vaccination beyond the hospital setting and into community, PHUs will be play a significant role in distribution of COVID-19 vaccines. As adults in First Nation, Métis and Inuit populations are identified as priority groups in Phase I of the provincial plan, it is recommended that community agencies do the following, if not done so already:

1) **Identify a COVID Vaccine Lead:** Determine who in the organization will lead collaborative efforts with external agencies.
2) **Connect with local PHUs:** Task the Vaccine Lead with reaching out to the Medical Officers of Health/Associate Medical Officers of Health at local PHUs to determine what planning tables are arranged, or in the process of being arranged. Ask the PHU for a copy of their local playbook. The playbook is a tool that they use to help guide vaccination implementation efforts within their region. In addition, if your community does not have a hospital that has access to the vaccine then it is important to convey this information to your PHU. They need to know how many health care workers you have in your organization that sees patients and clients on a daily basis. These are the individuals that will require vaccination.
3) **Advocate to sit on regional planning tables:** All 34 PHUs in Ontario received communication from the Association of Local Public Health Agencies (alPHa) January 15, 2021 that included the following documents to support collaboration with Indigenous communities on COVID vaccine planning:
    - IPHCC – Engaging Indigenous Communities with COVID Vaccine Implementation resource (Appendix A)
    - Summarized report of survey findings outlining vaccine distribution readiness among AHACs, ICHCs, and IIPCTs

Collaboration with Hospital Settings

In addition to adults in First Nation, Métis, and Inuit populations, Phase I of the provincial plan identifies health care workers providing frontline services to at-risk patients as a priority group. As such it is recommended that community agencies with patient-facing providers delivering health services to Indigenous Peoples – a priority group – do the following, if not done so already:

1) **Determine if local hospital is a vaccine disseminator:** As of January 18, 2021, there are 19 vaccination clinics offered in hospital settings across the province.
2) **Connect with hospital leadership:** Determine who the COVID lead is for the local hospital, and/or members of the senior leadership who hold decision-making capacity with regards to collaboration and partnerships. This may include the CEO, Chief Nursing Executive, or Chief of Staff.
3) **Explore partnership to vaccinate frontline staff:** Once the appropriate COVID lead or senior leadership member has been engaged, explore the possibility of establishing a partnership with the hospital. For instance, once the hospital has completed vaccinating their own patient-facing staff, if there are remaining vaccines available, arrange for your organization's patient-facing employees to be vaccinated. This form of partnership will speak to the hospital's expectation of meeting Phase I provincial planning of vaccinating health care providers who service populations that are at greatest risk of COVID-19 and severe illness.

Identify Opportunities for Reciprocal Resource Sharing

Whether establishing collaborative relationships is done for partnership purposes in the receiving of frontline workers vaccinations or supporting implementation of community-based vaccine clinics, identifying opportunities for reciprocal resource sharing will support needs being met in a timely and efficient manner.

Generally, there are five types of resources that can be explored for reciprocal sharing:

- Human: admin, coordinators, security, cleaning and/or health staff
- Equipment: PPE, cleaning supplies, vaccination supplies
- Materials: Standard operating procedures, policies, health education tools, consent forms, vaccine clinic set-up and flow through, documentation strategies
- Facilities: vaccine clinic space
- Miscellaneous: COVAX training, donning and doffing PPE training for non-health staff (e.g., clinic cleaning staff), mask fit testing if potential for providing aerosol generating procedures exists.

Step Two: Communication

In developing a communication plan to support clients with informed decision making with regards to receiving a COVID vaccine or not, it is recommended that efforts are placed on enhancing vaccine confidence, acknowledging vaccine hesitancy, and promoting motivational factors, while utilizing multifaceted approaches.

Enhancing Vaccine Confidence

Vaccine confidence is defined as the trust that patients or providers have in recommended vaccines, providers who administer vaccines, and processes and policies that lead to the vaccine development, manufacturing, and recommendations for use (Services, 2019). The perceived safety of vaccinations is fundamentally linked to vaccine confidence (Salmon, 2020).

Strategies to enhance vaccine confidence may include highlighting the number of vaccinations administered to date in comparison to the number of serious adverse events. As of January 18, 2021, 40.4 million vaccines have been administered worldwide, with 570,742 administered in Canada. According to the Health Canada COVID-19 adverse tracker site, which is updated every Friday at 4 p.m. EST, there have been a total of 24 adverse events following immunization (0.007% of all doses administered), with zero deaths. It may be useful to highlight the number of COVID cases (Jan 18, 2021 – 94,628,637) in comparison to related deaths (Jan 18, 2021 – 2,042,733).

Another strategy to consider is highlighting past successes of vaccines such as HPV, measles. Diphtheria, tetanus, pertussis (whooping cough), hepatitis B and polio.

Acknowledging Vaccine Hesitancy:

Vaccine confidence is defined as the delay in acceptance or refusal of vaccines despite availability of vaccine services (Dube, 2016).

Among Indigenous Peoples, where historical factors combined with current concerns of vaccine and distribution selection trustworthiness, there are significant issues of vaccine hesitancy that may negatively impact one's decisions to vaccinate. It is imperative that factors contributing to vaccine hesitancy are acknowledged and brought out into the open. While the intent of exploring vaccine hesitancy is not to coerce individuals to change their beliefs, as in many cases there is legitimacy to their concerns; rather, the intent is to ensure that factors are grounded in fact, rather than fiction or social media explodes.

A common contributing factor to vaccine hesitancy that has been widely communicated is the belief that Indigenous Peoples were identified as a priority group and selected to be one of the first to receive the vaccine because they are the 'Guinea pigs' or 'test subjects'. While it is important to acknowledge the legitimacy of this belief, there is also the opportunity to explain rationale for why Indigenous Peoples were identified as a priority group. Refer to the IPHCC COVID-19 Vaccine – Common Beliefs Explored resource for potential responses (Appendix B).

Promoting Motivational Factors:

While it is important to acknowledge and identify factors resulting in vaccine hesitancy, it is equally as important to acknowledge and capitalize on factors that motivate intent to vaccinate. This strength-based

approach to promote vaccination explores reasons why people intend to receive the vaccine and may be a useful tool to include in your communication plan, especially if there are trusted individuals within the community agency and/or community that are willing to share their rationale.

Strategies to promote motivational factors may include highlighting various rationale through different communication tools (i.e., posters, vlogs, infographics) with a picture of the individual and the starting line of "I'm getting my vaccine because…", followed by the motivational factor important to them (e.g., I want to do what I can to stop the spread; I want to be able to reopen my business; I want to protect my loved ones; I want my life back;, I want to do whatever it takes to keep people safe; I lost my friend to COVID, and I don't want to lose another person; my immune system is compromised, and if I get COVID, I don't think I'd survive…).

Additional strategies may include using social media to post pictures of how things used to be (i.e., pow wow circuit, bannock day, community feast), with the message of wanting things to get back to before. Similarly, use social media to post vlogs of those with lived experience with COVID and share their experiences, of how COVID has impacted their health, their lives, and their perspectives of the virus in general and adherence to public health measures.

Utilize Multifaceted Communication Approaches:
In the development of your communication plan to reach those mentioned above, consider implementing a multifaceted approach that includes:

1) **Mass Communication:** Emerging studies are showing various factors contributing to both vaccine confidence and hesitancy. In developing mass communication content, you can utilize available evidence and/or survey individuals in the community to learn of motivating and hesitancy factors to vaccine uptake. Once aware of contributing factors at a local level, you could target your messaging and implement through vlogs, posters, and/or social media posts.
2) **Community Level:** Consider hosting regular virtual community information nights where experts (i.e., infectious disease specialists, public health professionals) are invited to be guest speakers in a session that is facilitated by trusted health professionals in the community.
3) **Individual Level:** Leverage existing trusted relationships with health care providers to provide one-on-one health teaching. This will provide an opportunity for trusted health care providers to listen to the concerns of clients and explore any misconceptions and ensure vaccine hesitancy factors are grounded in facts. It also provides the opportunity to determine if additional referral support might be beneficial, such as cultural service provider referrals.

A supplement consideration is to identify vaccine information champions, who are trusted individuals in the community, build and strengthen their vaccine knowledge so they can regularly host and attend various

community virtual information sessions and/or be available to individual level consultation as needed. In addition, it is important to tell the patient/client that you have also received the vaccine. Reassure them that it is safe and share your experience with the vaccination process, if comfortable.

Step Three: Determine Vaccine Numbers

When connecting with vaccine distributors (i.e., PHUs, hospitals, municipalities), they will likely need to have an estimate of how vaccines may be required. Given the need for these life-saving vaccines across the province, it is important to be realistic with the numbers you provide PHUs, so they are about to allocate vaccines to other community agencies in need. Below is a recommended formula for determining the number of **anticipated** vaccines required:

Formula	Example
# of Indigenous clients served 16+ or 18+ (dependent on vaccine your agency is receiving – Pfizer: 16+, Moderna 18+)	7,500 Indigenous clients served
x 70% (potential percentage required for herd immunity)	7,500 x .70 = 5,250 (the goal)
x 49% (identified percentage of public willingness to receive the vaccine among Canadians)	7,500 x .49 = **3,675** (the anticipated)

The ultimate goal of a vaccination program is for all individuals to be inoculated. However, that is highly unlikely. Rather, a realistic goal is that a large percentage of the population becomes immune to COVID-19 through vaccination, resulting in the virus to slow down or stop. While vaccine protection is different for each disease, Associate Chief Medical Officer, Dr. Barbara Yaffe stated at a December news conference that 'usually for infectious diseases...70 to 80 percent of the population has to be vaccinated for what we call herd immunity" (Burman, 2020). As a result, the goal *should* be 70% of the Indigenous clients you serve; however, the COVID-19 Behaviour Tracker Data Hub, which gathers global insights on people's behaviours in response to COVID-19, reports that Canadians public willingness to receive a COVID-19 vaccine currently sits at 48.9% (Ritchie, 2021). As such, this would be the *anticipated* numbers to vaccinate.

For example, a community agency serving 7,500 Indigenous clients, the goal to potentially achieve herd immunity would be 5,250; however, it is unlikely that that is the number of clients *wanting* to receive the vaccine. Accounting for current behavioural expectations (formula should be updated regularly to account for variance), the number of anticipated clients to receive the vaccine would be approximately 3,675.

Develop a Vaccine Registry List:
Once you have determined the anticipated number of clients to receive the vaccine, the next step would be to attempt to identify the *actual* number of vaccines required through population of a registry list (Appendix C). To do this, it is recommended that you allocate members of your health team who will be able to answer vaccine and COVID related questions (nurses, nurse practitioners, primary care physicians, health promoters) to cold call your Indigenous clients to determine if they intend to receive the vaccine. This process allows for:

1) Identifying those ready to be vaccinated
2) Provide health teaching to those who are uncertain.

3) Acknowledge vaccine hesitancy and ensure rationale is grounded in facts and attempt to explore any misconceptions.
4) Identify eligibility, as well as potential contraindications or precautions (refer to vaccine specifics). It is recommended that an internal process be in place for when populating the registry list, clients with contraindications or precautions are referred to the primary care provider for assessment and endorsement to be added to the registry list.
5) Identify prioritization criteria that will support placement in a priority matrix.
6) Capture those who are currently undecided on whether they will get the vaccine or not and enable a follow-up process (Appendix C).

Populate a Vaccine Recipient Priority Matrix:

Given the high demand of COVID vaccinations, and the importance of administering to those at greatest risk of serious implications first, using data from the registry list to populate a priority matrix will ensure that those at greatest risk are vaccinated first and the Indigenous community in whole is inoculated in priority sequence. While the goal is to vaccinate all Indigenous clients, it may not be possible with the first round of vaccine clinics, due to either vaccine supply or organizational capacity. As such, a priority matrix supports proactive planning if vaccine clinics require phased implementation.

Health Canada outlines the following factors that increase risk of more severe disease or outcomes, which are criteria included in the priority matrix template (Appendix D). Note, that there are various versions of priority matrixes being developed. In particular, the Ministry of Indigenous Affairs has worked with the First Nations Vaccination Sub-Table and the Urban Sub-Table to develop a priority matrix that will be used to phase in vaccination across the province for Indigenous communities.

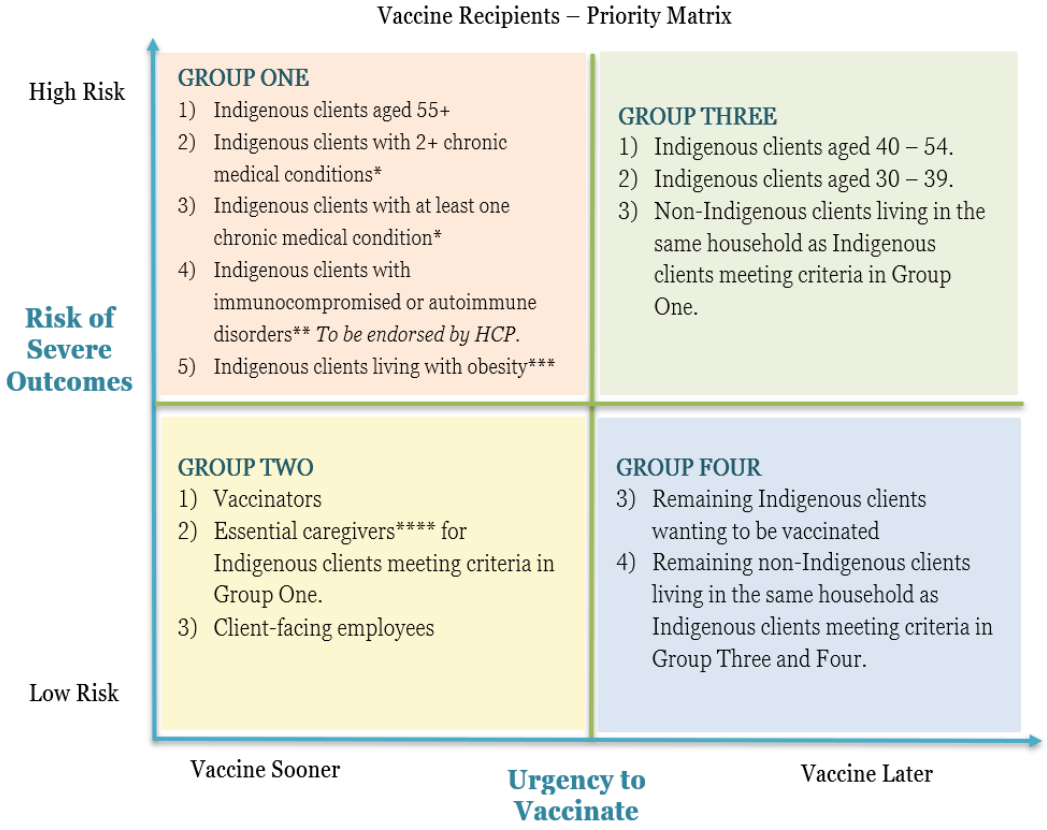
1) Older age (aged 55+, in consideration of lower life expectancy among Indigenous population)
2) Chronic medical conditions
    - Lung or Heart disease
    - Hypertension
    - Diabetes
    - Kidney disease
    - Liver disease
    - Dementia
    - Stroke
3) People who are immunocompromised, including those:
    - With an underlying medical condition (e.g. cancer, transplant recipient)
    - Taking medications that lower the immune system (e.g. chemotherapy)

    determine if immunocompromised is vaccine identified contraindication or precaution. If yes, refer to primary care provider for assessment and endorsement prior to adding to priority matrix
4) People living with obesity (BMI of 40 or higher)

Additional criteria included in the priority matrix are essential caregivers, as the provincial government identifies caregivers providing care for seniors as a priority due to the proximity and consistent interactions with at-risk individuals. Caregivers refers to a family member, loved one or paid helper who regularly

provides care to individuals in need. Additionally, autoimmune diseases were added to the priority matrix as autoimmune diseases in Indigenous populations are disproportionate and need to be considered. These include rheumatoid arthritis (for which many are on DMARDS "Disease Modifying Anti Rheumatic Drugs", and Systemic Lupus Erythematosus (SLE).

The priority matrix (below) includes four groups categorized high risk or low risk, with urgency to vaccinate outlined as sooner or later. As demonstrated in the matrix, Group One is categorized as high risk and urgency to vaccinate sooner. Rationale is that those within Group 1 are considered at-risk for serious outcomes if contracting COVID. Those in Group 2 are considered low risk but urgency to vaccinate sooner. Rationale being that those in Group 2 are considered low risk as when interacting with at-risk clients, they are protected by use of PPE. However, the frequency and proximity of interactions requires they be vaccinated sooner. When applying the matrix, note that subgroups are prioritized within groups.



Once the priority matrix is complete, the vaccine clinic list template (Appendix E) can be populated with names placed in priority sequence. Please be aware that there could be a variety of tools being used to support the prioritization process. This is why it is extremely important to outreach to your local PHU and/or your First Nation Inuit Health Branch lead if you have any questions.

If conducting a mobile unit and are wanting to apply the priority matrix, consider incorporating a triage system where you inquire about priority criteria at the same time as gathering registration information and consent. Use the priority criteria to place client in appropriate group as per the priority matrix. To facilitate seamless delivery of vaccines as per the priority matrix, you can provide colour-coded indicators (cards, bracelets, sticks, highlighted consent forms).

Step Four: Clinic Implementation

The Health Canada COVID-19 Vaccine Clinic Planning Guidance document outlines key considerations and steps implementation of safe and effective community level vaccination clinics. It is recommended that community agencies review the guiding document in its entirety; however, for purpose of information sharing through this toolkit, we will be pulling out key points of consideration and including additional recommendations.

Staff Preparedness:

Depending on roles and specificity of clinic approach (i.e. stationary, mobile, mass clinic), staff preparedness may include the following:

- Administrative – arrange to receive data entry training from local PHUs or hospitals.
- Health Care Providers – work with local PHUs to arrange immunizer training, which will include the following:
  - Clinic operations (vaccinator, plus recovery roles)
  - Medical directives for specific vaccine
  - Vaccine health education
  - Vaccine administration, storage, and handling
  - Obtaining informed consent
  - Documentation
  - Adverse Event Following Immunization (AEFI) reporting
  - Infection Prevention and Control (IPAC) measures
- Cleaning Staff – work with own health staff, PHUs or hospital staff to arrange donning and doffing PPE training for cleaning staff who will be supporting vaccine clinic.

Clinic Readiness:

There are several steps required to be in place to ensure clinic readiness, with each step having questions to consider, which include:

Step 1: Identify clinic model and location

- Will the clinic be stationary, mobile or a combined approach?
- Will vaccinations be by appointment only or drop-in?
- What processes will be in place to ensure public health measures are maintained?
  - e.g. no mask no service; wait in vehicles or waiting area with 6 ft spacing markers on the floor; clinic flow is one-way.

Step 2: Develop pre-clinic process for confirming appointment, completing COVID screening

- Will you implement a two-step screening process? Initial screen when confirming appointment, confirmation screen when client arrives at clinic to receive their vaccine.

Step 3: Review anticipated vaccine numbers

- After applying the formula to determine the number of **anticipated** vaccines required, how many vaccines will your community agency require?
- Have you confirmed if the local PHUs are able to accommodate the required amount? If not, how many can they provide?
- If necessary, have you applied the priority matrix to determine which Indigenous clients will be included in the initial round of vaccinations?

Step 4: Determine appropriate vaccinator and recovery area model

- In determining the number of vaccinators and recovery area staff required, how many staff does your clinic space allow for?
- Have you applied the formula for vaccinations to determine how many vaccines can be administered over an 8-hour day? (Pg. 5 of Health Canada Guiding Document)

Formula for Vaccinations:

$$10 \frac{\text{vaccinations}}{\text{Hour}} \times \_\_\_\_\_ (\text{\# vaccinators}) \times \_\_\_\_\_ (\text{number of clinic hours - breaks}) = \_\_\_\_\_ \frac{\text{\# vaccinated}}{\text{clinic site}}$$

For example, to immunize 100 people per day at one site in a six hour shift (minus half hour break), the estimated number of vaccinators is 2.

Step 5: Develop a vaccination capacity planning tool

- Immunization clinics require many human resources to ensure they run smoothly and seamlessly. Roles and responsibilities for clinic operations may include:
  - Administrative staff – data management purposes
  - Health Care Providers – vaccinators, recovery area monitoring, health education
  - Coordinator – directing flow, ensuring process is running smoothly
  - Greeters – complete COVID screening and direct to vaccination area
  - Security – facilitates safety of clinic, staff and clients, as well as assists in crowd control and clinic flow, walks clients and staff to vehicle as required
- Do you have enough staff to meet capacity needs?
  - If no, there are agencies or nursing schools you can partner with to resource share. As well as primary care providers across the province available as needed. These include the Alliance for Healthier Communities, Association of Family Health Teams of Ontario, College of Family Physicians of Ontario, Nurse Practitioner Led Clinic Associations.
- Does each member of your team feel comfortable and confident with their roles and responsibilities?
  - If no, would additional training help or should they transition to a different role?

Step 6: Comprise blueprint for clinic setup and flow, determine what clinic supplies are needed

- Does your space allow for different areas for registration, waiting, vaccination and recovery?
- Does your space allow for one way direction of traffic flow?
- If no, what can be done to maintain public health measures?

- Refer to the sample Clinic Setup and Flow provided by Health Canada (Appendix F)
- Do you have the needed clinic supplies?

Step 7: Arrange for physical security

- Has a safe and secure site for storage of the vaccine been identified?
- Has 24/7 security of vaccine storage area been arranged?
- Have you put processes in place to ensure storage areas are limited to authorized personnel only?
- Do you have the appropriate storage units for the vaccine?

Step 7: Pre-immunization process

- Do you have a process in place where both Dose 1 and Dose 2 appointments are booked simultaneously through non-contact methods (i.e. over the phone, through email, or electronic registry process)?
- Did your nursing team complete the eligibility, contraindication, and precaution screening prior to scheduling the vaccine appointment?
- If contraindications and precautions were identified, do you have written direction from a health care provider to proceed with the vaccination?
    - Do you have a documentation process in place for health care providers giving them direction on how to proceed with vaccination?
- Do you have a screening template the administrative staff is using to pre-screen when booking appointments?
    - Do you have a documentation process in place to track COVID screening results?

Clinic Implementation:

Once all steps are in place, you feel confident in your clinic readiness, and you have received the vaccines, you are ready for implementation. The following are a list of steps and potential considerations:

Step 1: Complete required documentation with client

- Have you confirmed the information on the pre-immunization assessment is completed and there are no changes?
- Do you have a process in place for drawing up of vaccines? Will each vaccinator draw up their own vaccine or will you have a designated health care professional draw up all doses?
- Have you reviewed and verified consent with the client?
    - Consent process will be determined in collaboration with your local PHU (can either be electronic or paper-based)
- Have you confirmed there are no contraindications/precautions? Or that you have verification of physician endorsement if a contraindication or precautions exists?

Step 2: Complete vaccine administration documentation

- Do you have a standard documentation process in place?
- Do you have secure location for documents, to ensure privacy protection?

Step 3: Post immunization waiting period

- Do you have a process in place for transporting clients to the recovery area if needed?
- Do you have a timing system in place to ensure clients stay for the 15-minute observation time?
- Are health care professionals monitoring the recovery area in the event of an adverse event?
- Do you have an emergency response cart available with emergency kits to manage anaphylactic reactions? Is it readily available and easily accessible for the staff?
- Do you have a private area, with stretchers available, if needed?
- Do you have the AEFI form available in the recovery area in the event documentation of an adverse event is needed?

Step Five: Vaccination Administration After Care

Vaccination administration after care involves two components: direct patient care and evaluation of vaccination services provided.

Direct Patient Care

Prior to the client being discharged from the recovery area, ensure they have had no reactions that require medical attention, and provide them with the COVID Vaccine After Care Sheet. As well, ensure that they are aware of the Dose 2 appointment date and time. Stress the importance of receiving the second dose within the recommended timelines.

In addition, to increase likelihood of second dose uptake, implement a process in which members of the health team check in with the client, especially if they are vulnerable individuals, post vaccine administration to see how they are doing and again remind them of their dose 2 appointment date and time.

An important piece of health education prior to and following vaccination involves explaining the importance of continuing to follow-up public health measures such as wearing a mask around others, wash your hands and practicing physical distancing. Reason being that both Pfizer and Moderna require two doses be given three to four weeks apart to achieve the best possible immunity. When clients are given their first dose, they do not become immune immediately. Rather, it takes at least one week to 10 days from receiving the second dose to become immune from COVID-19. Moreover, while the COVID vaccines were developed and tested for their ability to prevent severe illness and death from COVID-19, it is still unclear whether they also protect against asymptomatic infection and spread. There will be ongoing studies to evaluate this question, but it will be some time before this information is known. Therefore, it is imperative that clients are aware that even after they receive the vaccine, they should continue to take steps to protect other people who have not been vaccinated yet.

Evaluation of Services

Evaluation of clinic services provides an opportunity to assess the clinic process, identify areas for improvement and implement an action plan in the moment, rather than after the fact. The Health Canada guiding document recommends providing staff and clients with the opportunity to evaluate their clinic experience. Consider strategies to implement data collection, whether it be through surveys, debriefing sessions, and/or random phone interviews. The Health Canada guiding document includes both employee and client post-vaccination clinic surveys for use.

Please be mindful that as important as it is to complete an evaluation, it is equally as important to have a process in place to act on the findings of the evaluation.

Evaluation Questions May Include:

1. Was the appointment registration process clear and easy to follow?
2. Were staff able to answer the questions you raised?
3. Did the clinic seem organized?
4. Did you receive a 2nd dose appointment before leaving?
5. Did you receive post vaccine instructions?
6. Were the staff pleasant and made you feel comfortable?
7. Any suggestions for improvement?

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Appendices

Appendix A

Engaging Indigenous Communities with COVID Vaccine Implementation

1) Conduct an **environmental scan** to identify Indigenous communities/agencies within institutional catchment area. This includes the following:
    - First Nation/on-reserve communities
    - Aboriginal Health Access Centres
    - Indigenous Community Health Centres
    - Indigenous Interprofessional Primary Health Care Teams
    - Indigenous Family Health Teams
    - Inuit Family Health Teams
    - Ontario Federation of Indigenous Friendship Centres
    - Metis Nation of Ontario local chapters
    - Inuit Associations and Affiliated Organizations

**note: your institutional catchment area may not have any of the Indigenous communities/agencies within it or may have some some/all that are listed. It is essential to identify all potential Indigenous organizations within your local area.*

***note: catchment areas of Indigenous communities/agencies may not align with your institutional catchment areas. It is essential to take the jurisdictional direction from the local Indigenous communities/agencies.*

2) Be aware of **jurisdictional alignment** and institutional accountability
    - Follow Jordan's Principle[1] – do not let the patient go without service in the presence of jurisdiction ambiguity.
    - Engage with Indigenous Services Canada – regional lead – to ensure there is an alignment, and not duplication, of services.
    - Be aware of federal, provincial and regional accountability for **all** Indigenous communities, including but not limited to, on-reserve First Nation, off-reserve rural/remote communities, and urban Indigenous settings.

3) **Outreach** to identified Indigenous communities/agencies within catchment areas, confirming the following:
    - The catchment areas align and if additional communities/agencies need to be engaged
    - Stage of involvement the Indigenous communities/agencies would like to be engaged
        - idea conception
        - planning
        - implementation
        - evaluation
    - The level of involvement the communities/agencies would like
        - part of planning tables, committees, advisory circles…
        - dissemination site for health service delivery (vaccine)
        - providing/receiving staff to support vaccination clinics

- Determine current capacity/services offered by the communities/agencies
    - COVID assessment and testing site
    - self-isolation capacity
    - food security
    - mental health supports
    - Traditional healing/cultural supports…

- Determine if the community requires support, and if so, what support is needed – being prepared to provide the support as able.
    - Take the direction from the community – do not go engage with the community expecting to the be the 'saviour', but at the same time, do not expect to receive support without willing to give something in return – reciprocity is key.

- Recognize the strengths that the Indigenous communities/agencies have and are able to provide the institution in the COVID response, such as:
    - Physical space for COVID vaccine clinics
    - Health staff (nurses, physicians, allied health, Traditional Healers, cultural coordinators, navigators, community wellness workers…)
    - PPE supply
    - Public education
    - Communication to community-specific health providers
    - Support with prioritization of vaccine dissemination based on risk stratification

**note: the first point of contact for these Indigenous communities/agencies typically include one of the following:*

- *Health Director/Community Health Nurse*
- *Executive Director*
- *Chief Executive Officer*

***note: it is imperative that you involve the local Indigenous communities/agencies at the onset of putting your COVID Vaccine Planning Table together to ensure they are meaningfully engaged in the planning process.*

4) When it comes to **communication**, recognize the diversity among the Indigenous population and target your communication strategies accordingly. Consider the following:
    - Engage Indigenous communities (First Nation, Metis, Inuit) to assist with development of key messaging for their respective communities.
    - Collaborate with Indigenous groups for effective, widespread dissemination of messaging
        - Metis Nation of Ontario chapters within institutional catchment area
        - Inuit affiliation and associated organizations within institutional catchment area
        - On-reserve First Nation communities within institutional catchment area
        - Urban Indigenous settings/communities within institutional catchment area

    - Determine if there are community leaders that are willing to support and advocate for vaccine uptake within their communities.

5) Support and promote **cultural safety approaches** among institutional staff. This may include, but is not limited to:
    - Participate in cultural safety training, such as IPHCC
    - Ensure policies and procedures are inclusive of Indigenous population, such as:
    - Complaint policy in place and response mechanism to address racism (e.g., change in services provided when self-identifying as Indigenous)
    - Ensure policies are in place to support bringing issues forward (e.g., Whistleblower policy)
    - Recognize that Indigenous population is diverse – no one size fits all mentality

6) Ensure **data governance** agreements are in place to support Indigenous data collection and sharing of information. Strategies may include, but are not limited to:
    - Inform communities of importance of data collection, taking the time to respond to questions and inquires from community agencies, patients…
    - Co-develop data collection method and selection of data fields
    - Train frontline staff on collection of data in a safe and effective method
    - Anti-racism training to be delivered to frontline staff to establish a safe environment for self-identification
    - Indigenous communities must benefit from the use of the information (i.e., being informed of the vaccination uptake numbers among community members).
    - Putting a data collection and reporting strategy in place to track racism when it is captured and subsequent actions taken.

Appendix B

IPHCC COVID-19 Vaccine – Common Beliefs Explored

Even if you understand the scientific process, trust medical experts, and know how important vaccines are for fighting infectious diseases, you might still have some questions or concerns about the new COVID-19 vaccines – especially with so many rumors floating around online.

It is normal and healthy to experience hesitation and is totally reasonable to be asking questions before making the decision to receive the vaccine or not.

That being said, it is also important to seek out trusted sources of information, as much of what is posted online, particularly on social media, is not from medical professionals nor based on scientific evidence. Below is evidence-based information to help set the record straight on some common questions, concerns and myths about the COVID-19 vaccines.

Common Belief 1: We can't trust COVID-19 vaccines because they were rushed.
The first vaccines for COVID-19 do involve new technology, and they were developed in record time. But it is not because there were shortcuts in the process.

Messenger RNA, or mRNA, is the basis for the Pfizer and Moderna vaccines. While this is the first time it's being widely used in a vaccine for the public, researchers have actually been working on this vaccine strategy for more than three decades.

All vaccines are put through rigorous clinical trials involving tens of thousands of volunteers. In Canada, volunteers in the clinical trials will be followed for up to two years after receiving the vaccines to make sure they are safe and effective. Because of how prevalent COVID-19 is, it only took a few months for the clinical trials to collect enough data to make an initial evaluation. Through a thorough evaluation process, both Pfizer and Moderna vaccines have been found to be safe and effective for emergency use, this is in Canada and throughout the world.

Common Belief 2: The vaccine will give me COVID-19.
Vaccines cause your immune system to recognize and fight off the virus but does not actually cause the infection itself.

The basis for the Pfizer and Moderna COVID vaccines is mRNA. When the mRNA enters your cells, it instructs them to make a piece of the "spike" protein that's present on the coronavirus that causes COVID-19. Those protein pieces do not actually harm your body, but they do trigger your immune system to mount a response to fight them off.

You might have some fatigue, muscle aches, a headache or a fever after you get the vaccine. That's normal with any vaccine – it's a sign that your immune system is responding.

Common Belief 3: We don't know what's in these vaccines.
Both Pfizer and Moderna have published the ingredient lists for their vaccines. In addition to the star ingredient, the COVID-19 mRNA for the spike protein, both vaccines contain lipids (fats) that help deliver the mRNA into your cells and a few other common ingredients that help maintain the stability of the vaccine. Despite theories circulated on social media, they do not contain microchips or any form of tracking device.

Common Belief 4: These vaccines will alter my DNA.
The vaccines use mRNA to instruct our cells to make a piece of the coronavirus's hallmark spike protein in order to spark an immune system response. Once the mRNA does that, our cells break it down and get rid of it. While mRNA is something that is made from DNA, it is not designed to integrate with our own DNA. It does not permanently change our DNA make-up or who we are in any way.

Common Belief: I already had COVID-19, so I won't benefit from the vaccine.
We do not yet know how long natural immunity to COVID-19 lasts. Right now, it seems that getting COVID more than once is not common, but there are still many questions that remain unanswered. Experts say that, even if you've had COVID-19, it would still be appropriate for you to get the vaccine to make sure you are protected.

Common Belief 6: Since COVID-19's survival rate is so high, I don't need a vaccine.
It's true that most people who get COVID-19 are able to recover. But it's also true that some people develop severe complications. So far, more than 1.9 million people around the world have died from COVID-19 – and that does not account for people who survived but needed to be hospitalized. Because the disease can damage the lungs, heart and brain, it may also cause long-term health problems that experts are still working to understand.

There's another reason to consider getting the vaccine: It protects those around you. Even if COVID-19 does not make you very sick, you could pass it on to someone else who might be more severely affected. Widespread vaccination protects populations, including those who are most at risk and those who can not be vaccinated. It will be important for ending the pandemic.

Common Belief 7: Once I get the vaccine, I won't have to wear a mask or worry about social distancing.
Even if you get the vaccine, you should continue to wear a mask around others, wash your hands and practice physical distancing. There are a few reasons for this.

1) Both Pfizer and Moderna require two doses be given three to four weeks apart to achieve the best possible immunity. When you get your first shot, you do not become immediately immune. It takes at least a week to 10 days from receiving the second dose to become immune from COVID-19.
2) The second is that these vaccines were developed and tested for their ability to prevent severe illness and death from COVID-19. It's not clear whether they also protect against asymptomatic infection and spread. There will be ongoing studies to evaluate this question, but it will be some time before we know. So, after you get the vaccine, you should still take steps to protect other people who have not been vaccinated yet."

Common Belief 8: Now that we have vaccines, the pandemic will be over very soon.
It would be amazing to flip a switch and have everything go back to normal, but it's actually going to take a long time for us to be able to vaccinate an adequate number of people to where we'll start to see the cases really drop.

Common Belief 9: Indigenous Peoples were identified as a priority group and selected to be one of the first to receive the vaccine because they are the 'Guinea pigs' or 'test subjects'.
It's natural to question the motive as to reasons why Indigenous Peoples are identified as a priority. Indigenous Peoples, along with healthcare workers and residents of long-term care/retirement homes, have been identified as priority populations as evidence in illness severity and mortality rates have shown these groups to be at greatest risk of serious, life-threatening implications if they contract COVID-19. Moreover, chronic medical conditions such as respiratory disease, heart disease, diabetes, kidney and liver disease, have been found to be at greater risk of more severe outcomes from COVID-19. These are conditions in which prevalence is greater among Indigenous Peoples than the general population.

To achieve what is called herd immunity – the point at which the disease is no longer likely to spread – about 70% of the population will need to have been vaccinated or infected. But the companies that make the vaccines can only make so many at a time. Because of this, the vaccines are distributed in phases, with priority given to people with greatest need.

In Canada, Indigenous communities have been identified as a priority group. However, for the general population, the vaccine will not be available until likely April, with most people not being vaccinated until September 2021. Timelines are based on vaccine availability and subject to change.

For now, we should all continue to do our part to help slow the spread of the virus, including wearing a mask, washing our hands and physical distancing.

If you have more questions about the vaccine, talk with your trusted healthcare provider or look to reliable sources like your local public health unit, Health Canada, or the World Health Organization.

Resource: https://health.clevelandclinic.org/8-common-covid-19-vaccine-myths-explained/

Appendix C

COVID-19 Intent to Vaccinate – Registry List

Complete for clients indicating current intent to vaccinate.

Client Name	Age	Chronic Medical Conditions	Immuno-compromised (Yes/No) →	If yes, endorsed by MD (Yes/No)	Living with Obesity (BMI 40 or higher)	Essential Caregiver (for aged 55+)

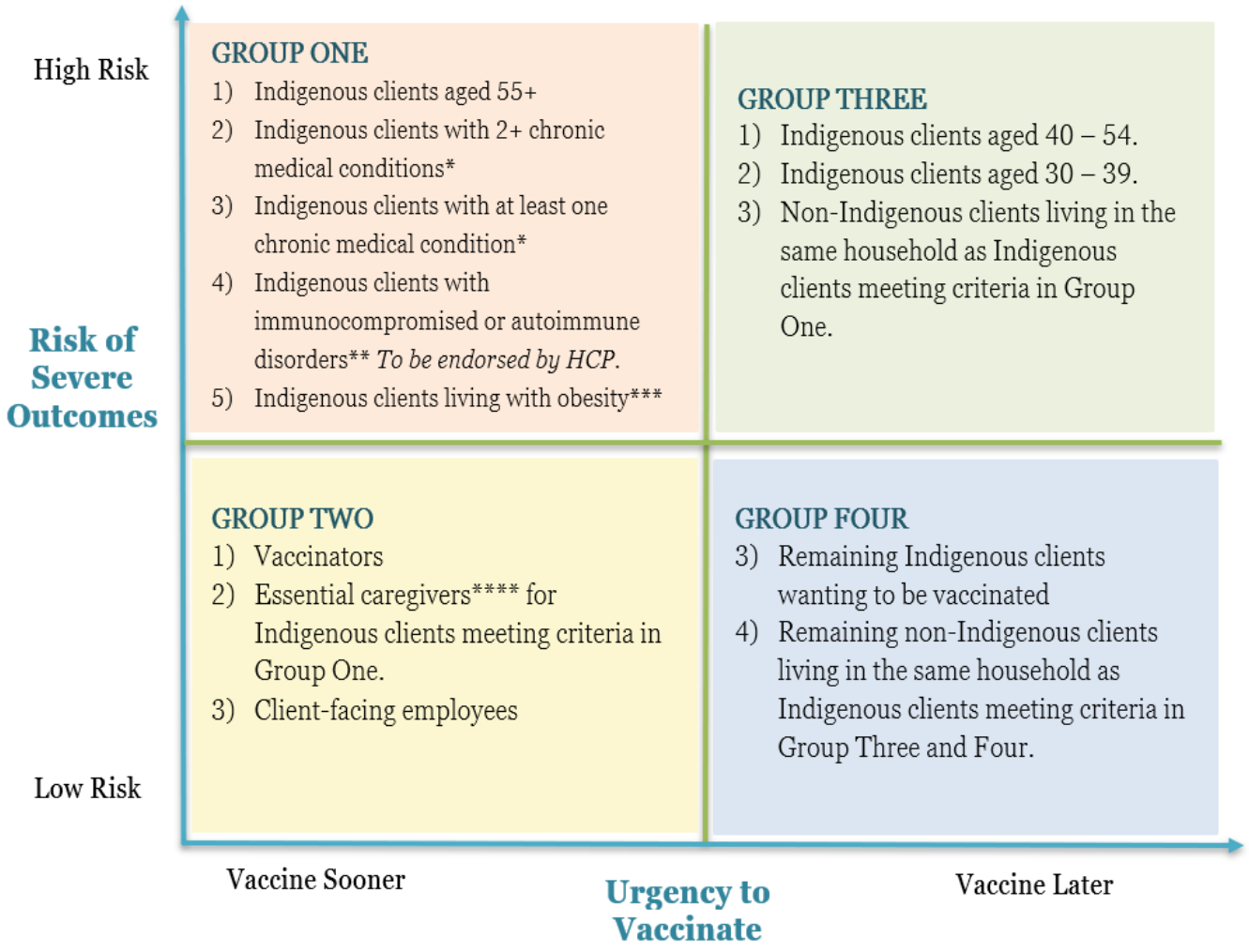
COVID-19 Undecided on Intent to Vaccinate – Registry List

Complete for clients indicating they have not decided but are open to reassessment.

Client Name	Date Contacted	Planned Date to Reassess	Reassessed (✓)

Appendix D

Vaccine Recipients – Priority Matrix



*Chronic medical conditions increasing risk include: Lung and heart disease, heart disease, hypertension, diabetes, kidney disease, liver disease, dementia, stroke.

People who are immunocompromised due to underlying medical conditions (e.g. cancer, transplant recipient), and treatment that lowers the immune system (e.g. chemotherapy). People with autoimmune disorders (e.g. rheumatoid arthritis, Systemic Lupus Erythematosus), and required medical interventions (e.g. Disease Modifying Anti Rheumatic Drugs). It is essential that those who are immunocompromised and/or with autoimmune disorders are referred to a primary care provider for assessment and endorsement prior to adding to priority matrix*.

***Obesity is defined as BMI 40 or higher.

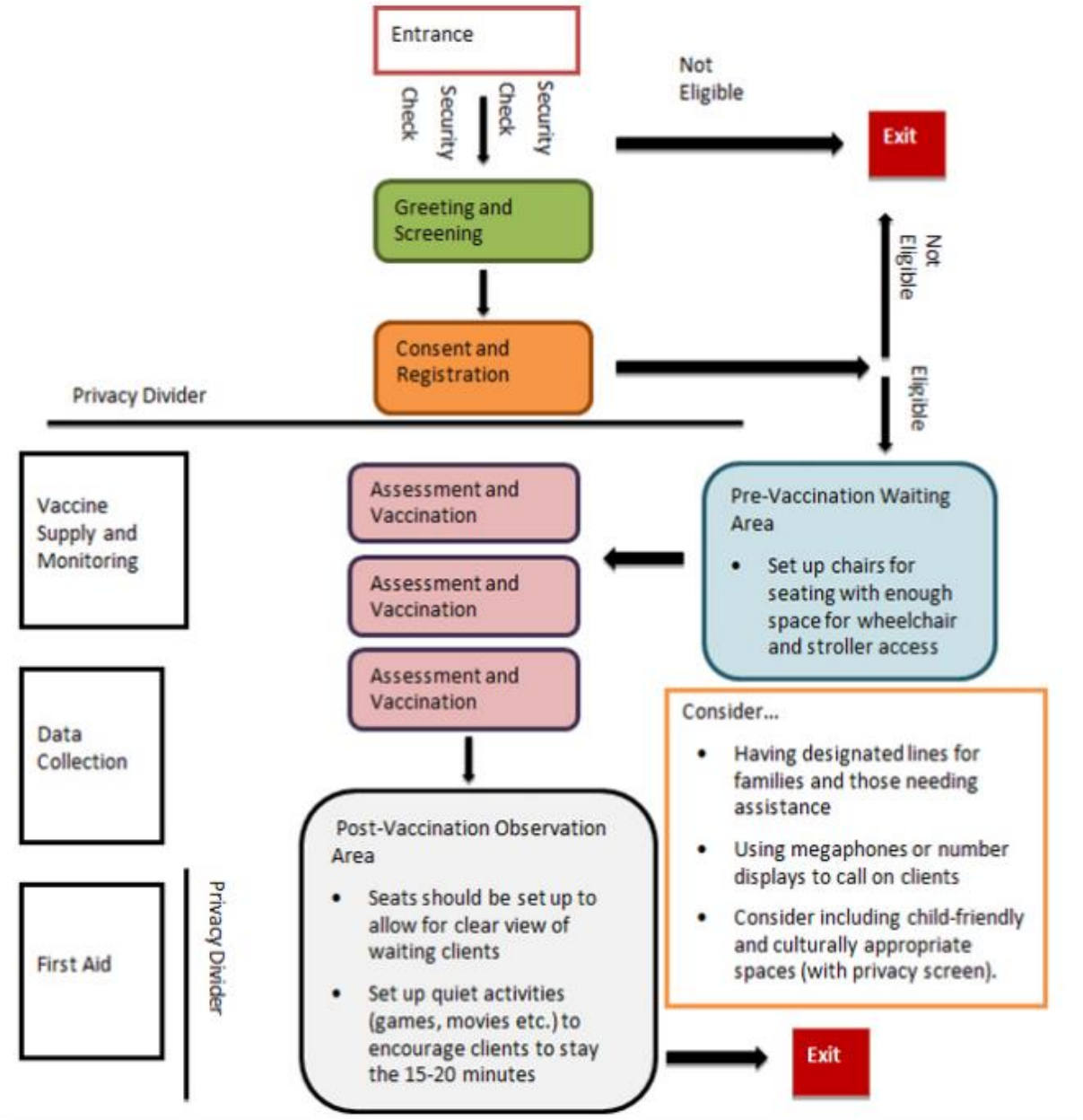
****Essential caregiver refers to a family member, loved one or paid helper who regularly provides care to individuals in need.

Appendix E
Vaccine Clinic List Template

Priority Sequence	Last Name	First Name	DOB	Gender	Email Address	Phone Number
G1						
G2						
G3						
G4						

Appendix E

Immunization Clinic Setup and Flow



(Health Canada, 2020)