COVID 19 VACCINE COMMUNICATIONS TOOLKIT

Communication Resources

About this document

This toolkit is intended to provide resources to facilitate training with your staff and others to prepare them for having conversations related to the COVID vaccine. The information presented here is sourced from NC DHHS and the CDC retrieved the week of 12/7/2020.

Jenie Abbotts (NCCHCA)
abbottsj@ncchca.org

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COVID-19 Vaccinations: Those most at risk get it first.

A tested, safe and effective vaccine will be available to all who want it, but supplies will be limited at first. Independent state and federal public health advisory committees have determined that the best way to fight COVID-19 is to start first with vaccinations for those most at risk, reaching more people as the vaccine supply increases from January to June. Keep practicing the 3W's—wear a mask, wait six feet apart, wash your hands—until everyone has a chance to vaccinate.

1 Health care workers fighting COVID-19 & Long-Term Care

Every health care worker at high risk for exposure to COVID-19—doctors, nurses, and all who interact and care for patients with COVID-19, including those who clean areas used by patients, and those giving vaccines to these workers.

Long-Term Care staff and residents—people in skilled nursing facilities and in adult, family and group homes.

2 Adults at highest risk of severe illness and those at highest risk for exposure

Adults with two or more chronic conditions that put them at risk of severe illness as defined by the CDC, including conditions like cancer, COPD, serious heart conditions, sickle cell disease and Type 2 diabetes, among others.

Adults at high risk of exposure including essential frontline workers (police, food processing, teachers), health care workers, and those living in prisons, homeless shelters, migrant and fishery housing with 2+ chronic conditions.

Those working in prisons, jails and homeless shelters (no chronic conditions requirement).

3 Adults at high risk for exposure and at increased risk of severe illness

Essential frontline workers, health care workers, and those living in prisons, homeless shelters or migrant and fishery housing.

Adults 65+

Adults under 65 with one chronic condition that puts them at risk of severe illness as defined by the CDC.

4 Students and critical industry workers

College and university students.

K-12 students when there is an approved vaccine for children.

Those employed in jobs that are critical to society and at lower risk of exposure.

5 Everyone who wants a safe and effective COVID-19 vaccination

Click to expand the graphic.

VACCINE DISTRIBUTION PRIORITIZATION FRAMEWORK

Risk-based prioritization based on National Academy of Medicine Framework for Equitable Allocation of COVID-19 and CDC Advisory Committee Immunization Practice. Refined by input by North Carolina Institute of Medicine Vaccine Advisory Committee. May be revised based on Phase III clinical trial safety and efficacy data and further federal guidance

Phase 1	Phase 2	Phase 3	Phase 4

Phase 1a:
• **Health care workers at high risk** for COVID-19 exposure based on work duties or vital to the initial COVID vaccine response
  ○ High risk of exposure is defined as those caring for COVID-19 patients, cleaning areas where COVID-19 patients are admitted, performing procedures at high risk of aerosolization (e.g., intubation, bronchoscopy, suctioning, invasive dental procedures, invasive specimen collection, CPR), handling decedents with COVID, administering vaccine in initial closed or targeted vaccination clinics.
  ○ Population includes: nurses, physicians, respiratory techs, dentists, hygienists, nursing assistants, environmental services staff, EMT/paramedics, home health workers, personal care aides, community health workers, health care trainees(e.g., medical students, pharmacy students, nursing students, etc.), morticians/funeral home staff, pharmacists, public health nurses, public health and emergency preparedness workers who meet the above definition of "high risk of exposure."
• **Long Term Care staff and Residents** (e.g., Skilled Nursing Facilities, adult care homes, family care homes, and group homes; individuals with intellectual and developmental disabilities who receive home and community-based services and the workers directly providing those services)
Phase 1b:
• **Adults with high risk of complications** per CDC and staff of congregate living settings
Operationally prioritize settings based on risk of exposure
• **Migrant farm and fisheries workers** in congregate housing with 2+ Chronic Conditions* or ≥ age 65
• **Incarcerated individuals** with 2+ Chronic Conditions* or ≥ age 65 and jail and prison staff
• **Homeless shelter residents** with 2+ Chronic Conditions* ≥ 65 and homeless shelter staff
• **Health care workers** not included in Phase 1A with 2+ Chronic Conditions
• **Frontline workers** with 2+ Chronic Conditions at high risk of exposure (e.g., firefighters, police, workers in meat packing plants, seafood and poultry not in congregate housing, food processing, preparation workers and servers, manufacturing, construction, funeral attendants and undertakers not included in Phase 1A, transportation workers, retail workers (including grocery store workers), membership associations/org staff (e.g., religious orgs), education staff (e.g., child care, K-12 or IHE) and workers in government, public health, emergency management and public safety whose functioning is imperative to the COVID-19 response)
• **Other Adults** with 2+ Chronic Conditions*:
* Defined by CDC as increased risk for COVID
	• Migrant Farm/fishery workers in congregate living without 2+ Chronic Conditions
	• Incarcerated individuals without 2+ Chronic Conditions
	• Homeless shelter residents without 2+ Chronic Conditions
	• Frontline workers at high or moderate risk of exposure without 2+ Chronic Conditions
	• All other Health Care Workers not included in Phase 1A or 1B
	• Education staff (Child Care, K-12, IHE) without 2+ Chronic Conditions
	• Other adults age 18-64 with one chronic condition*
	• 65+ year olds with one or no chronic conditions*
		• Workers in industries critical to the functioning of society and at increased risk of exposure who are not included in Phase 1 or Phase 2
		• K-12 students (if data from clinical trials), college students
			• Remaining population

Prioritization Framework – Phase 1

Phase	Population	Population Range	Population Details	Identification Approach
1A	Health Care Workers and COVID Responders *at High Risk for Exposure or Vital to the COVID Response*	102,000 – 117,000	• High risk of exposure/vital to initial COVID response is defined as those caring for COVID-19 patients, cleaning areas where COVID-19 patients are admitted, performing procedures at high risk of aerosolization (e.g., intubation, bronchoscopy, suctioning, invasive dental procedures, invasive specimen collection, CPR), handling decedents with COVID-19, administering vaccine in initial closed or targeted vaccination clinics. • Population includes: nurses, home health workers, personal care aides, physicians, respiratory techs, dentists, hygienists, nursing assistants, environmental services staff, EMT/paramedics, community health workers, pharmacists, public health nurses, public health and emergency preparedness workers and morticians/funeral home staff who meet the above definition of "high risk of exposure."	• List generated by employer based on classifications
	LTC Staff	38,000 – 44,000	• Staff in skilled nursing facilities, adult care homes, family care homes, group homes, and intermediate care facilities for individuals with IDD (ICF-DD).	• List generated by facilities
	Subtotal for Phase 1A	**140,000 – 161,000**		
1B	LTC Residents	67,000 – 77,000	• Residents in skilled nursing facilities, adult care homes, family care homes, group homes, and ICF-IDDs.	• List generated by facilities
	Adults with high risk of complications per CDC and staff of congregate living settings. Operationally prioritize settings based on risk of exposure			
	Migrant Farm/Fisheries Workers in *Congregate Housing with 2+ Chronic Conditions* or ≥ age 65*	5,000 – 6,000	• Migrant farm and fisheries workers *in congregate living settings with 2+ chronic conditions* or ≥ age 65 listed below*. (Note that migrant farm workers will enter NC on a staggered schedule based on harvesting calendar, with only a small proportion likely present in November and December)	• Self-identification
	Incarcerated individuals *with 2+ Chronic Conditions* or ≥ age 65* and jail/prison staff	19,000 – 22,000	• Incarcerated individuals in jails, prisons, and immigration detention centers *with 2+ chronic conditions*or ≥ age 65* and all jail, prison, and detention center staff	• List generated by facilities
	Homeless shelter residents *with 2+ Chronic Conditions** or ≥ age 65 and homeless shelter staff	2,000 – 3,000	• Homeless individuals (based on average number of homeless individuals in shelters per night) *with 2+ chronic conditions* or ≥ age 65* and all homeless shelter staff	• List generated by facilities
	Health Care Workers with 2+ Chronic Conditions and Not Included in Phase 1A	*45,000 – 52,000 (included in total individuals with 2+ chronic conditions above)*	• *Health Care Workers with 2+ chronic conditions* who are not in Phase 1A* • *Population includes inpatient and outpatient staff who are not directly caring for COVID patients*	• List generated by employer based on classifications
	Other Frontline Workers with high risk of exposure and 2+ Chronic Conditions	*88,000 – 116,000 (included in total individuals with 2+ chronic conditions above)*	• *Firefighters, police, meat packing plant workers, seafood/poultry workers not in congregate housing, food processing, preparation workers and servers, manufacturing, construction, funeral attendants and undertakers not included in Phase 1A, transportation workers, retail workers (including grocery store workers), membership associations/org staff (e.g., religious orgs),child care workers, and workers in government, public health, emergency management and public safety whose functioning is imperative to the COVID-19 response with 2+ chronic conditions**	• Self-identification
	Other individuals *with 2+ Chronic Conditions**	362,000 – 513,000		• Self-identification
	Subtotal for Phase 1B	**587,000 – 790,000**	*For all populations 2+ Chronic conditions means those defined by CDC as increased risk for COVID (Cancer, Chronic kidney disease, COPD, Immunosuppressed from organ transplant, Obesity, Serious heart condition, Sickle Cell disease, Type 2 Diabetes)	

Prioritization Framework – Phase 2

Phase	Population	Population Range	Population Details	Identification Approach
2	Migrant Farm/fishery workers in congregate living *without 2+ Chronic Conditions and under 65*	13,000 – 18,000	• **Population includes:** Migrant farm and seafood workers *without 2+ chronic conditions and under 65. (See comment on previous slide about migrant farm worker arrival dates).*	• Self-identification
	Incarcerated individuals *without 2+ Chronic Conditions and under 65*	13,000 – 15,000	• Incarcerated individuals in jails and prisons or immigration detention centers *without 2+ chronic conditions and under 65*.	• List generated by facilities
	Homeless shelter residents *without 2+ Chronic Conditions and under 65*	1,600 – 2,200	• Homeless individuals (based on average number of homeless individuals in shelters per night) *without 2+ chronic conditions and under 65*.	• List generated by facilities

	Frontline Workers in Essential Industries *at Moderate Risk of Exposure without 2+ Chronic Conditions*	202,000 – 266,000	• **Population includes the following individuals *without 2+ chronic conditions*:**
			  • Firefighters and Police
			  • Meat packing workers
			  • Food processing, preparation workers and servers
			  • Manufacturing
			  • Construction
			  • Funeral attendants and undertakers not included in Phase 1A
			  • Transportation workers
			  • Some retail workers (including grocery store workers)
			  • Some membership associations/org staff (e.g., religious orgs)
			  • Child care workers
			  • Workers in government, public health, emergency management and public safety whose functioning is imperative to the COVID-19 response
				• Self-identification

	All Other Health Care Workers *not included in Phase 1A or 1B*	145,000 – 168,000	• All other Health Care Workers who were not identified as at high risk of exposure for Phase 1A or included in Phase 1B due to having 2+ chronic conditions. • Population includes inpatient and outpatient staff who are not directly caring for COVID patients	• List generated by employer based on classifications
	Education Workers	44,000 – 59,000	• Population includes K-12 and University staff	• Identification by schools • Self-identification
	Adults age 18-64 *with 1 Chronic Condition who are not included in other categories*	557,000 – 775,000	• All adults with exactly one chronic condition. • Excludes individuals captured in other categories in Phase 1 and 2.	• Self-identification
	Adults age 65+ *with 1 or 0 Chronic Conditions who are not included in other categories*	200,000 – 270,000	• All adults age 65 or older with 1 or 0 chronic conditions. • Excludes individuals captured in other categories in Phase 1 and 2.	• Self-identification
	Total for Phase 2	**1.18 M to 1.57 M**		

Prioritization Framework – Phase 3 and 4

Phase	Population	Population Range	Population Details	Identification Approach

3	Workers in industries critical to the functioning of society and at increased risk of exposure who are not included in Phase 1 or Phase 2	34,000 – 46,000	• **Population includes:**
			  • Energy and telecom workers
			  • Water, energy, and waste operators
			  • Retail workers (including grocery store workers) not included in Phase 2
			  • Membership association/orgs not included in Phase 2
				• Self-identification

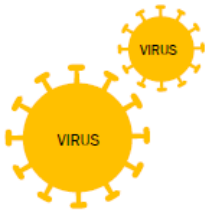
	Students	619,000 – 826,000	• **Population includes:**
			  • K-12 students (if there is evidence for children from studies)
			  • University students (undergraduate and graduate)
				• Identification by schools
				• Self-identification

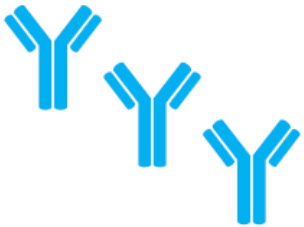
	Overlap Adjustment	(79,000 – 105,000)	• Adjustment to account for overlap with populations with multiple or one chronic conditions captured in earlier phases.	
	Total for Phase 3	**574,000 – 767,000**		

Phase	Population	Population Range	Population Details	Identification Approach
4	Remaining population not in Phases 1-3	3.60 M – 4.00 M individuals	▪ Remaining population for whom the vaccine is recommended by ACIP and for whom there is sufficient safety and efficacy data	▪ Self-identification
	Total for Phase 4	**3.60 M – 4.00 M**		

How Do Vaccines Work?

To understand how vaccines work, you need to first understand how our body fights infections. Let's take the example of an infection with a virus:





When we are exposed to a virus, our body's immune system fights back

To fight the virus, our immune system creates proteins – called antibodies

Our immune systems create different antibodies for different viruses it meets

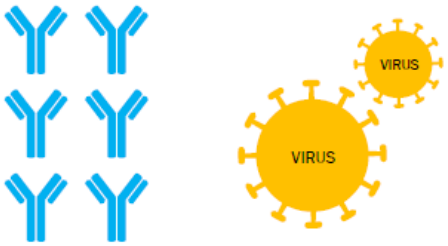
After the infection, our immune system remembers and has antibodies ready to go faster if the virus reappears, helping to prevent us from getting sick

How Do Vaccines Work?

It takes time for the body to build enough antibodies. Some viruses can make people very sick, and even die, because their immune systems aren't able to fight it off.

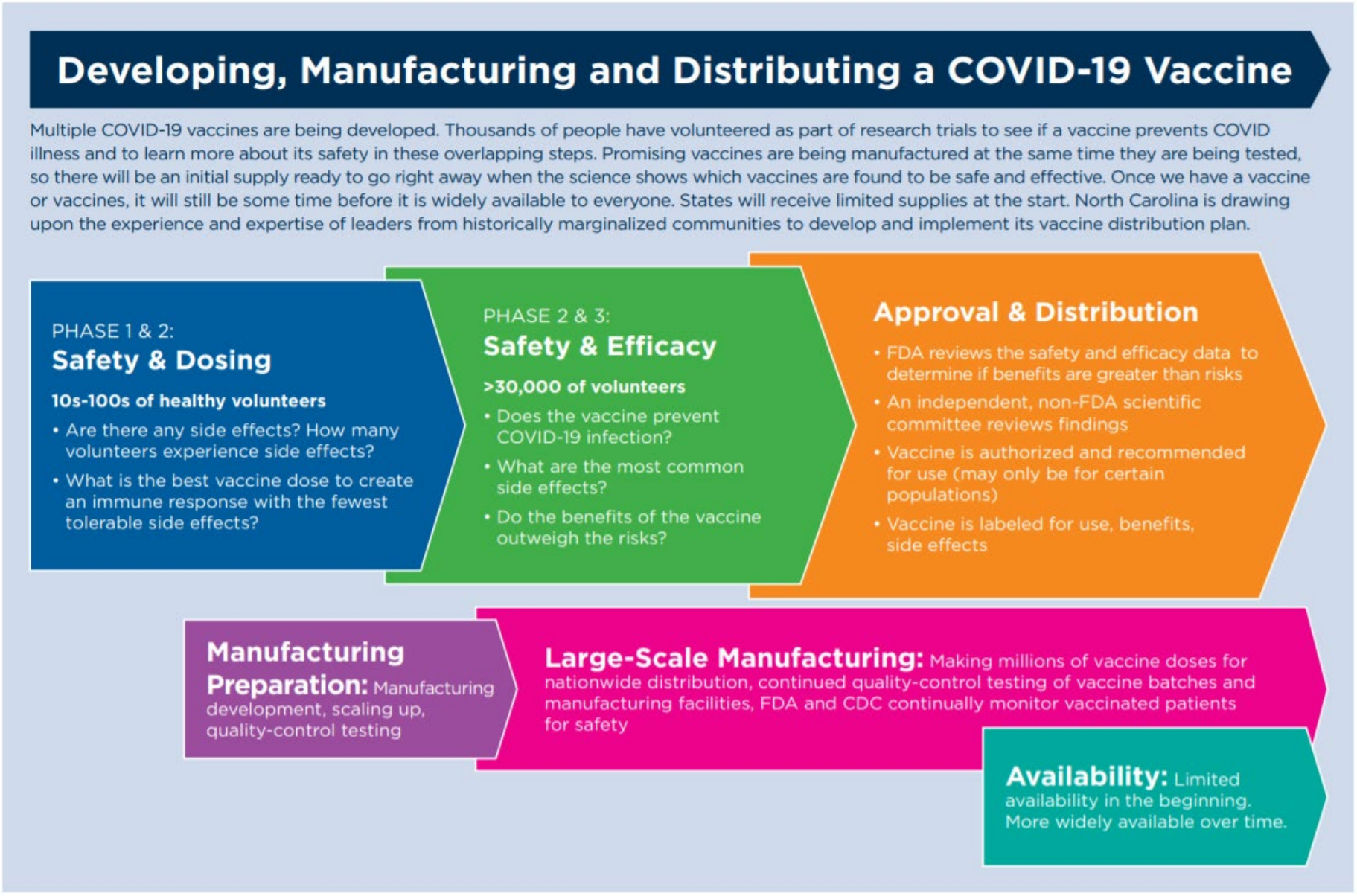
That's where vaccines come in:

Vaccines imitate an infection, so that our bodies think a virus is attacking and our immune systems create the antibodies that we need if the real virus attacks



After getting vaccinated, you develop immunity to that disease so that your body remembers how to fight the virus in the future.

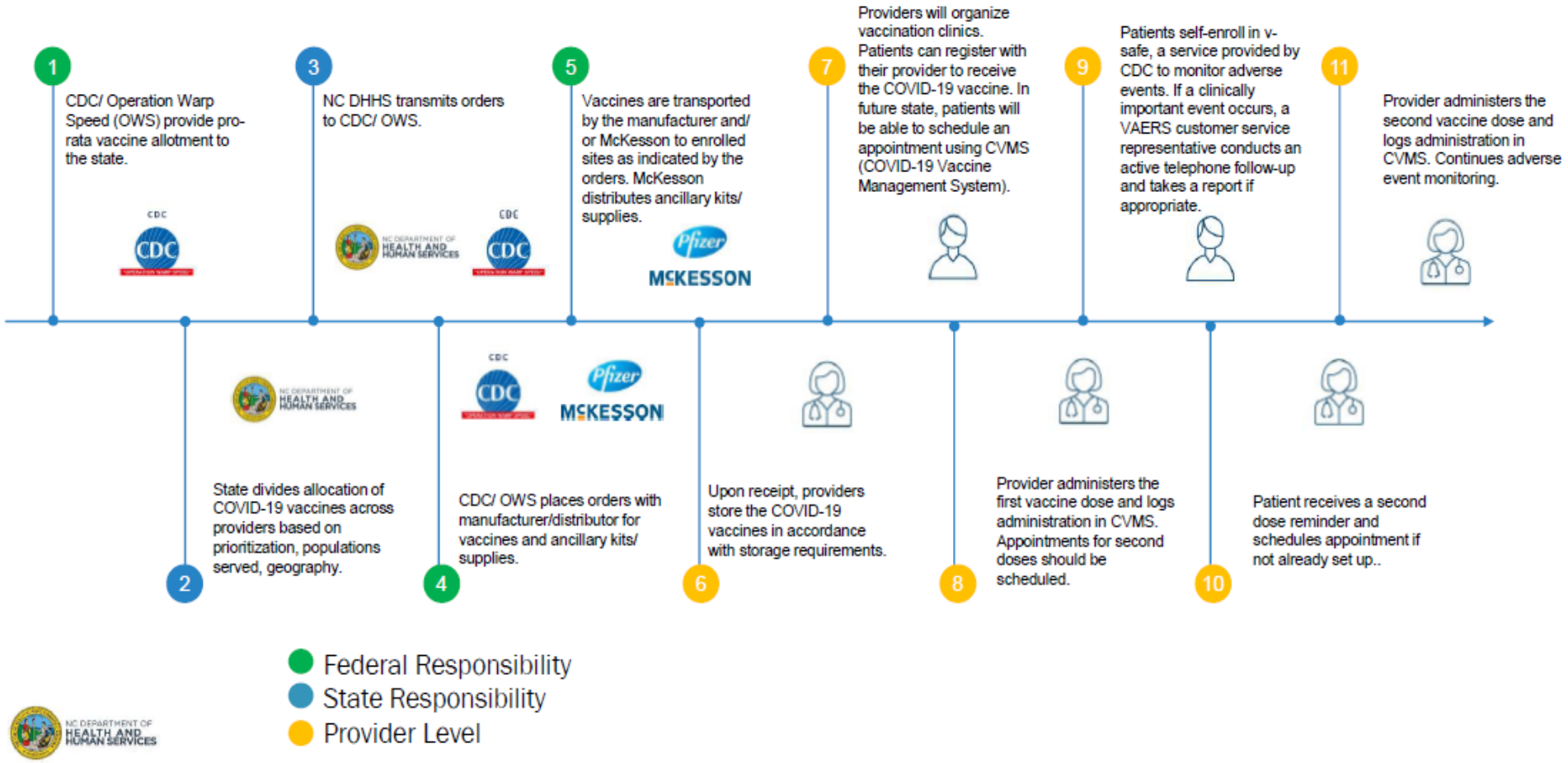
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES: October 27, 2020


Developing, Manufacturing and Distributing a COVID-19 Vaccine
Multiple COVID-19 vaccines are being developed. Thousands of people have volunteered as part of research trials to see if a vaccine prevents COVID illness and to learn more about its safety in these overlapping steps. Promising vaccines are being manufactured at the same time they are being tested, so there will be an initial supply ready to go right away when the science shows which vaccines are found to be safe and effective. Once we have a vaccine or vaccines, it will still be some time before it is widely available to everyone. States will receive limited supplies at the start. North Carolina is drawing upon the experience and expertise of leaders from historically marginalized communities to develop and implement its vaccine distribution plan.
PHASE 1 & 2:
Safety & Dosing
10s-100s of healthy volunteers
• Are there any side effects? How many volunteers experience side effects?
• What is the best vaccine dose to create an immune response with the fewest tolerable side effects?
PHASE 2 & 3:
Safety & Efficacy
>30,000 of volunteers
• Does the vaccine prevent COVID-19 infection?
• What are the most common side effects?
• Do the benefits of the vaccine outweigh the risks?
Approval & Distribution
• FDA reviews the safety and efficacy data to determine if benefits are greater than risks
• An independent, non-FDA scientific committee reviews findings
• Vaccine is authorized and recommended for use (may only be for certain populations)
• Vaccine is labeled for use, benefits, side effects
Manufacturing Preparation: Manufacturing development, scaling up, quality-control testing
Large-Scale Manufacturing: Making millions of vaccine doses for nationwide distribution, continued quality-control testing of vaccine batches and manufacturing facilities, FDA and CDC continually monitor vaccinated patients for safety
Availability: Limited availability in the beginning. More widely available over time.

NC COVID-19 Vaccine Operational Plan: Overview

	Planning *Where we are now*	Implementation *Begins when first vaccine doses are allocated to states*	Adjustment *Large number of vaccine doses available*	Transition *Sufficient supply of vaccine doses for entire population*
Populations	• **Establish priority groups**	• Phase 1 populations • Stabilize health care delivery system and protect individuals at highest risk	• Continue to move through phased populations as vaccine supply allows	• Offer vaccination to all populations through Phases 3 and 4
Vaccination Channels	• **N/A**	• Through local health departments and on-site vaccination clinics (in closed settings)	• Require more points of access, mass vaccination clinics, and broad vaccination sites	• Vaccination in established channels • Fewer mass, mobile, or community-based clinics
Enrollment/ Ordering/ Allotment	• **Identify/enroll priority providers** • **Expect CDC centralized distribution to providers**	• Continue to enroll providers • Allocations to state, allotted to enrolled providers	• Transition to provider ordering vaccines based on need for population and local demand	• Ordering similar to annual seasonal flu vaccine campaign
Shipment	• **None shipped** • **Expect vaccine and anc. supplies procured and distributed by fed gov't**	• Shipment in increments of 1,000 for some • 2-dose series that may require ultra-cold storage	• Shipment minimum of 100 for most vaccines	• Move to high supply/lower demand
Data	• **Confirm capability for required functionality, data collection, and reporting**	• Data systems for ordering, scheduling, dose tracking, inventory, data collection and reporting requirements	• Data systems for ordering, scheduling, dose tracking, inventory, data collection and reporting requirements	• Data systems for ordering, scheduling, dose tracking, inventory, data collection and reporting requirements

Vaccine Journey



Great care has been taken to make sure COVID-19 vaccines are safe and effective.

Scientists had a head start. Although the vaccines were developed quickly, they were built upon years of work in developing vaccines for similar viruses.

Testing was thorough and successful. More than 70,000 people participated in clinical trials for two vaccines to see if they are safe and effective. To date, the vaccines are nearly 95% effective in preventing COVID-19 with no safety concerns.

There is no COVID-19 virus in the vaccine. The vaccine imitates the infection so that our bodies think a germ like the virus is attacking. This creates the antibody defenses we need to fight off COVID-19 if and when the real germ attacks.

No major side effects. Some people may have temporary reactions after being vaccinated, such as swelling from the injection, tiredness or feeling off for a day or two.

Those who need it most will get it first. A tested, safe and effective vaccine will be available to all who want it, but supplies will be limited at first. The best way to fight COVID-19 is to start first with vaccinations for those most at risk, then reach more people as the vaccine supply increases throughout 2021.

Will there be enough vaccine for everyone?

When FDA first authorizes or approves the use of one or more COVID-19 vaccines in the United States, there may be a limited supply. This would mean that not everyone will be able to be vaccinated right away. It is understandable how concerning this would be for people, especially for those who are at increased risk for serious illness from this virus and for their loved ones.

That is why, early in the response, the federal government began investing in select vaccine manufacturers to help them increase their ability to quickly make and distribute a large amount of COVID-19 vaccine. This will allow the United States to start with as much vaccine as possible and continually increase the supply in the weeks and months to follow. The goal is for everyone to be able to easily get a COVID-19 vaccine as soon as large quantities are available. Several thousand vaccination providers will be available, including doctors' offices, retail pharmacies, hospitals, and federally qualified health centers.

Who is paying for COVID-19 vaccine?

Vaccine doses purchased with U.S. taxpayer dollars will be given to the American people at no cost. However, vaccination providers will be able to charge an administration fee for giving the shot to someone. Vaccine providers can get this fee reimbursed by the patient's public or private insurance company or, for uninsured patients, by the Health Resources and Services Administration's Provider Relief Fund.

Are there special considerations on who should get the COVID-19 vaccine first?

At first, there will be a limited supply of COVID-19 vaccine. Operation Warp Speed is working to get those first vaccine doses out once a vaccine is authorized or approved and recommended, rather than waiting until there is enough vaccine for everyone. However, it is important that the initial supplies of vaccine are given to people in a fair, ethical, and transparent way. Learn how CDC is making COVID-19 vaccine recommendations, including recommendations if there is a limited supply, based on input from the Advisory Committee on Immunization Practices (ACIP).

If I have already had COVID-19 and recovered, do I still need to get vaccinated with a COVID-19 vaccine when it's available?

There is not enough information currently available to say if or for how long after infection someone is protected from getting COVID-19 again; this is called natural immunity. Early evidence suggests natural immunity from COVID-19 may not last very long, but more studies are needed to better understand this. Until we have a vaccine available and the Advisory Committee on Immunization Practices makes recommendations to CDC on how to best use COVID-19 vaccines, CDC cannot comment on whether people who had COVID-19 should get a COVID-19 vaccine.

Do I need to wear a mask and avoid close contact with others if I have received 2 doses of the vaccine?

Yes. While experts learn more about the protection that COVID-19 vaccines provide under real-life conditions, it will be important for everyone to continue using **all the tools** available to us to help stop this pandemic, like covering your mouth and nose with a mask, washing hands often, and staying at least 6 feet away from others. Together, COVID-19 vaccination and following CDC's recommendations for how to protect yourself and others will offer the best protection from getting and spreading COVID-19. Experts need to understand more about the protection that COVID-19 vaccines provide before deciding to change recommendations on steps everyone should take to slow the spread of the virus that causes COVID-19. Other factors, including how many people get vaccinated and how the virus is spreading in communities, will also affect this decision.

When can I stop wearing a mask and avoiding close contact with others after I have been vaccinated?

There is not enough information currently available to say if or when CDC will stop recommending that people wear masks and avoid close contact with others to help prevent the spread of the virus that causes COVID-19. Experts need to understand more about the protection that COVID-19 vaccines provide before making that decision. Other factors, including how many people get vaccinated and how the virus is spreading in communities, will also affect this decision.

Does immunity after getting COVID-19 last longer than protection from COVID-19 vaccines?

The protection someone gains from having an infection (called natural immunity) varies depending on the disease, and it varies from person to person. Since this virus is new, we don't know how long natural immunity might last. Some early evidence—based on some people— seems to suggest that natural immunity may not last very long.

Regarding vaccination, we won't know how long immunity lasts until we have a vaccine and more data on how well it works.

Both natural immunity and vaccine-induced immunity are important aspects of COVID-19 that experts are trying to learn more about, and CDC will keep the public informed as new evidence becomes available.

How do I report it if I have a problem or bad reaction after getting a COVID-19 vaccine?

CDC and FDA encourage the public to report possible side effects (called adverse events) to the Vaccine Adverse Event Reporting System (VAERS) . This national system collects these data to look for adverse events that are unexpected, appear to happen more often than expected, or have unusual patterns of occurrence. Learn about the difference between a vaccine side effect and an adverse event. Reports to VAERS help CDC monitor the safety of vaccines. Safety is a top priority.

Healthcare providers will be required to report certain adverse events following vaccination to VAERS. Healthcare providers also have to adhere to any revised safety reporting requirements according to FDA's conditions of authorized use throughout the duration of any Emergency Use Authorization; these requirements would be posted on FDA's website .

CDC is also implementing a new smartphone-based tool called **v-safe** to check-in on people's health after they receive a COVID-19 vaccine. When you receive your vaccine, you should also receive a **v-safe** information sheet telling you how to enroll in **v-safe**. If you enroll, you will receive regular text messages directing you to surveys where you can report any problems or adverse reactions you have after receiving a COVID-19 vaccine.

What percentage of the population needs to get vaccinated to have herd immunity to COVID-19?

Experts do not know what percentage of people would need to get vaccinated to achieve herd immunity to COVID-19. Herd immunity is a term used to describe when enough people have protection—either from previous infection or vaccination—that it is unlikely a virus or bacteria can spread and cause disease. As a result, everyone within the community is protected even if some people don't have any protection themselves. The percentage of people who need to have protection in order to achieve herd immunity varies by disease.

PREPARING FOR THE NEW COVID-19 VACCINE MANAGEMENT SYSTEM (CVMS)

What is CVMS?

CVMS is a secure, cloud-based vaccine management solution for COVID-19 that enables vaccine management and data sharing across providers, hospitals, agencies, and local, state, and federal governments on one common platform.

When the CVMS MVP is launched on 12/10, providers will be able to:

- Enroll in the COVID-19 Vaccine Program and upload employees so they can register for COVID-19 vaccination
- Manage COVID-19 vaccine inventory
- Track COVID-19 vaccine administration

In future CVMS releases, providers will also be able to schedule clinics.

Who will use CVMS?

NC State officials will enroll providers and verify provider eligibility along with verifying site readiness.

Providers will verify patient eligibility, log dosage administration, and track frequency and timing of additional dosages.

CVMS will be available to select providers for a soft launch on 12/8 and the remaining providers will have access to the system on 12/10.

Why CVMS?

CVMS provides a flexible approach for managing, delivering, and administering vaccine programs. It consolidates multiple legacy, siloed systems into an integrated platform with configurable modules. This will allow for quicker updates to the system in order to meet business needs. In addition, built-in automation features means less time on routine tasks and more time on high-value activities.

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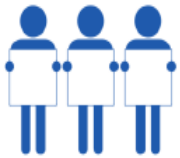
CVMS Training

NCDHHS will provide a range of tools and methods for CVMS and vaccine training including: communications, user guides, live trainings, and helpdesk support.

Communications: Communication towards end users facilitates the training process and increases awareness. Communications are tailored to each audience and can include job aids, recorded demonstrations, and user guides.



Live Training: Live training provides end users with real-time training modules that target a set of training objectives. A key feature of live training is its high engagement and interaction from trainees.

User Guides: Step-by-step guide combines text instructions and screenshots to guide users through a process. It helps audience to simplify and breakdown a multi-step process.

Helpdesk: A channel where relevant questions could be answered or directed to relevant personnel. Helpdesk has staff scheduled during predetermined hours.

Initial training of Phase 1 enrolled provider training starts week of 11/30
Expanded provider training to follow

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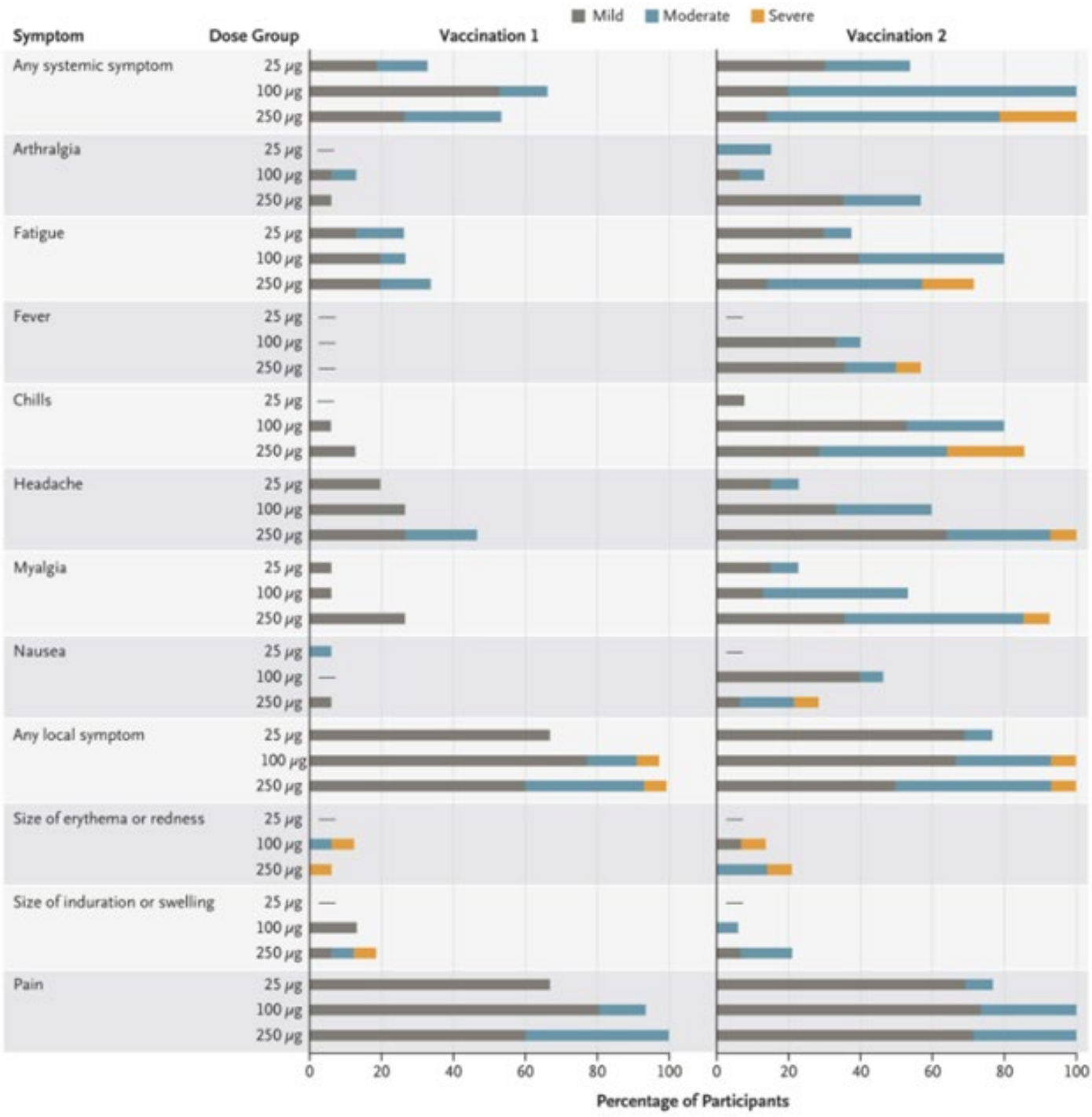
Reported Side Effects from Moderna Vaccine



Retrieved from: New England Journal of Medicine https://www.nejm.org/doi/full/10.1056/nejmoa2022483

Pfizer Clinical Trial Overview

Retrieved from: https://www.pfizer.com/science/coronavirus/vaccine on 12/9/2020

Pfizer/BioNTech Vaccine Update

BIONTECH Pfizer

Progress Update

On 11/18, Pfizer concluded their final efficacy analysis of their Phase 3 clinical trial - which indicated a **final efficacy of 95%** in preventing COVID-19 in participants. The final data analysis revealed the following data:

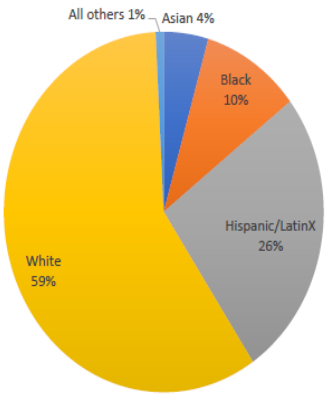
- **94% efficacy** in adults 65+ years old
- **10 severe cases** of COVID-19 – **9** of which occurred in placebo population
- **170 total cases** of COVID-19 – **162** of which occurred in placebo population

Applied for EUA 11/20/20. FDA advisory review Dec 8-10, CDC Advisory Committee on Immunization Practice soon after that. May have initial supply mid- December

Fast Facts

	Pfizer Vaccine BNT162b2
Efficacy Data	95% effective
Temperature/Storage	-75 degrees Celsius (cold storage); can last up to 5 days at refrigerated temperatures
Dosing	2 dose schedule; administered 21 days apart
Vaccine Type	mRNA
Safety	No observed serious safety concerns

Diversity Breakdown



***Pfizer did not provide the exact breakdown of participants living with comorbidities

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Source: https://www.pfizer.com/science/coronavirus/vaccine

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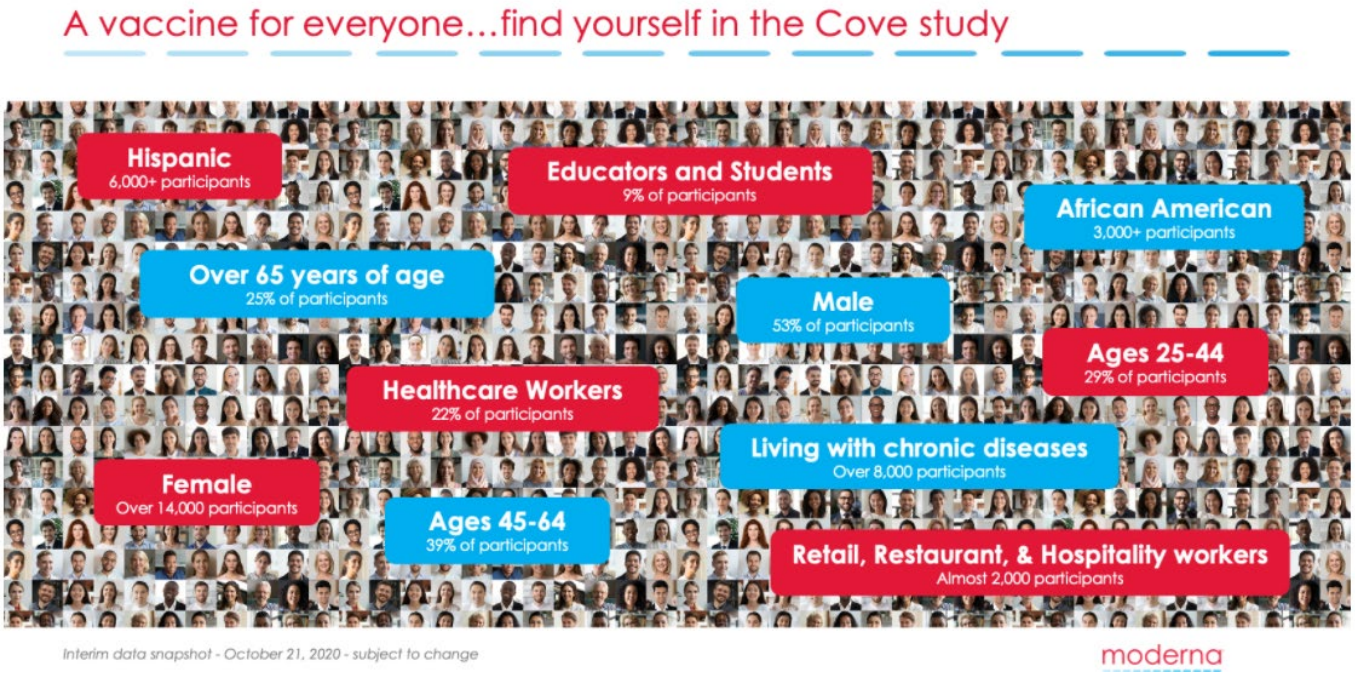
Moderna Clinical Trial Overview



Moderna Vaccine Update

moderna
messenger therapeutics

News Update

On 11/30, Moderna announced further data analysis has shown that their mRNA vaccine candidate **has an efficacy of 94.1%** against COVID-19. This data analysis revealed the following data points:

- 15,000 trial participants received **the real vaccine** – 11 developed COVID-19, with **no severe cases observed**
- 15,000 trial participants received **the placebo** – 185 developed COVID-19, with **30 severe cases observed**

Expect to apply for EUA 11/30. FDA Advisory Board and ACIP scheduled for Dec 17th. Possible to have vaccine late December.

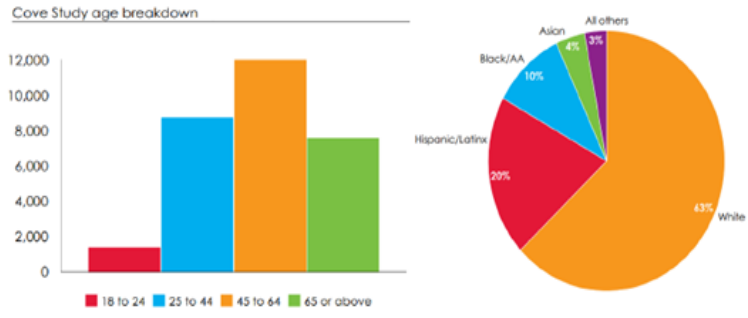
Fast Facts

	Moderna Vaccine mRNA-1273
Efficacy Data	94.5% effective
Temperature/Storage	-20 degrees Celsius; can last up to 30 days at refrigerated temperatures
Dosing	2 dose schedule; administered 28 days apart
Vaccine Type	mRNA
Safety	No observed serious safety concerns

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Diversity Breakdown

27% of participants living with comorbidities including: diabetes, cardiac disease, lung disease and obesity



Source: https://www.modernatx.com/sites/default/files/content_documents/2020-COVE-Study-Enrollment-Completion-10.22.20.pdf 6