Transcript for COVID-19 Vaccine: What North Carolina Practices Need to Know

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6:00-7:00 pm

Presenters:

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Hugh Tilson

Good evening, everybody, it's six o'clock. So let's go ahead and get started. Want to thank everybody for participating in today's webinar for providers on COVID-19 vaccinations, What North Carolina practices need to know. This webinar was put on by the North County Department of Health and Human Services and supported by North Carolina AHEC got organized after DHHS reached out to multiple providers associations want to provide relevant timely information about COVID-19 vaccination distribution plans, to as many providers as efficiently as possible. On behalf of those associations and the providers we all serve we thank DHHS, for setting up this webinar. And more importantly, for all the work that this webinar reflects. My name is Hugh Tilson, I'll be moderating this evening. There's a ton of great information coming your way. So I'll be brief. These slides are available on the joint AHEC/CCNC website. I think Paul's gonna put a link to it in the QA. So thank you, Paul. If not, we'll get it on there. It will stuck in there quickly, so you have access to these slides. So you can follow along. We'll record this webinar, and we'll post that on that website as well. In addition to giving it to DHHS to make it broadly available. After today's presenters provide their updates, we'll turn to your questions. Please know the provider associations have already submitted lots of questions to DHHS as they prepare for this webinar. I encourage you to wait until after the presenters have covered a topic before you submit a question on that topic. If you are going to submit a question, please know that everybody other than the presenters is muted. So if you're participating through the webinar, you can use the q&a function on the black bar on the bottom of the screen. If you're going to on the phone, you can't do that. And you're muted. So send us an email to questionscovid19webinar@gmail.com. Again, we'll put that link to the slides in the q&a bar as quickly as we can. And now let me turn it over to Dr. Tilson.

Dr. Betsey Tilson

Yesterday was really a historic day. This has been such a long haul with our pandemic, we have been in this dark tunnel. And yesterday, I think as most of you know, was the first day we had vaccine in North Carolina. And we were able to start vaccinating people for COVID-19. To me, it sent chills up my spine. It was such an exciting and historic day it is that light at the end of the tunnel. And it was really, really exciting. Now there's a huge amount of work ahead of us.

Dr. Charlene Wong

Okay, I think maybe while Dr. Tilson is getting her audio fix this is Charlene Wong, I will just present this information on the slide and then we'll figure out who can present the next slide. If that's okay, yeah. Okay. Thank you. Okay, perfect. So we wanted to share with you all we're going to talk a lot about vaccines. But we would really appreciate you all partnership also in sharing our winter holiday guidance. Because we are, of course very worried about our current trends. And in our guidance, we really emphasize two messages. One is that we are aligning with the CDC to say avoid holiday travel and gatherings with those you don't live with. But then second, if you must travel or gather, get tested ahead of time, wear a mask all the time, and keep it small and outdoors. And you can see on the slide here a one page flyer and detailed guidance with a link. And this is a link on our website, if you guys would please also use this flyer to disseminate to your patients in your practices. And then we have some vaccine talking points here. But it looks like Dr. Tilson or Mandy are going to take over we're going to go into a lot of detail here. Thank you.

Dr. Betsey Tilson

Wonderful. Oh, you back. I'm back. Yep. So I really get great case in point that as we roll out this vaccine, it is not going to be perfect. We are going to have glitches we are going to have distribution glitches and technical glitches. And I will say this almost exact same thing happened when we're doing a webinar with some of our health systems on Sunday. That right as we're saying this is exciting but there's going to be glitches and we had a glitch. So thank you for your flexibility and I You're welcome for for my example of how we're going to need to be flexible and just adjust and go with the flow as we move forward. Okay, next slide. Nevin, please. So there you have it. That will be the mantra for the next three or four months. There is going to be glitches, there's going to be answer, questions that we don't have an answer for. There's information we won't have. We won't be moving as fast as you want us to move. There's going to be technical glitches. I assure you, all of that will happen. But we will make it through and six months from now, we will have vaccine for everybody who wants vaccine. So over the next six months, we will all keep calm and carry on and work through what is really unprecedented moment in time. And we I promise you, we do not have all the answers, but we're working as hard as we can to move us all along. Okay, next slide, please.

Wonderful. So these are some of the topics that we're going to go over tonight. We did get a bunch of your questions ahead of time. So we hope that we have proactively answered many of those questions. I know there'll be more questions. beyond that. We do have a lot of information tonight. So we may not have a huge amount of time to answer all of the outstanding questions. But what we want to do is if we can arrange it to have an office hours type thing next week, where it's mostly just q&a, and that we can think about all the unanswered questions. So we're trying to work that out with different people's holiday schedules, but hoping to set that up. So this is this is not the only opportunity. We'll be setting these up so we can get your questions answered as we move forward. So stay tuned for hopefully an office hours just devoted to q&a next week. Okay, next slide. Please, Nevin. Wonderful. Oh, before we move on, I also wanted to introduce my teammates who be helping me through this, I will start and work through some of the clinical information of the prioritization, I'm going to turn it over to Amanda Fuller Moore, who is our public health pharmacist or operational lead and an absolute Rockstar and getting this done. And then I'm

going to turn it over to Danielle Brady, who is on our IT team, and she'll walk you walk you through some of the CVMS stuff. We also have Angie Taylor, who's our COO of it, and she'll be available for QA. And then I'm going to turn it over to the lovely Dr. Wong, who you met to go through some more of our communication pieces. So you have a rockstar group with you tonight.

Okay, so first, I'm going to give a pretty high level overview of what maybe you've heard is operation warp speed, it is the process for how this COVID 19 vaccine or vaccines have been developed. I think it's really foundationally important that people understand this process, because what we hear time and time, again, is that people are really concerned about the safety of the vaccine because it was sped through. So I really want to highlight how it is that the speed of this vaccine was able to accomplish the speed of the production of that scene. But without cutting corners. The speed of affect scene was due to some, I think pretty good policy decisions on how we were able to move this forward. So we just talked through some of those key policy decisions and science scientific based decision. So the first thing is, we had a head start on this messenger RNA technology, which is the type of vaccine both for Pfizer and the moderna vaccine are the messenger RNA scientists had already been started to work on for the past couple years, we had a head start, they were working on it with other coronaviruses. So once we had the genetic code for this virus, they we're able to apply that mRNA technology to this specific virus, we have had a head start, which was great.

The second decision for the federal government that instead of waiting until all the clinical trials were done, and we knew which vaccine was safe and effective, and then start producing vaccine, what the federal government decided was they're going to financially back the vaccine production. So as soon as clinical trials started, vaccine production started. Knew that was a big financial risk. If a clinical trials didn't pan out, they would have funded the production of vaccines that weren't effective, but felt that it was so important to have vaccine ready as soon as the science says they're safe and effective. So that's what you see in parallel lines. Going up to the top line a little bit more just want to walk you through that the same phase one, phase two, phase three clinical trials that typically happen, happened with this vaccine or vaccines as well. But a couple differences. One, we got efficiency of speed, because as soon as the clinical phase one clinical trials was starting, we're already planning phase three clinical trials. So there was no gaps between the stages. Second, in that green bar, in the phase three clinical trials, typically there's maybe 3000 or 4000 people in a phase three clinical trial. With these clinical trials, there were 30,000-45,000 with the Pfizer, so 10 times as many people enrolled in these clinical trials, which then were allowed, then the speed of getting the data, the safety and efficacy data more quickly because of the number of people enrolled. And then finally, in terms of the authorization and approval, all the same processes with the external advisory board for the FDA, the Advisory Committee on Immunization practice for CDC. All of those scientific reviews and boards happened the normal way, it's just that they were scheduled back to back to back so there was no delay between the FDA review and the CDC review. So all of the processes were sped up in terms of administrative but not sped up in terms of the of the science. So I just wanted to give you a foundation in that and so you could have some of those talking points of how is it we have a vaccine this early and it's not because they were cutting cut corners of safety and efficacy, it was really quite good planning and logistics.

Okay, next slide, please. Nevin, wonderful. So I'm since this is a group of providers, I am going to take you deep into some of the data around this vaccine because I know your patients are going to be asking

you and I want to be sure that you know, the science and the data behind it. First, I'm going to just talk about the Pfizer vaccine, which is the one that just got authorized and then recommended from the Advisory Committee on Immunization practice, or ACIP. So let's focus in on that. This one had 43,000 people in the clinical trial. On the right hand side, you will see the makeup of people that were enrolled in the clinical trials. So about 42% with diverse backgrounds, only 10% African Americans, we get this question a lot. So it was not just not proportionately representative of African Americans living in the country, but at least 10% African American, and then almost half of the people had comorbidities that put them at high risk of severe illness with COVID-19. And you see, the range was 16, up to 85 years. The data from this showed 95% effectiveness in preventing illness or severe illness up at seven days after the second dose. And this was consistent across age demographic comorbidity, very consistent findings of effectiveness across those subgroups. And so far, I have found no waning protection two months after the second dose, of course, this is something that we're going to need to wait and learn more as how long does immunity last? That will only time will we'll be able to tell us that data point.

We get this question a lot. If somebody is vaccinated, can they still transmit the disease? That's a great question. But it was not a question that was asked in the clinical trials. So we cannot answer that question. It is feasibly possible they can, people can still spread the disease, which is why the prevention messages and the three W's is still going to be important until enough people are vaccinated. The timeframe of this authorization, of the FDA Advisory Committee endorsed this on the 10th that FDA delivered an emergency use authorization on the 11th. And then over the weekend, CDC /ACIP recommended it for populations on the 12th. So this is hot off the press information that happened this weekend. This is the vaccine that requires the ultra cold storage, however, it comes with a shipping container. And if you refill it with dry ice, it can last up to 30 days and five days at refrigerated temperature. This vaccine as well as most of them in production do require two doses, the way the doses schedule in the clinical trials 21 days apart, but there's a little bit of wiggle room according to ACIP of 17 to 21 days. We do know that some protection starts about 14 days after the first dose, but we do not have sufficient data to understand what is the long term protection from only one dose? Because almost everybody in the clinical trial got two doses. So we do not know that that that answer we do think that there is some protection after the one dose.

As I alluded to this mentioned, this is mRNA technology. Which means what happens is a tiny little piece of the genetic code of the virus, just the piece that codes for different a specific protein. That little piece of genetic material is wrapped in a lipid envelope. And that is basically what's in the vaccine, and then that then the cells and just that, and then it that viral. That genetic material will tell ourselves to produce just one tiny little piece of the protein one of the spike proteins on that on the vaccine, and that triggers the immune response. So there's no live virus, no whole virus, no stem cells, it's just a teeny piece of genetic material encapsulated in an lipid envelope. In the clinical trials, there was no reports of serious safety concerns across all demographics. There were there were four cases of Bell's Palsy in the vaccine group, but the analysis was that is still within the normal frequency of populations, but they will continue to monitor that there is and people should be counseled to expect temporary reactions soreness, fatigue, headache, fever, about 24 to 48 hours after the vaccine. These temporary reactions can last about one two days and finding that it is more prominent after the second dose than the first dose but less so with people over 55. And in the clinical trials. It said that there were they did include people that had a history of COVID infection. And so through that data brief is recommended that people could get the vaccine without a problem if they'd had a history of infection.

Okay, next slide. Please. Never this Just a little bit of a graph, I think it's really exciting to show the effectiveness of the vaccine. The red bar is people that got the placebo. The blue bar is people that got the vaccine. And you can see about 14 days after dose, one where those lines started to diverge. And that consistent protection of those people in the in the vaccination group. Okay, next slide, please. This just gives you a little bit of a rundown, I wanted to give you details of how much to expect these temporary reactions, I think it's going to be really, really important for us to counsel our patients to expect this. And so I broke it out, you see the 18 to 55 year olds on the left the greater than 55 year olds on the right, and then the frequency of those different reactions after dose one and after dose two, you can see that a lot of people had pain in this at the site of injection. And then there's more systemic effects, you can see it's fatigue, headache, muscle pains, those are the most common reactions um fever, down lower, but but to expect, and then again, you'll see that dose to you have more frequent reactions than dose one. And then the older people tend to have less than the younger people. So I wanted to break those out. So you would have those and two, you could counsel your patients. At the bottom, I do want to highlight that the data in the graph came from the clinical trials. And many of you may have heard that once mass vaccination happened in the UK, there were three people who had a severe allergic reaction, two was anaphylaxis, one with non anaphylaxis, but a severe allergic reaction that happened outside of the clinical trial. So clearly, that's something that's going to be followed in terms of post production, safety. Next slide, please.

Okay, a couple other data's from the EUA and then I'm also going to turn to the ACIPs recommendations. So the EUA says that this vaccine is authorized for people 16 and over there is that pregnant women and lactating women were not included in the clinical trial. So there is no data specific to that population in the clinical trials. But I will get to what the ACIP recommendation is for that population. And a little bit of a warning that people with immunocompromised with immunocompromised may have a diminished immune response. There is also no information on the administration of a Pfizer vaccine with other vaccines because they didn't co administer in the trial. And we'll get to the recommendations for that. Here are all of your helpful links, if you want to dig deep into all of those data, the fact sheets for healthcare providers, the clinical recommendations, everything that you ever wanted to know about this vaccine are all in these links, you can dig into that data as deeply as you want on all of those helpful links. Next slide, please.

Great, a little a couple other things. So people ask us what's in the vaccine, people ask that all the time what's in the vaccine. So here it is, this is what's in the vaccine directly from the EUA. A little bit of that messenger RNA, four lipids that make up that liqid envelope, and then a little bit of salts and sodium, some some sugar and some potassium. And then when you mix it up with a diluent, a little bit of sodium chloride. That's what's in the vaccine. There is no preservatives, this has come up a lot. There's no preservatives in the vaccine. I bolded, the polyethylene glycol because the running assumption or hypothesis is that those anaphylaxis was was potentially due to Paul polyethylene glycol. So that is, if you have any patients that have an anaphylaxis to polyethylene glycol, that that might be what is triggering these those were anaphylaxis. So there is a contra indication in the EUA that if you have a patient with a known allergy to any of these ingredients, they should not get the vaccine. And then there is a warning also that until we start understanding more about this anaphylaxis, that being ready to respond to anaphylaxis is important if you are vaccinating people. Next slide, please Nevin.

Okay, about informed consent. We get this question all the time. For people enrolled in the clinical trial, there was an informed consent process that needed to take place because somebody was involved in a clinical trial as part of an investigational process. Now that this vaccine has been authorized, the informed consent that goes along with an investigation or an experimental product is no longer needed because it is authorized. However, there is requirements based on the EUA that providers must do. They must share the fact sheet for the recipient and caregiver for patients getting the vaccine. They have to explain that it is authorized, not a fully approved vaccine. They have to make it clear that people can accept or refuse the vaccine and walk through the pencil the potential risks and benefits of the vaccine. And so consent must be obtained before vaccination, but it can be a verbal consent and or written written consent, just like you consent for other vaccines. Next slide, please. Great. The other requirement as part of the EUA is that providers must report adverse events for this vaccine and administration error or serious adverse events. And that'll be through the VAERS system as you report your other vaccine adverse event events. There is also for this vaccine a V-safe program that patients themselves can report, they can self enroll and report their own adverse events. So it's another way that we can gather more information on adverse events.

Nevin, if you go to the next slide, please, here, if you have forgotten and put aside, where do I report any of my adverse events, making sure you know that the website or the phone number that you can report your adverse events, it's the same system that you report any of your vaccine adverse events, same system for the COVID vaccine. Next slide, please. And this is a V-safe. So it's an app that patients can download. They can get text messages that can get prompts through their second dose, and they can also self report adverse events that they have. So another way that we can kind of crowdsource any of the adverse events. Next slide, please. Okay, and then just a little bit from the ACIP. On some clinical recommendations, I'm hoping that I'm answering a lot of your clinical questions that we got ahead of time. One, because there is no data on this vaccine with other vaccines, you should administer this vaccine alone with a minimum interval of 14 days before or after any other vaccine. You can give a vaccine regardless if a person has had COVID infection or not in the past. If someone is actively having a COVID infection, you should wait until they're beyond that acute illness beyond that the 10 days. If people do have had a COVID illness, we do think that the risk of reinfection is low within 90 days, so people could potentially wait 90 days before getting an infection. And then a little bit about if they've had passive antibodies it would probably good to wait 90 days to avoid any interference with the vaccine. And again, people with immunocompromised it's not an indication but they may have less uptake from the vaccine.

Next slide. Please never. Although there is no data on pregnant and lactating women, because of the risk of COVID during pregnancy, and because this is not alive virus. A sub says that pregnant or lactating women may be offered the vaccine, they can choose after they've thought about the benefits and the risks to accept the vaccine so it can be offered to a pregnant or lactating woman. And then the contraindication that I said before a true contraindications is a known allergy to any of the ingredients. But additional guidance from ACIP is that anybody that has had a serious severe reaction to any vaccine or any injectable therapy, there should be a caution for those patients with with an allergy to an injectable or a vaccine, but not somebody who has a severe allergy to like shellfish, or by mouth medicine is an injectable or vaccine. There's a caution there. Okay, next slide, please

Now I'm not going deeply as deeply into all the vaccines of that. But the Moderna is the next on the mark, it will be up for FDA review at the end of this week. ACIP probably review the data this weekend, we

will have a lot more data on that for the Moderna of this weekend. And if that is all approved, then we may have Moderna next week as well. So that is all coming. The beauty of Moderna is that it does not require that ultra cold storage so it'll be easier to get out to our community providers. It does require a two dose schedule. This is 28 days apart. And it's the same mRNA technology. Next slide please.

Dr. Amanda Fuller Moore

And there's a bunch more in the pipe that I'm not going to go into details but just make you're aware there are many more in the pipe, they probably will not be ready, if at all until next year. But these aren't these won't just be the only two candidates and we will talk to you as we get more candidates. Next slide please. Okay, and we have a lot of questions about reimbursement and payments and what will be the administration fee so I wanted to be sure that you had this. First and foremost, all people receiving the vaccine should receive the vaccine at no cost to that person. There should be no cost sharing. There should be no charge. Everybody should receive this vaccine without any cost. The vaccine itself is paid for by the federal government. And then the administration fees will pay be paid for by Medicaid, Medicare by commercial insurance. And people who are providing vaccine for uninsured patients can also get reimbursement through the Provider Relief Fund. I was asked specifically what will be the reimbursement for that and you can see Medicaid will equal Medicare reimbursement, the first dose will be $16.94. The second dose $28.39 for the administration for the vaccines. Next slide, please never. Okay.

Dr. Betsey Tilson

So coming down a little bit more to our plan. And I'm going to be wrapping up soon once I get through here and then turn it over to Dr. Fuller Moore forgive me. I'm one we know the details are going to change. We know logistics are going to change. We know the priority, we also things are going to change. We want to hold true to our principles, that all North Carolinians have equitable access to vaccine, we've had a very intentional equity lens, we've been really trying to engage as many of our partners as possible, including our leaders from historically marginalized populations, because we know there is increased hesitancy in those populations because of past wrongs and trauma from our healthcare and medical community. We want to be sure we're being as proactive communicating as possible. We're going to be collecting and reporting data as much as we can to be sure that people follow along with us. And we will get better with time. This is an agile process, we don't have all the answers tonight. And as we move along, we're going to get better and better and have a continuous quality improvement. So at the end of this, we have hit a home run, but it will not be perfect day one.

Next slide, please, never wonderful just to highlight a little bit of the people that we've we've intentionally engaged the North Carolina Institute of Medicine has convened for us at the vaccine Advisory Committee, we had good representation from many of our primary care and health care associations, that more than 60 stakeholders are greatly involved in our prioritization framework up front, and they're helping us in through our operational details as well in our communication. We've leaned very heavily on our historically marginalized population advisory group as well in thinking through how do we reach those populations, get the trust in those populations, making sure they have what they need. And we also are leaning on a communications advisory group as well. Next slide, please.

Wonderful, okay, so let's get to prioritization because we get tons of questions on this. And I know everybody wants to know where they land and everybody wants to be higher up than they are on the prioritization and I am sorry, that we can't get everybody into 1A, I would love to get everybody into 1A but we have people have very, very, very limited supplies in the beginning. And so we had to upfront do this prioritization. Again, we we framed the prioritization with the National Academy of Medicine framework for equitable vaccine distribution, we had input from our external Advisory Committee of IOM and also aligning to ACIP recommendations on who should be in the earlier prioritization. It is a risk based prioritization, people at the highest risk of exposure and the highest risk of severe illness are prioritized first. So, you will see in our phase 1A, it is our health care workers at the highest risk for COVID-19 exposure based on their work duties. It is also those people initially involved in the in the initial COVID mask vaccination responses. And so that means people at more than the usual risk of health care, health care workers are at the more than the usual risk of exposure to COVID-19. So this means our people in our COVID units, in the ICU, in the on the COVID floors that are day in and day out caring for patients with COVID-19 at highest risk of exposure and not just the doctors and the nurses but also the environmental health people, the cleaning, folks who are cleaning those areas. On the inpatient on inpatient wards our respiratory therapists. It is also those people performing very high risk procedures, intubation, suctioning, those very, very high risk procedures. It's also people that are doing CPR directly with those patients. So thinking through our medical first responders are ATMs that are going in homes, doing CPR very high risk procedures with our patients or with people with COVID. And then, as I said, Those directly involved in those initial COVID vaccination clinics.

We have talked a lot about where do outpatient providers fit into the into 1A and where we are landing is that unfortunately, we will not have enough vaccine in the beginning to do even though we know people in primary care have risk of exposure. Of course they do. But we just won't have enough vaccine in the beginning to have it be available to all outpatient primary care providers. So in that primary care setting, if there are outpatient providers who really have an increased risk of exposure above and beyond what would be in our normal everyday outpatient care, so for example, outpatient providers who are really focused and dedicated to COVID care, maybe they're in a respiratory diagnostic center, or part of a respiratory care team that day in day out, they're only caring for respiratory patients, or they are actively involved in a lot of community testing, above and beyond testing that might be in a practice based setting. So those outpatient providers that have above and beyond the risk of COVID exposure could be considered up there in though in the in 1A. But very quickly, I also want to say that any healthcare provider who has two or more chronic conditions that put them at severe risk of severe illness for COVID, all of those providers are in 1B, regardless of their that that level of risk. But when we wait before we get to 1B, the other group in 1A is all of our long term care staff and residents are in nursing homes our adult care homes, because we know there's very high risk of spread and exposure in those in those settings. Moving to 1B as I said, now all of our people are at the highest risk of severe illness. So any person with two or more chronic disease, especially any of our frontline workers, including all of our health care providers that have two or more chronic conditions that put them at high risk, there's soundly in one. And then phase two, those of you are people without including our health care providers have no underlying chronic conditions. And then not a yes a risk of exposure being a frontline worker, but not that that increase above and beyond typical risk of an outpatient provider. And then as you move along, you can see the lower risk of exposure and illness as we move forward. Next slide, Nevin.

So one thing is why we've had to prioritize is that this is the amount of people that we think are in those groups, this is expected uptake, so an estimate of how many people would fit into those groups. And then we're not assuming everybody will take the vaccine. So this is the number of people in these groups, when you start with only again, our first allocation was only 88,000 that will not get us very far. So that is the reason that we have to make some of these hard prioritization decisions. Next slide, please. Never. Okay. So again, those people that are in that 1A that we decided, where would they? How would they get vaccine? Where would they where would vaccine be going on in the beginning, and just in the in those first couple weeks vaccine is going to hospitals and local health departments. So any people who are fit into that 1A can get the vaccine through either closed vaccination clinic as part of their hospitals, or in our health departments that will be more targeted vaccination clinics, and then any of our staff and residents in long term care will be getting those vaccinations through their long term care setting most through our long term care program with the federal government, which is involving CVS and Walgreens. In addition, some of our long term care staff and residents will also be covered by our health departments, or other long term pharmacies that we'll be able to deliver to those long term care. Next slide.

Okay, so how will people know if they're in phase 1A. So we're asking healthcare employers to determine who meets that criteria for 1A, who are your staff that are above and beyond the risk of a typical health care worker. And then those health care employers should work them with our local hospitals and local health departments to understand the availability of vaccine and vaccine clinics and those health care employees and should notify their employees that they they qualify for 1A and help them understand where they can go to get vaccinated. And then again, our long term care staff will, so they'll they'll know when they have vaccination because their long term staff will be a long term care facility will notify them when vaccine is available. Next slide, please.

Okay, that is done with me who I bet you're sick of my voice. And now I'm going to turn it over to the illustrious Dr. Amanda Fuller Moore who is truly the rock star of this whole show. I shouldn't say that because the other people on the call are rock stars too. But she is way more rock stary than me. So let me turn it over to her.

Dr. Amanda Fuller Moore

Thank you doubt yourself. And thank you everybody for joining us. And we really appreciate the opportunity to share this information with you all. So just a look at how the plan is operationalized. The plan is posted online. At our DHHS website, there are some changes that have been made to the plan since then, and we're trying to keep updated information there on our DHHS website. So we've officially moved out of planning and into implementation, which for our vaccine team is amazingly exciting. So we are in the implementation phase where we have just a little bit of vaccine from here, we're going to go through an adjustment phase where we start to have time where our supply of vaccines is increasing, maybe our demand starting to increase, and then we'll eventually reach what we think will become more of a more routine vaccine. But again, because we're just shortly out of our clinical trials, we don't have an exact schedule of how this will look and those long term studies after vaccination are continuing. Next slide, please.

So this really gives us a look at how the COVID vaccine moved through the process to the green dots represent things that are happening at the federal level. The blue dots represent exact things happening at the state level and the yellowy orange dots are things happening at the provider level. So it's likely no surprise to any of you that the dots for things happening at the provider level. So a large bulk of the work and we are greatly appreciative of our on the ground team members in this effort. So operation warp speed is giving us our allocation amount they tell us what the state allotment is each week those amounts are based strictly on population. We at the state then take that amount and divide it up between enrolled providers based on the priority group that we are serving. So right now, we are dividing up our allocations only between hospitals and local health departments. We transmit those amount to CDC and operation warp speed who then okays them and sends them on to McKesson or the manufacturer, Pfizer. So Pfizer is shipping their own orders because of their ultra cold vaccine requirements. So Pfizer ships the Pfizer vaccine, and then McKesson will be shipping the Moderna vaccines, as well as any of the other vaccine candidates that might become available down the line.

Also coming from McKesson is the ancillary kits, these kits that contain the supplies needed to administer the vaccine, or in the case of the Pfizer vaccine, the diluent. So then, once they ship the vaccine that goes via UPS or FedEx, just like any other package here at the holiday season, it is going from those locations directly to the providers doorstep. So yesterday, three hospitals in North Carolina received vaccine and eight more were scheduled to arrive today, the providers log their inventory into our COVID vaccine management system, which Danielle is going to tell you all about in just a few minutes. Then the providers are scheduling clinic, they're having patients come in for their dose and administering vaccines. They're recording any information in their system that they need to in our CVMS system, taking note of adverse effects, giving the patient information about the V-safe program which is a real time adverse effect monitoring that the patient can report for themselves. That V-safe program also once they enter their data will give them information about second dose reminders as well. We are asking providers as patients come in for their first dose to schedule that second dose to give the recipient and card that comes in with the ancillary kit. It is a shot card a shot record. And it also allows the patient to take that away and have information about exactly which vaccine they received. The vaccines aren't interchangeable, so very important to make sure that they can recall which one they got the first time around. We also encourage people with a smart Phone as soon as they get that shot record to take a picture of it. So they have that pictorial record as well.

Dr. Amanda Fuller Moore

Come back in for that second dose, because that second this is really important. Once they get people back in for that second dose administrator report that dose administer and continue that adverse event, monitoring both in the provider office when the patient returns home and asking the patient to participate in the V-safe program so that we can be having any signals from across the country on adverse events, that's what that be safe program is going to do, it's going to watch for national signals of adverse events. Next slide please.

So, we are required by the federal government to enroll providers. And the way that we are enrolling providers we initially were using a system called red cap that system is a survey based system that the database on the back end is clunky, for lack of a better way to put it. And so we have gone through a huge system overhaul. So, we enrolled our hospitals we enrolled our local health departments and we got started with our rural health clinics with our free and charitable clinic with our FQHCs, and then we put a

pause on provider enrollment so we can switch over to our new more automated CVMS system. Not only is it more automated on the front end for the provider, its also more as automated on the back end for us doing the reviews and approvals. For every provider than enrolled, we not only have to review basic information about the providers into, including checking every license for providers that will prescribe the vaccine. We also have to do checks of vaccine storage equipment so we have to visualize through photographs, the refrigerators or freezers that are submitted on all of those provider applications.

So, right now, as we've got our new provider enrollment system open we are focusing on some remaining providers and our safety net providers in our congregate living setting our corrections facilities trying to get them on board, also enrolling some long term care pharmacies that will help us with the long term care facilities that did not sign up for the federal program. So soon, probably that first week in January is when we anticipate really opening up provider enrollment to a much broader audience. Next slide please. So, one of the programs that we said mentioned several times is our federal Long Term Care pharmacy program. This program is between CDC operation warp speed, CVS and Walgreens, CVS and Walgreens have put together strike teams that will go into long term care facilities that signed up for the program. We have about 79% of our adult care homes, 100% of our skilled nursing facilities, they will go in and really do end to end management of the vaccination process, and these long term care facilities. Next slide please.

Just to give you a look at our allocations and one of the reasons that we really aren't making a move on broad provider enrollment is we don't have the allocations to do it, we don't have the vaccine supply. The Pfizer vaccine has a minimum ship amount of 975 doses. The Moderna vaccine is a minimum ship amount of 100 doses. So this week we shipped 85,800 doses, Pfizer shipped 85,800 deaths across our state by the end of this week they will have arrived. We have 11 hospitals that have already arrived and 42 hospitals are scheduled to receive their vaccines starting on Thursday of this week. Next week with our Moderna vaccine we will take a bulk of that to get started on our long term care program in our long term care facilities with CVS and Walgreens, and then the remaining doses, will be spread throughout our smaller hospitals, and also to our local health department. This allocation of our Moderna vaccine will help us get back seen in every county across the state. We are told that by Friday of this week or on Friday of this week we will get an allocation of Pfizer vaccine for next week so that will help us get even more doses of vaccine into our community. Next slide please.

So, this just really is a different way of looking at our vaccines and what's happening over the week, the second dose is all the vaccine that we're shipping right now all the vaccine that we're shipping, having shipped next week. They are all first as this second doses are being held at the federal level, and in week two at the end of week two, we will initiate the orders and the shipping for second doses to our week one locations and then in week four we will do second doses from week two and it will continue on that way, so the further we move we'll have multiple vaccine candidates, as well as shipping first doses and second doses each week. Next slide please. So now I have the great pleasure of turning over for discussion to Danielle Brady who is going to give you some information about our COVID vaccine management system.

Danielle Brady

So, what I'm going to present to you today is the COVID-19 vaccine management system, otherwise known as CVMS. At the top of the slide here we've got a timeline of sort of what we've done since the end of last month. We started with a soft launch, with just a few different providers in provider enrollment, and we moved over into a priority access preview with 120 participants. From there, We did an MVP soft launch now MVP stands for minimum viable product because we built this so quickly. There was only so much functionality that we can squeeze into it in a short amount of time. So we have an MVP soft launch here. And then we have an MVP, go live for phase one, and some of the phase 1B providers. The CVMS MVP release two go live is 12/17. And then, we're still determining when we're going to be doing the CVMS release three go live. So what exactly is cvms. It's a secure, cloud based vaccine management solution for COVID-19. It enables the vaccine management and the data sharing, not only across providers, but across hospitals agencies, local, state, federal governments in one common platform. CVMS launched the initial functionality on 12/10. And, as I said, we started to put that provider involvement. So, who will use CVMS? State officials will role providers and verify provider eligibility, along with verifying site readiness. This includes verifying that the correct storage is present at the site providers will verify patient eligibility log dose administration and track the frequency and timing of additional doses. There is training for phase 1A providers that started the week of 11/30. And as I mentioned, we went live on 12/10.

So who won't use CVMS? Pharmacies, such as Walgreens and CVS will not use CVMS to administer and manage their vaccines, they're going to use their current systems to report to the federal program, and then building that capability to ingest vaccine data files from pharmacies into CVMS is going to be one of our future releases. Next slide please. So provider enrollment is where we kind of started as Dr Fuller Moore said we started with a red cap system which was a different system, we migrated all the data over here into our provider enrollment system, and to begin the provider enrollment process, a provider can get all the information they need, by going to the immunization website. They can go to the provider enrollment section, where they can see a demo. You can see the onboarding template, the bulk recipient upload template. But most importantly, the CVMS readiness checklist, which does contain both of these onboarding templates over here. And the reason I say that's most important is because we've really put a lot of time and energy into helping you make sure that you're ready for this vaccine. There's just a lot of T's to cross and I's to dot, so that CVMS ready readiness checklist really, really helps out. Next slide.

DHHS is going to provide a wide range of tools and methods for CVMS and vaccine training. We've got communications that include provider portal announcements, enhancement updates, training event informations on new user guides and video demonstrations. We have a step by step guide that combines not only text with, but also includes screenshots to walk users through each task in the CVMS provider portal. And it breaks those tasks down into the key steps, including annotated screenshots and helpful tips. We've also got live training, which will include step by step demonstrations of those key tasks with opportunities to ask questions, and do replays to take a closer look at what the trainers are doing. We also have a help desk that you can email for all CVMS users during the published hours for all CVMS related questions. And we are switching over to ServiceNow. It's a portal that will contain a number of knowledge articles and FAQ, that will provide information such as self help, troubleshooting and task resolution. Next slide.

So, that help desk is live today. Um, the provider can send in an email to CVMS-Help@dhhs.nc.gov, or the ServiceNow will be available December. Today, December 15 to December today. The North Carolina Help Desk personnel will receive that email and then they're going to go find an appropriate answer for you. Now this could be an email about CVMS, it could be an email about the vaccine. Um, there are a wide range of folks that are part of this help desk, so that we can make sure that all the question types get answered in a timely manner, um, then we'll send back an answer. And, you know, continue the question to answer, until we get your problem resolved. The helpdesk hours of operations are Monday through Friday from 8am to 5pm, Saturday and Sunday, the help desk is open from 10am to 6pm. Next slide.

So we've had some common questions about CVMS that I've included here. How does someone get training on CVMS and what is the easiest way to get signed up for CVMS. So the quickest and easiest way to get training. Um, and all that you need to do to enroll is use the tool to track vaccine and its administration through the immunization branch website, full of all sorts of information, it's got the appropriate materials, checklists for enrolling, and the steps to complete once you're enrolled are contained within that website as well. Will CVMS have guided questionnaire, or logic to help clinicians, decide what phase people have distribution that their patients fall into. Um, so CVMS will automatically determine the priority tier, and the eligibility for recipients. In a future release, we don't have that right now. Um, so right now, the health care providers, we are asking that they confirm that priority tier and eligibility. The readiness checklist contains a summary of the prioritization approach that North Carolina is currently following. Will CVMS integrate into EHRs including CureMD and Patagonia, which covers the majority of the health departments in the state. This is very popular question, um, CVMS does not currently integrate with electronic health record systems. This is an area that the state is investigating as a future enhancement, we have heard that you have a need for it. And we are going to do everything that we can to make this happen to reduce the amount of double entry data and just to really streamline your your your experience.

So how does cvms work with NCIR and how will the medical home know that a patient got a vaccine from a pharmacist. The state is using CVMS to track all of our COVID-19 vaccines administered across the state, with the exception of the ones administered at those pharmacies. CVMS will interface with NCIR to capture and really complete immunization information. The state is exploring how to integrate the vaccine administration data from the pharmacies participating in the federal program for long term care program into CVMS. Next slide please. And now I'm going to turn it over to the one and only Charlene.

Dr. Betsey Tilson

Hey, before Charlene goes, I, we were so excited to get you so much information that we probably were overly ambitious and how much information that we could get you so we are calling an audible. And we are going to go until 715, to be sure we can get through this and feild some questions. Also, the email, we will email out to the presentation tonight. And this will be recorded and will be sent out, we'll post it on the website, tomorrow morning. Okay, so with that calling the audible. Go ahead. Dr. Wong and I am sorry there's so much content but we just knew there was so much that we wanted to get to you. They

were overly ambitious and what we could do so. Go ahead, Dr. Wong and I hope you with us for 15 extra minutes so we can get through and try to answer some of your questions at least wonderful.

Dr. Charlene Wong

Thanks, Dr tilson. All right, so we wanted I wanted to go over some of our communication strategy and also some of the research that went into what our communication strategy, first to start with we're committed in North Carolina to providing early transparent, consistent and frequent communications, so that North Carolinians trust the information they get understand the risks and benefits of vaccination make informed decisions and know how and where to get vaccination, and that includes all of us as well who are health care providers. Next slide please. We have also committed to creating a proactive inclusive and evidence based communications plan that's guided by research, leads with transparency determines proactive and culturally sensitive and linguistically responsive communications approaches, communicates clearly and engages trusted community leaders. Next slide.

To that end, we really want to make sure that we're addressing vaccine confidence because we actually did a need or another poll for ourselves to know that many North Carolinians are hesitant about this vaccine, a particular black African American populations do as Dr Tilson mentioned to long standing and continuing racial and justices in our healthcare system. Instead, we partnered with Niemand collaborative and Artemis Strategy Group, to do our own work to uncover the underlying drivers of awareness, choice and action in healthcare decisions to generate actionable data. And so our research really examined perceived benefits emotional, motivations and trusted sources and spokespeople about the vaccination. Next slide. So we did some very rapid work with a survey of almost 2000 North Carolinians in November. You can see in this breakdown here that we really over sampled for some of our key populations where we knew there would likely be higher hesitancy, also conducted qualitative in depth interviews with another 30, North Carolinians about a third of them being health care workers because we know that they're so important. Next slide. Thank you. Here are just some high level summary findings and also how it has really influenced the way we've developed our campaign. We know that there is some potential for early adoption being weak, because less than half of North Carolinian residents are both adherent health decision makers, meaning they follow, they tend to follow our recommendations and see greater reward than risk in the vaccine but still a lot of them express hesitancy.

Also we found that COVID vaccine is not a normal vaccination product, actually people looked at it more as a new product, and that their experiences with other vaccines for example flu vaccine don't really necessarily apply. We also found that North Carolinians are mostly taking a wait and see approach, um, regardless of their demographic, and that women interestingly are the most hesitant and that's something that we're really thinking carefully about because as we all know, women often tend to be the medical decision makers in the family. And that this hesitancy is driven by legitimate concerns about testing, safety, side effects effectiveness this work speed that we all hear about and political polarization. And that these concerns need to be addressed before any discussion of potential benefits. Also the messengers are 90% of message effectiveness and I'll tell you why this affects everyone on this call is because across demographics, who we found to be by far the most trusted messenger were healthcare providers and not any health care provider, but that person's health care provider. And so we really want to make sure that we as healthcare providers are the champion messengers of this of this of these messages around vaccine.

And then also vaccine supplied vaccines in experience play a large role in communications and people are looking for what people like them and their experiences are with the vaccine. Next slide.

So with that in mind, and you know hopefully these strategies can help inform the way that you speak with your patients about that, about the vaccine and we'll also be providing materials. We think the best strategies will be based on the evidence to not frighten people into wanting to take a shot they already fear and take COVID seriously we want to acknowledge their vaccine fears and hesitancy as valid. We want to give people honest information about the vaccine development, testing, safety and reactions. We want to build trust in and during the prioritize vaccine rollout and that includes Of course, those of us who are frontline workers health care workers, help direct our patients, and our colleagues to their spot for reliable information, official sources versus if they are really looking to the community and to their peers, we're really working as you just heard on the logistics of getting people to vaccination sites if they're not as connected to our health care system border ensure everyone has equitable and inclusive access and have a clear call to action that works across all campaign spaces and complements our three W's message. Next slide.

And so here are our key vaccine message themes, we would love for you all to really help disseminate these messages. The first is convey safety and the development process really emphasizing that great care has been taken to make sure that these vaccines are safe and effective. As Dr Tilson mentioned, we talked about it a scientists have been had a head start because they were developed based on years of work in developing these vaccines for similar viruses, but the testing was thorough and successful you guys have asked a lot of great questions in the chat about those trials. We are demonstrating commitment to transparency and inclusivity. Dr. Tilson mentioned our work with historically marginalized population leaders across the state, setting expectations for our patients that those who need it most will get it first in the safe tested safe and effective x team will be available to all want it, but as we were just talking about supplies will be limited. And then our call to action is you have a spot take your shot, and to continue practicing the three W's until everyone has their shot at fighting COVID-19. Next slide please.

And so we wanted to direct you at the top there it is a short web link https://covid19.ncdhhs.gov/vaccines. Everyday we are adding additional materials on already up on the website you can see there are several PSAs that are leveraging trusted voices you see our Secretary there as well as our Deputy Secretary Ben Money, and several long term care workers. I'm talking about COVID-19 vaccine that are already available on our website now for you to use. Next slide. We also have a lot of other materials that we think will be particularly helpful to you all. The first is a new one page flyer that actually just went online today about COVID-19 vaccines that you can give to your patients that will also be available in Spanish. We have a frequently asked questions that is available online in a PDF that is in English and Spanish we are updating that every week because we are getting new information every week. This was also just updated today. We have a COVID-19 vaccines 101 deck, and that it contains some of the material content that we discussed today that was also updated this week. And then finally we have the infographic on prioritization, that you all saw today, there is much more on the website but one of the highlights some of these pieces that we think you all would find particularly useful and again I'll just call out that one page flyer, because we have been asked by practices is there something I can start posting handing out to patients and this is what we've created, and there will be much more coming in a toolkit. Next slide. I think that's it.

Dr. Betsey Tilson

Wonderful. All right, look at that, well we're only five minutes over which are our planned remarks, and I am actually scrolling I hope you can hear me I'm scrolling through some of the questions I've started answering some of them electronically. I'm scrolling through the questions a lot of the questions are yes I'm so sorry the links in the presentation didn't work but the links will be live when, when the presentation is posted. Let me see. I'm going to get through some of our questions. One of the questions that we get this a lot. What are the plans for children under 16. What is the estimated time for availability for under 16. So that will really depend on the clinical trials Pfizer did include people 16 and up. So that's why there was data and ACIP was comfortable recommending 16 and up, Madonna and Pfizer all have plans for enrolling children 12 and up, they haven't started, I don't believe enrolling those kids yet but that is in the queue so we'll have to see when we have data for that, but I still haven't heard any news of children under 12 so those, you know the elementary school children so we'll have to wait on a little clinical trials and, or if the Advisory Committee on Immunization practice, ACIP feels comfortable maybe with the data, the 12 and under how low they would go for their recommendation so I think we'll have to wait wait on that.

Um, let's see Christoph said you have a q&a anytime we'll show up where your warriors Thank you Christoph you are awesome sauce. And we will work to set up a q&a as much as we can. Ah, let me see. Okay, so a lot of questions, some questions again about help us define 1A help us to understand how outpatient providers fit into one a and I know this is a little bit squishy. But again, that's what I was at the beginning, saying that, unfortunately, as Dr Fuller Moore said we won't, we don't have enough vaccine for everybody day one, I wish I really, really, I promise you I wish we did. So instead, again it is this risk based prioritization both the risk of exposure and the risk of severe illness. So in the phase 1A again originally we had in our head those again, the healthcare team, taking on the COVID units in the ICU, intubating, doing CPR on you know all day every day on COVID 19 patients or again EMS go into the home and doing CPR on a COVID-19 patient or hospice and home care, who are going and doing direct patient care for COVID-19 patients, day in and day out. But we also do recognize that there are some outpatient settings that have a higher risk than a typical outpatient setting. And so again if it is that you as an outpatient setting and you really are dedicated, you are a team, or your, your setting is really dedicated to COVID care or you're in a respiratory diagnostic center maybe some practices I know they've set them up but they're sending all their respiratory patients to either one team or one site so your art of respiratory diagnostics center, you're really focused on COVID-19, or you are a provider out and doing community based testing day in and day out so above and beyond the, the normal risk of an outpatient provider, could be that in that 1A. And again, all outpatient providers if they themselves have two or more chronic conditions that put them at risk for severe illness, and they're, you know, direct patient care. They are all in 1B. So, I know I wish I could just say this is absolute, this is the clear line but that is what we're getting at those people with that really increased risk of COVID exposure above and beyond normal outpatient exposure.

Um, let's see, have a couple more minutes. We had a couple other questions about contraindications, allergies contract indication and again the only contract. The only firm contraindication that we have right now is that if you have a known anaphylaxis to the ingredients in the vaccine and again the ingredients of vaccine is a little bit of the RNA of the backs of the virus I'm not quite sure how anybody would know if anaphylaxis to the, the RNA of the virus, but it really is more the lipid. So, anyone known anaphylaxis

have that polyethylene glycol. And if they've had a severe allergy to an injectable or a vaccine there's a warning on that, but not that there was a question about not like severe snake venom or animal exposure, bee exposures, shellfish exposure, none of those types of allergies is considered a contraindication or a or a warning.

Alrighty, oh another question this is great is what documentation what people need to prove that they are in a priority group. It really is, so there's a couple ways that people be identified as a priority group one is we talked about especially with health care employers health care employers can really identify which staff. They are identifying as at higher risk of exposure and either they're doing their own vaccination clinic and they've identified their risk or again working, if you're not affiliated with a healthcare system working with your local health department or your hospital, and to say hey, especially with our local health departments because they'll be setting up clinics for that 1A that the employer that could be identified how to say hey I'm sending over these, these people, but we'll also as, especially as we move more into the 1B and that's going to be more of a community based vaccination, then it'll be somewhat of a self attestation because we were afraid that there would be a barrier especially for those without great ready access to health care system we didn't want there to have to be medical documentation for people so there'll be somewhat of an honor system that they people fall into on the prioritization categories.

Um, a couple questions where to dentists fall into that so dentists for example may be impatient dentists that are doing an intensive treatment for COVID patients. They may be in the 1A otherwise dental offices would be falling far more in that phase two, with other outpatient practices. Um, a couple other questions about frontline workers like clergy and other frontline workers. So any non care health workers so anybody any person that has two or more conditions that put them at higher risk fit into 1B, and then a special priority of those that are frontline workers, but in phase two, any frontline worker that has a lot of interaction with the public, including clergy, without any chronic conditions they would fall into a phase two.

Dr. Amanda Fuller Moore

Dr. Tilson, I had a couple that I answered that give a verbal answer to say answered it several times. Related to pharmacies and reporting so there are a number of pharmacies participating in the federal program receiving their allocations directly from the federal government. They have some required reporting to CDC and so we are working to ingest that information into our system. Pharmacies that enroll directly with the state and receive their allocation to the state will report using our CVMS system. And I saw several questions related to how are we going to be sure that the hospital's stick to the prioritization. So one of the pieces that have been added to the provider agreement that all providers agree to is that they will abide by their jurisdictions for prioritization framework. So we have been very sure to share that with enrolling providers, make sure they are aware of, we're in 1A, we are only vaccinating 1A and what they should do if they vaccinate all of their internal 1A staff, they should then reach out into the community and help with the community effort of vaccinating 1A. Once we have enough doses in the state spread across the state to get to a point where we believe we should have reasonably been able to vaccinate, our 1A people, and seeing the data come in on vaccination administration's into CVMS, we will be able to signal to everyone to move to 1B, so they are agreeing in provider enrollment, to stick to the prioritization that North Carolina has put out, we've already been made aware of a couple of snags in

that and we have been in contact with hospitals where we thought there might be any question about that. We are asking people to really stick to our prioritization as presented. Two things, Dr Tilson.

Dr. Betsey Tilson

Great. And we are at 7:15, there are a ton of other questions I wasn't sure if either Danielle or Charlene as you were trolling through the questions. Are there any other ones that you want to be sure that we get to otherwise.

Dr. Charlene Wong

I think there were Dr. Tilson start shortly and I think that one that's in here multiple times is when will we be moving to phase 1B or phase two, and I think we've sort of addressed that a couple times but just to say it again because it keeps coming up. It depends on when we get the vaccine supply, to be able to move from phase to phase.

Dr. Betsey Tilson

Yeah, yeah, I hope as quickly as possible you saw in one of the slides early on we estimated, how many people we thought were in those groups and then you've seen what our allocation is so it all and as Dr Fuller Moore said, We don't even know how much Pfizer we're going to get next week, so we don't have great visibility into exactly how many doses we're going to get when, to really be able to predict how quickly we can move the phases obviously we want to move to those phases as quickly as possible and get to people as quickly as possible. We just don't have the numbers from the federal government to know our hope is that we can move to phase 1B, maybe in January mid to end January I shouldn't even say that out loud, maybe and then maybe February into phase 2, but it all depends on how much vaccine we get. We will be moving to push that out as quickly as possible. But it all depends on how much we get and as I alluded to, we don't even know how much Pfizer we're going to get next week. So we are we're working as hard to push it out as much as possible.

Anything else that caught your attention Dr. Wong that we want to be sure that we get that we get to?

Dr. Charlene Wong

So many others but I think that was one that just came up so many times to say it out loud.

Danielle Brady

Yeah, yeah. Okay, Dr. Tilson If I could just jump in real quick on CVMS. There were a couple folks asking how they get access to it. And if they can have the link. The link is not something that we can just send out because there are some very specific steps that have to be taken in order to get you into CVMS, and we haven't begun those steps with private practice just yet. Once you are enrolled you do get an email

from the system with a link, asking you to login with your NC ID. And I know that Cone health has asked that they're having some sign on issues some single sign on issues and Dan if you could just send an email with the five people who are still having problems. I will take a look at that tonight and see what I can do.

Dr. Betsey Tilson

And another question that comes up as well on the CVMS and then I promise we'll stop is right when, when will the bulk of all of outpatient providers will be able to enroll in CVMS. So a couple things just to point out one that Amanda had said that we are standing CVMS is brand new and Danielle went over this as well. It is brand new, we are in the minimal viable product right now there are kinks we are still working out. So we want to be sure that we're working out those kinks before we open up to the 1000s of providers that we really desperately want to enroll. But right now, I will tell you, it'll be exceedingly frustrating for you to try to enroll as we're working through some of these kinks so one is for your own sanity. We want to make sure that it is up, and we've gotten all those kinks worked out so that it's an easy glide path for you. And, and then second we want to be sure that as we're enrolling providers because that we also are getting, we'll be able to get that vaccine to you as we are enrolling so we hope to maybe over. We would rather under promise and over perform, but I think realistically just so you know that probably, it'll be the beginning of January we think until we open up to full providers. Just so setting that expectation and again as Dr. Moore said, we have will have very limited supply of vaccine before that. So even if we were to enroll you we wouldn't be able to really push vaccine out to you for a while anyway so. Set your expectations for probably the beginning of January, to have that wide open provider enrollment and at that point the system hopefully is working much more smoothly it'll feel an ease and then we can get you enrolled and then as we're getting more and more supply we can start pushing vaccine out to you.

Okay with that lots of questions so then at the very top I said that we could maybe collect some of those questions and I think since we have so many questions, we'll try to see if we can just do an open hour, an open office hours. Next week, and just kind of answer questions but we just we wanted to be sure we got a lot of that foundational information to you. But we can do more of an office hours. Next week to go through some of the frequently asked questions that we didn't get to tonight.

Okay, with that first, and thank you for staying 20 minutes over for us. I can tell people are still on because we're still getting questions so thank you, too. I want to thank AHEC in the Peds society and family medicine and CCNC and the psychological association and Medicaid and all the community health centers the Hospital Medical Society, I'm sorry. I shouldn't start naming yay. Thank you for helping us to organize this, and then our DHHS team who have been promised you have been working 24 7 and I know it is frustrating that you can't get on to CVMS right now I know it is frustrating that you're not in 1A, I know as frustrated that you don't have vaccine today, I noticed frustrating that you can't answer all your patients questions I know that and I promise you, but I also promise you, our team, literally, are up all night long. Up 3am, 4am they are working 24 7 to get this to you as quickly as possible so I will ask you for your grace for your patience and to know that we are working very hard and we are getting out to you and I and I wish we had all the answers and all the systems and all the vaccine that we possibly could have day one, but we are working there. So I ask again for your patience for your grace and know that we are working as hard as possible for you. What is really the biggest and most complex public health

vaccination campaign in history. So it's not going to be perfect day one, it's not going to be perfect day 60, but everyday we will be better than the day before, everyday we will get more vaccine out than we had the day before, more providers enrolled, and our systems will work that much better.

I appreciate you being on this ride with us being patient with grace. And I appreciate the service you do for your patients everyday. And with that, we will end 22 minutes late, a record! So thank you, we will set something up for Q&A and take a little break over Christmas and in the new year we will be sure we are setting up regular communications as well. Thank you and good night!