Medi-Cal Managed Care Plan Name:	Partnership HealthPlan of California

1. Describe how the MCP will provide evidence-based information to members, providers, community-based organizations (CBO), tribal partners, and other local partners about the COVID-19 vaccine to encourage vaccine uptake from all members. Character limit: 2,500 characters.

Partnership HealthPlan of California (PHC) has four regional offices, located in Fairfield, Santa Rosa, Eureka, and Redding, in our 14 county service area. Each office has a designated leader who is responsible for collaborating with their local communities. Throughout the pandemic and across all counties, this regional management team has actively participated in Vaccine Collaboratives comprised of universities, tribal health centers, federally qualified health centers, local governments, K-12 schools, and county health departments. These collaboratives planned and executed of large scale COVID-19 vaccine clinics. Vaccine Collaborative meetings occur weekly to monthly, depending on the county. Our regional teams collect and share best practices across our service area in order to synergize with activities in each county, including collaboration with local health departments and CBOs.

PHC also hosts quarterly Clinic Consortia meetings in each region. These gatherings will be leveraged to provide data, discuss best practices, support each community, and promote access to the COVID-19 vaccine.

In both the Vaccine Collaboratives and the Clinic Consortia meetings, special attention will be given to progress toward outcome goals, particularly in the priority populations: persons who are homebound, Black Native American, and teens and young adults.

Evidence-based materials shared with providers include up-to-date materials provided by the Centers for Disease Control (CDC), California Department of Public Health (CDPH), The Medical Letter, and our county health departments. PHC also provides evidence-based materials from the CDC and CDPH to our members through the PHC website, the member newsletter, our COVID vaccination media campaign, and through PHC social media accounts.
PHC will share data on member vaccination status with our provider network to identify members that have not been vaccinated to recommend vaccination, understand their individual questions about the vaccines, and to understand their individual barriers to vaccination. This effort will focus on an individual targeted approach that leverages a trusted messenger to address a member's hesitancy, an approach that will be more effective for the vaccine hesitant than a general vaccine marketing campaign.

Each of these opportunities, and others, will give PHC a platform to discuss effective member messaging to encourage vaccine uptake. This will also include the sharing of messaging and collateral to be used in provider offices and throughout the community.

2. Describe how the MCP will provide information on where to get the vaccine within the member's community. Character limit: 2,500 characters.

Since the COVID-19 vaccine became available, and continuing today, PHC has posted vaccine locations on our website and shared community clinic sites on social media. These include links to myturn.ca.gov, pharmacies (CVS, etc.), and other vaccine finder sites. This information along with vaccine FAQs are consistently shared with each member-facing department. Additionally, in collaboration with local community groups, PHC's Population Health team outreaches directly to members about locations of vaccination clinics in our service area.

As PHC partners with vaccine clinics, we will promote the events throughout the community with print media, and outreach via radio and television media (as appropriate in the particular community where the event is located) to increase event awareness.

Additionally, PHC plans to work with pharmacy chains to provide vaccine information on pharmacy prescription bags that will prompt pharmacy staff to offer the vaccine to an unvaccinated individual, or if they can help answer any questions about the vaccine.

In all outreach activities in which PHC is involved in publicizing one-time events such as pop-up clinics and mini-vaccination teams, special attention will be given to outreach to priority populations: persons who are homebound, Black, Native American, teen (12-17 years of age), and young adult (18-29 years of age).

3. Describe the MCP's plans for a local media campaign to disseminate information to members about vaccines, resources, and availability. MCPs can consider amplifying existing media campaign efforts using a variety of media channels. Character limit: 2,500 characters.

PHC will continue to maximize our digital communications to inform members where they can get vaccinated in their community, including using paid ad campaigns, social media, paid influencers, and local news outlets. PHC will be utilizing digital communication channels to target specific communities identified in question 1.

CDPH has noted that individual one-on-one discussions with a trusted primary care provider (PCP) is one of the most effective ways of addressing vaccine hesitancy. Messaging through social media, outdoor advertising, and local community gathering locations will include complimentary messaging encouraging members to connect with their PCP to answer questions and concerns. The recent FDA approval of the Pfizer vaccine provides a new information that we will utilize in order to emphasize the safety of the vaccine in our messaging.

PHC will also identify opportunities to capture earned media through outreach to various local media in order to promote specific vaccine clinics within the community. We will be looking for opportunities to partner with community influencers to enhance this outreach.

In prioritizing options for the media campaign, PHC will give special attention and consideration to priority populations: homebound, Black, Native American, teen, and young adult.

PHC is working with some of our local Community Health Information providers to include PHC resources related to COVID vaccination.

a. Describe how the local media campaign will counter misinformation. Character limit: 2,500 characters.

Consistency is critical in vaccine messaging. In order to maintain consistency, PHC will identify opportunities to partner with appropriate communities to enhance well established messages. Additionally, PHC will leverage the many communications toolkits – CDC, CDPH, counties, etc., to ensure that the messaging is credible, consistent and continues to build trust in the community. Many of these exiting toolkits already utilize well-tailored messaging to specific demographic groups.

PHC will be working with community partners to identify local experts and trusted community messengers (influencers) to deliver a message of vaccine safety. Where already available, PHC will disseminate PSAs, print, video messages, videos featuring individuals with a diverse background that the community can relate to. For example, in a number of counties, community partners have hosted Facebook live events. PHC will leverage these events to ensure a trusted community member is delivering a message of safety. The goal is for members to see themselves in the messaging and be motivated to act.

b. Describe how the MCP with engage trusted partners and tribal partners where applicable in the local media campaign. Character limit: 2,500 characters.

PHC will partner with trusted messengers, both medical and otherwise, within targeted communities. These trusted messengers will include health care providers, tribal leadership, faith-based organizations, grassroots community organizations, and other community partners, and CBOs. Several members of the PHC Board of Commissioners represent or serve different Black, Indigenous and, People of Color (BIPOC) populations, and their insights have already informed several aspects of this plan. PHC regional managers will collaborate with organizations serving these communities within each county, and maintain relationships with these groups to facilitate dissemination of information and coordinate activities to reach and engage the community. It is our goal to identify these individuals or organizations as trusted messengers to the community that reflect regional and demographic diversity.

Staff from PHC will promote vaccination at high impact gatherings, such as Native American tribal events that draw multigenerational families.

We will also utilize the expertise of our Consumer Advisory Committee (CAC) to identify additional community organizations serving tribal partners with whom we can collaborate with. Our CAC members are very involved in their local communities and can offer suggestions, advice and connections.

PHC is also looking at opportunities to partner with community-based organizations for local media campaigns that may not traditionally be in the health care sphere. We want to meet our members where they are. We hope that this medium will help amplify grassroots efforts that provide opportunities for face-to-face discussions with community members that are hesitant.

4. Describe how the MCP will collaborate with schools and colleges to target youth who are 12-25 years of age. Character limit: 2,500 characters.

PHC is working with several CBOs and public health departments to support school based vaccination clinics. We are actively working across our regions to expand these efforts, as some local jurisdictions specifically requested assistance in this area, including the on-site provision of incentives. We plan to expand these efforts, particularly in areas where vaccination penetration has been low, including those schools and school districts with large BIPOC student bodies.

An effective way to reach young people is through peers and social media. Our communication campaign team is developing messaging specific for this group. PHC will use the media materials they identify and develop when conducting outreach at school and youth oriented sites. We want to identify and involve peer "vaccine ambassadors" at schools who can talk with peers about vaccinations, providing them with information about the safety and efficacy of vaccines, how to discuss and dispel misinformation and provide schedules for standing vaccination venues and planned pop-up clinics. If possible, we will identify "social influencers", local young celebrities and music, entertainment and sports figures popular in PHC's regions to help get out our messaging to youth.

In PHC's Southeast region, our Population Health team is already collaborating with Touro Medical School, Solano County, and other partners to assist with clinics at middle and high schools. PHC will expand those efforts to reach more middle and high schools (especially), as well as junior colleges and colleges. We will expand collaboration with local CBOs, clinics and public health departments providing on-site vaccination clinics, including the provision of incentives and media materials. PHC will tailor the incentives we offer to be attractive to the groups with which we are working, within the DHCS regulations around incentives.

We also plan to scale the model started by our Southeast Region to residency programs and nursing schools in our other regions. The young healthcare providers at these learning centers are usually enthusiastic, energetic and eager to assist with community-based projects. These young people may be more readily accepted and trusted by the young people they will serve.

PHC plans to hold vaccine campaign events and partner with healthcare providers to present pop-up vaccination clinics at youth and adult sporting events on weekends, and at schools and city/county sports leagues.

5. Describe the MCP's strategy for countering misinformation and reaching vaccine hesitant individuals who may have a fear of vaccine side effects, have a mistrust of the government and/or vaccine makers, believe that vaccines are not needed for persons in good health or persons who have already had COVID-19, and/or have an insistence regarding a person's right to not be vaccinated. Character limit: 2,500 characters.

Partnership has two strategies for addressing misinformation and vaccine hesitancy. Based on our conversations with our members, we categorize reasons for begin unvaccinated as follows:

1. Passive: Includes individuals not worried about contracting COVID, those too busy to get around to getting vaccinated or with limited access to vaccine sites, those with other competing things going on in life, those with previous infection who think they are immune,

those with vague fears of vaccination but who have not weighed the options carefully, and those who would like to be vaccinated but are subject to social pressure not to be vaccinated.

2. Hesitant/Vaccine Curious: Individuals in this group have typically done extensive on-line searching and reviewing of materials they find in internet searches, from social media, in their email inboxes, or ads with enticing titles within their other usual internet activity. They may have taken other vaccines in the past (i.e. they are not opposed to all vaccinations), and might be willing to take the vaccine in the future, if some conditions are met (like a vaccine is fully approved by the FDA, or a vaccine that did not involve human stem cells at any point in its production is available).
3. Opposed: Individuals unwilling to be vaccinated, with deeply-held beliefs that will not be swayed with new information or evidence, even from a trusted source. They often have refused all or some other vaccines for themselves or their family. This category includes those with beliefs that all vaccines are prohibited by their religion.
4. Medical Contraindications: The proportion of our membership in each group varies by the social and ideological environment in their immediate community and the wider county/regional level. We are exploring the usefulness of Google Health COVID Vaccine Insights to break down different geographic areas into the relative prevalence of these groups. This may help more with community-wide activities than individual outreach, in which a respectful individual inquiry approach is best.

PHC's strategies for addressing misinformation include:

A. Provider education on best practices for communicating with unvaccinated individuals, including ascertaining which group they are in, understanding their concerns, finding shared aligned goals and sharing information and stories in a respectful way. This is done through our medical director newsletters, and promoting trainings from CDPH and Kaiser, available on-demand.

B. Posting and linking to trusted, objective, and factual resources in materials on the PHC website, member newsletters, and social media accounts, particularly resources that specifically address common misinformation.

6. Describe how the MCP will partner with trusted community organizations (e.g., Indian health facilities, faith-based partnerships, advocacy groups, food banks, race/ethnic based organizations) that can assist with outreach, communication content and messaging, and identify strategies as defined above, which can be used to also target Medi-Cal Fee-For-Service beneficiaries. Character limit: 2,500 characters.

In August 2021, PHC engaged stakeholders in our 14 counties to identify:

1. Current vaccination activities
2. The highest priorities
3. Trusted and effective CBOs (Community-Based Organizations)
4. Best practices for increasing vaccination
5. Lessons learned/practices that have not been as effective

CBOs identified in this process included Tribal Health, faith-based organizations, advocacy groups, race/ethnic based organizations, First 5 Councils, county health coalitions, community colleges and universities, K-12 schools, neighborhood organizations, community health centers, and others. CBO's are often best positioned to assist in the following ways: State of California

1. Publicizing, promoting, and supporting:
    a. Popup vaccination clinics.
    b. Standing (regularly scheduled) vaccination clinics.
    c. Mini-vax teams (2 person teams going to remote areas, to homebound individuals and going door-to-door).
2. Providing logistical support for distribution of mRNA vaccines to sites with no freezer.
3. Training workforce (e.g. community health workers) to be effective communicators of information about vaccination, including a respectful and person-centered approach for the vaccine hesitant.
4. Performing outreach activities, including by text, phone, social media etc.

CBOs need both monetary support and communication/collaborative support. PHC's regional managers and Population Health departments will leverage and expand on existing communication/collaborative relationships with CBOs we identify as being most impactful in each community. A grant program infrastructure will leverage expected incentive dollars to provide monetary support for CBOs. Grants are planned to be awarded on September 20, and should be fully expended by March 1, 2022.

Some principles of evaluating grant proposals for CBOs are:

1. Aligned with county-stated priorities and with ideology/culture of county?
2. Proposed activity helps support other existing activities?
3. Intervention already successful on small scale and needs funding for full implementation?
4. Track record or experience of the CBO that would indicate likelihood of success?
5. County of location of the CBO, competing proposals in the same county, scope of proposal relative to budget?
6. County prioritization based on baseline vaccination rate and proportion of populations of focus?

The activities of the CBOs will be targeted to the low income and vulnerable members of the community, whether they are PHC Members, FFS Medi-Cal members, or other low-income members of the community.

7. Describe how the MCP will collaborate with local public health agencies to coordinate with vaccine response plans and learn best practices, including what has and has not worked. Character limit: 2,500 characters.

PHC considers providing comprehensive health services to PHC members, and the communities in which they live, to be a partnership between PHC and local public health entities (LHDs). For years, PHC has held biannual meetings with the County health officials of the counties within its catchment area.

In preparing this plan, PHC met with local health department leadership and vaccine program staff to describe the project PHC is embarking on and obtain their assessments of vaccination status in their jurisdictions, successful strategies, what didn't work, and remaining challenges to their work. PHC will

continue to meet with LHDs throughout the project period to ensure successful coordination and the ability to pivot as needed as the situation on the ground changes.

Additional areas of coordination include:

- Education and outreach: To the degree desired by the LHD, PHC will use locally developed educational materials and key messages or those recommended by the LHD. PHC will also provide materials for LHDs if requested. The goal is for all PHC supported/conducted education and outreach to be coordinated with existing local outreach and designed to increase the reach of, rather than to supplant, existing LHD work.
- Trusted messengers: PHC aims to work primarily through trusted messengers in providing information regarding COVID vaccines and in increasing ease of access to vaccination. PHC will work with trusted messenger organizations and individuals known to and recommended by the LHD as successful partners. In supporting community-specific "pop-up" vaccination sites PHC will support LHD vaccination efforts and/or those of CBOs recommended by the LHDs.
- PCP provider vaccination: PHC seeks to increase the number of primary care providers willing and able to provide COVID vaccination during routine office visits. Accomplishing this will require close coordination with the LHDs (to the degree they are able) to ensure that clinic registration with MyCAVax and CAIR are successful. PHC will prioritize providers the LHD feels are most likely to be successful.
- Several counties within PHCs coverage area are currently severely impacted by fires. PHC aims to assist these LHDs in whatever ways possible to maintain COVID vaccination efforts while the LHD's provide necessary support services to those impacted by the fires. PHC will make every effort to ensure the work of this project imposes no additional burden on these or any other LHDs with whom PHC is coordinating.

8. Describe the MCP's efforts to build additional capacity to address member vaccination needs in future years (identification, education, and follow-up). Character limit: 2,500 characters.

Public health experts predict the future of COVID will be a seasonal increase in cases, requiring annual booster vaccination, containing the strain of virus thought to be most likely to circulate that winter, and the potential pairing with an annual influenza vaccine. The high-priority target for this annual vaccine will be vulnerable populations, but annual COVID vaccination will be offered to those of all ages, likely down to 6 months of age. As such, COVID vaccination must be built in to the community vaccine infrastructure, like influenza vaccination. Extrapolating on how annual influenza vaccine is provided, this will include providers' offices, hospitals, community pharmacies, county vaccination clinics, and work-based vaccine offerings.

In addition, starting in 2022, PHC anticipates an annual COVID vaccination to be incorporated into the VFC vaccine distribution system currently used for pediatric vaccines in provider offices and county health departments.

PHC has a long history of supporting the infrastructure of vaccination. Pay for performance measures for vaccination of children and/or adults, and the consistent use of CAIR are found in PHC's Primary Care, Hospital, and Perinatal Pay for Performance programs. Thanks to these past efforts, many of PHC's PCPs are already providing vaccines routinely, and most of the rest are providing vaccine on scheduled days.

Our plan for quickly increasing vaccination rates of the Medi-Cal population in our county includes elements that support long term vaccine capacity. Our plan includes several tactics for encouraging primary care providers and hospitals to routinely offer COVID vaccines at all sites at all times. For PCPs, we are planning an incentive program that requires them to give vaccines in the office, record all vaccines in CAIR, accept a gap list of patients PHC believes are unvaccinated, and do outreach to encourage these individuals to be vaccinated. This incentive program will be complemented with leadership engagement, publicly comparing PCPs and hospitals, and sharing of best practices.

It is certain that new pandemics will arise in future years requiring mass vaccination. Capturing knowledge we gain, in terms of best practices and lessons learned from COVID vaccination, and periodically referring back to this in community simulation exercises will be essential to planning for the next pandemic. PHC will carefully document the knowledge we gain in the process of supporting community COVID vaccination.

9. Describe how the MCP will provide information and support for members with access barriers, especially transportation, navigating appointment systems, and language needs. Character limit: 2,500 characters.

PHC performs member outreach calls and mailings offering help to vulnerable members and those with access barriers. We have many bilingual staff members and also have the ability to utilize contracted translators when calling non-English speaking members. They ask if members are vaccinated, offer assistance scheduling appointments for the members while on the call, and offer to arrange transportation, as well. PHC has contracted with vendors to provide transportation to and from vaccination sites. PHC offers members translation services at provider sites.

In media campaigns, we will include messaging to encourage members to contact PHC if they need transportation to attend a vaccine appointment.

In addition to focused outcall campaigns, members who contact PHC are assisted with identifying a vaccination clinic close to them and scheduling an appointment during the call. PHC has contracted with interpreter services to assist members who call into Partnership asking for help scheduling appointments. Members who have already scheduled a vaccination appointment may call PHC and request transportation to their vaccination appointment, and these services are provided at no charge to the member.

Through the grant process developed for this project, PHC will also support already existing and additional Mini-vax teams operated by LHDs and CBOs to vaccinate homebound members and others who cannot go to standing vaccination sites (this includes members who fear community stigmatization if they are seen going to be vaccinated).

10. Describe the MCP's current primary care vaccine access and how the MCP will collaborate with primary care providers (PCPs) to conduct direct outreach to unvaccinated members assigned to that clinic's/doctor's office.

a. Describe the MCP's current primary care vaccine access, including an analysis of any pockets and/or regions that lack access. Character limit: 2,500 characters.

The PHC primary care network is composed of Kaiser as a full risk Plan, multi-specialty group, individual physician, physician groups, FQHC/RHC and Tribal Health centers. PHC contracts with all willing and qualified primary care providers; DHCS and NCQA audits have found our primary care coverage to be adequate. Direct Members are assigned a medical home (for example children with CCS), but not capitated to a PCP. Other Direct Members typically receive primary care services from a contracted PCP.

PHC has surveyed all of our PCP sites (including some parent organizations answering for multiple sites). A majority of the PCPs are either offering vaccine by appointment only or during a regular visit. There is incomplete access to COVID vaccine in the PCP offices in our network, which includes 2 regions. Our Northern Region counties include: Shasta, Trinity, Humboldt, Modoc, Del Norte, Siskiyou, Lassen. Our Southern Region counties include: Solano, Napa, Yolo, Sonoma, Marin, Lake, Mendocino.

Reasons given for not providing routine vaccination include:

1. Concern about wasting vaccine doses.
2. Other providers better suited to provide vaccine/referred to affiliated organization or site, for efficiency.
3. Corporate policy deferring provision of vaccine for now.
4. Space/staffing challenges (licensed staff monitoring patients after vaccination for reaction).
5. Excessive administrative burden with signing up with myCAvax.
6. Only logistics for J&J vaccine, which is in low demand.
7. Want to offer outdoors and don't have space to do so.
8. Lack of demand.

PHC will prioritize interventions based on providers that indicate a lack of access, proportion of members affected, and the proportion of priority populations of focus.

b. How will the MCP collaborate with PCPs to conduct outreach to members? Character limit: 2,500 characters.

- Generation of "Gap Lists" - Beginning 8/30/21 (awaiting the refresh of CAIR data), PHC will generate PCP site-specific lists of members showing in CAIR as not yet vaccinated. The lists will be distributed to PCP offices to facilitate member contact. These lists will be updated regularly (frequency TBD).
- PHC's Provider Relations (PR) Team and Regional Directors have well-established relationships with our PCP offices and frequent contact with these providers. Future contact will routinely include communication about how PHC can assist with member outreach and

contact, utilizing generated gap lists. Our PR representatives and Regional Directors can target those sites that are struggling and/or have the largest gaps to offer additional assistance. PHC is prepared to leverage staff from Care Coordination, Population Health, Member Services, and other departments as needed to assist with the member outreach campaign.

- PHC will include opportunities at our committees with external PCP partners (e.g., the PCP Pay for Performance Advisory Group, Quality/Utilization Advisory Committee, Physician Advisory Committee) to solicit feedback regarding the provision of vaccines in their offices and clinics and how PHC can support those efforts, including member outreach.
- PHC's Care Coordination team is already contacting identified high-risk members and homebound members to encourage and facilitate vaccinations. These efforts will continue and will include information that many PCPs are offering vaccines and about the now available member incentive.
- PHC's Communications team has member-facing messaging for our website, member newsletter, and telephonic "on-hold" messaging system. Messaging will inform members that vaccines are available at many PCP offices.

c. How will the MCP encourage more PCPs to enroll as vaccine providers? Character limit: 2,500 characters

PHC is collecting data on PCP COVID vaccination status every two months and sharing this widely with public health officers, community clinic consortia, county vaccination collaboratives, PHC advisory committees and Board of Commissioners, in an attempt to use comparative data and social pressure to induce lagging providers to agree to provide COVID vaccination at all sites at all times.

In addition, a multi-tiered program will provide fiscal incentives for PCPs administering vaccines on site.

All participating sites must show proof of registration with myCAvax.cdph.ca.gov to participate in this incentive program. Incentives from the state are available to subsidize this process.

Vaccine Plan Implementation - For registered PCP sites, PHC will offer a one-time incentive for submitting a plan to offer vaccinations at their site. Plans must include the following details:

- Vaccination process – address where vaccines will be given, patient monitoring
- Vaccine storage – demonstrate proper vaccine storage
- Inventory control process – ensure a steady vaccine supply
- Documentation – address CAIR entry
- Outreach plan – describe plans to conduct outreach to unvaccinated PHC members using internal data and gap lists from PHC
- In-reach plan – describe process for offering vaccination to each patient presenting for care
- Describe marketing – posters, mailers, radio, social media, etc., including locations and specific target audiences and available languages

Report on Implementation - Report on vaccination implementation progress. An incentive of (TBD) to be paid upon approval of received reports, which must contain:

- Date vaccines first routinely offered
- A copy of the vaccine inventory control log
- A summary report on results of vaccination outreach and in-reach campaigns
- A description of marketing approach for publicizing vaccine availability

Per Member Vaccination Bonus

Starting 8/29/21, PHC will offer a bonus for each member vaccinated and entered into CAIR. CAIR documentation is required to receive this incentive.

High performer Pay for Performance Bonus Incentive

Any eligible site with a PHC member vaccination rate by 02/28/22 that is >20% higher (up to a maximum of 85%) than their home county's overall vaccination rate at program onset (8/29/21) will have a multiplier applied to their points earned in the 2021 PCP Pay for Performance.

11. Describe the MCP's strategy for supporting vaccination pop-up clinics and other vaccination sites, especially in communities of color and/or other communities with lower vaccination rates. Character limit: 2,500 characters.

As noted earlier, in question 6, PHC investigated the vaccination strategies of all 14 counties in our service areas and worked with local county health departments to prioritize future vaccine outreach activities. This included

1. Fixed sites offering vaccination at set times
2. Pop-up clinics (generally with teams of four) able to run mini-mass vaccination events associated with events, remote locations, employers, schools, cultural institutions
3. Mini-vax teams of two able to more efficiently serve smaller populations, community pharmacies, provider offices, and hospitals.

PHC will use the grant process outlined in question 6, above, to support vaccination sites.

We have identified the geographic areas and with the highest concentration of Black and Native American populations (which are our two lowest vaccinated race/ethnicity populations), along with the providers who serve them. We have identified CBOs who currently partner with counties or other coalitions to run different types of vaccination clinics. PHC specifically gathered information about which organizations have a track record of success with promoting vaccination in these populations. These organizations will be encouraged to apply for funding through the previously outlined grant process. The target population ethnicity and vaccination gaps will be important factors in evaluating different options for grant funding support for vaccination clinic options.

In addition, PHC's Population Health Department Staff will provide staffing support, publicity, and coordinate distribution of member incentives at many of these vaccination events over the next 6 months.

12. Describe the MCP's strategy that can be used to make getting a vaccination as convenient and easily accessible as possible. Character limit: 2,500 characters.

PHC's plan is to publicize the many fixed locations that vaccines are available, to promote pop-up and mini-vax teams for locations and events likely to be attended by those who are unvaccinated but willing to consider vaccination, and to promote routine offering of vaccinations in the inpatient setting and emergency department of all hospitals in our region, and also at all PCP sites, at all times in our region.

CBOs help define options for deploying pop-up clinics and mini-vax teams, with the goal of making receiving vaccination as convenient as possible, whether in workplaces, schools, churches, events, neighborhoods, congregate living facilities etc. As noted in question 11, these clinics are supported and promoted by PHC in many different ways. This approach is essential to reach the passive and hesitant populations of unvaccinated individuals, as outlined in question 5.

PHC's Population Health team has done multiple outreach campaigns targeting the elderly and members believed to be homebound, offering assistance scheduling vaccinations along with transportation to vaccinations.

In some instances, CBO or County partners have been contacted to send a home-visit vaccinator. This outreach effort to home-bound members will be repeated to see if any who declined vaccination in the past may have changed their minds.

a. Describe how the MCP will collaborate with CBOs, trusted local partners, tribal partners, community health workers, promotoras, local health departments, and faith-based partnerships to serve the homebound population. Character limit: 2,500 characters.

Since the onset of the COVID-19 pandemic, PHC has aimed to meet the emerging need of the homebound population. Beginning in March of 2020, PHC's population health team has coordinated outbound calls to over 75,000 vulnerable members including the elderly, those with chronic conditions, and those believed to be homebound.

Vaccinating our homebound members is met with many challenges including; ensuring proper vaccine storage, logistics, and a lack of available personnel to administer the vaccine. PHC will leverage our relationships with county governments, public health departments, and community groups to overcome these barriers in the following ways:

Member-level Data: PHC can leverage data to help identify members of the unvaccinated homebound population in our 14-county service area. Sharing this data will allow for more coordinated outreach with local county and public health department strike teams in geographic areas where vaccines are needed most. Data can also be used to prioritize unvaccinated members who have high-risk medical conditions. In our collaboration with CBO's and local and tribal governments, PHC will be judicious with sharing available data to target outreach to this population.

Pop-up clinics and mini-vax teams: Mobile teams are already being utilized by public health departments or local governments within PHC's service area. In one example, residents may call a phone line, available in three languages, between 7 a.m. and 8 p.m. to receive a vaccination in their home on the same day. Staff from the county HHSA will then drive to a resident's home to administer the vaccine. Building upon this model will increase the vaccination rate of the homebound population. Through the grant process described in question 6, PHC will support the highest leverage mobile vaccination teams with funding, personnel, and/or additional resources.

Community groups: In all 14 counties in PHC's service area, our regional management staff are active participants in Vaccine Collaboratives, made up of universities, FQHC's, consortia, local governments, K-12 schools, and county health departments. Additionally, the PHC Population Health Department will dedicate staff to monitoring and participating in vaccine outreach and other activities to promote COVID vaccination in each county. PHC's connection and participation in community groups will assist in reaching communities, faith-based organizations, and CBOs to which our homebound members might belong.

13. Describe how the MCP will collaborate with pharmacies to share data on members' vaccine status or other efforts to use members' visits to the pharmacy as an opportunity to increase vaccination rates. Character limit: 2,500 characters.

PHC is collaborating with community pharmacy operators and leadership to help create a pharmacy point-of-service intervention by the pharmacy technician and/or pharmacist. Working with PHC's Pharmacy Benefit Manager (PBM) and internal data analytic team, we will identify members not just by the pharmacy they use, but also by key characteristics that pertain to member's risk for COVID disease and demographic health inequities. Providing pharmacies with a targeted list of members for COVID-19 engagement will help streamline workflow and optimize resources expended by the pharmacies for this effort.

In addition to data sharing, PHC is exploring opportunities to incentivize direct face-to-face member consultation by the pharmacy team at point of service (POS). One potential program is CVS's HealthTag initiative whereby PHC will identify unvaccinated members to prioritize and target for this intervention. When the member fills their prescription at CVS regardless of which CVS pharmacy, a COVID-19 specific message will be printed on the member's prescription bag. When the member picks up their prescription at the pick-up counter, the COVID-19 specific message that appears on the prescription bag will prompt the pharmacy team to talk to the member about COVID-19 vaccination. In addition, a QR code is also printed on the prescription bag to provide general information on the vaccine. Through this POS intervention, the pharmacy will not only inform and encourage the member to receive the COVID-19 vaccine, but is also able to offer the vaccination at the time of consultation.

PHC aims to partner with community pharmacies and leverage our data analytics and data sharing capabilities to support pharmacies in the collective effort to better inform the public about the COVID-19 vaccine and improve vaccination rates in our communities. By focusing on key member specific characteristics such as age, where they live, existing medical conditions, previous vaccination history, and ethnicity, we hope to increase COVID-19 vaccination for those at highest risk for COVID disease complications and improve vaccine equity for racial and ethnic minority groups.

14. Describe the MCP's efforts that will bring vaccinations to members, such as mobile units or home vaccinations. Character limit: 2,500 characters

PHC will support mobile vaccine units (sometimes known as pop-up clinics), mini-vax teams of two, and individual home-visit vaccinators to bring vaccines to homebound and members living in remote locations. This will be done in cooperation and coordination with county health departments, local CBOs and local partnerships who promote and staff such efforts. PHC's support will consist of financial support through the grant process outlined in question 6, as well as deploying PHC staff to assist and distribute member incentives, in all PHC geographic areas. A special focus and attention will be on the

Black and Native American populations, which are the race/ethnicity categories with the lowest vaccination rates among PHC members.

15. Describe how the MCP will use data obtained from DHCS to track vaccination data in real time and at granular geographic and demographic levels and identify members to outreach.

PHC uses CAIR data supplied by DHCS, matched to other patient data from our state enrollment file and data obtained from local and regional health information exchanges, to build a COVID-19 vaccination data mart. This will be used to generate baseline gap lists of unvaccinated individuals for Primary Care Providers (PCP) to reach out to, and encourage to be vaccinated. In addition, we plan to use the next refresh of this data from DHCS to populate a Population Health Module in our campaign management system, to allow our Population Health team to do member-level outreach activities, track vaccination status and member incentive tracking in real time. Such outreach activities will be broad-based, but with some prioritization of populations with lower levels of vaccination. The process for collecting updated vaccination data from PCPs, as a result of their outreach efforts, is still evolving. Options being considered include securely sharing spreadsheets of updated information, using an existing web-based data entry system to collect the data and ingest in to our data-mart, or waiting for the information to be updated in the next version of CAIR.

Progress in vaccination will be focused at the county level; for some counties zip-code level analysis and interventions are appropriate.

Of note, vaccine data incompleteness and delays in receiving vaccination data will have an impact on the efficiency and accuracy of using data to drive vaccine efforts. These include:

1. Missing vaccine data in CAIR because a member received a vaccine from a provider who only entered the data into the federal vaccine registry
2. Missing vaccine data in CAIR because a member declined to share their data in CAIR or with other providers (estimated at 5% of all patients in CAIR).
3. Delayed refreshing of CAIR data available from DHCS.
4. Illegible paper-based vaccine data obtained at prior mass vaccination sites not entered into CAIR.
5. Data from prior vaccinations entered into a CAIR profile that doesn't match the profile demographics from DHCS or PHC. (One provider described finding four different CAIR profiles for a single patient, defying easy reconciliation).

PHC will use the data available to perform analyses and track the progress of vaccination of our members over the months to come. PHC's provider incentive program will include a component that will incentivize entry of all vaccine data into CAIR in a way that is captured by the profile used by DHCS to track Medi-Cal vaccination rates.

a. Describe how the MCP will share data with providers, trusted partners, or tribal partners, where applicable to drive outreach. Character limit: 2,500 characters.

PHC has already started to share county-level data on COVID vaccination, provider provision of vaccination and hospital provision of vaccination to county health officers, tribal health centers, community leaders, consortia leaders, groups of PCPs and hospitals and the PHC board of

commissioners. Part of the impetus to sharing comparative data is to spotlight lower performers who may not realize that they are outliers.

This comparative data analysis will be repeated with each data refresh, and shared widely in the months to come.

In addition, PHC is preparing to distribute vaccine gap lists to all PCPs, after the next CAIR data refresh. As described in question 10, PHC will implement a PCP COVID vaccination incentive program in the next month, to incentivize active outreach to these members to encourage them to be vaccinated.

Finally, PHC will also work with one or more pharmacy chains to include point of care reminders to get vaccinated and counseling if the member has any questions for a pharmacist.

16. Describe how the MCP will use data obtained from other sources to track vaccination data and identify members to outreach. Character limit: 2,500 characters.

PHC will use data from CAIR (provided by DHCS), local and regional health information exchanges, data provided directly by providers as they work their gap lists, and data gathered by our Population Health team to track vaccination data and update the lists of patients who need outreach. This data is stored in a data mart, part of PHC's data warehouse infrastructure.

PHC receives data from several local and regional health information exchanges. Data from these sources will be used to update the list of patients who need outreach.

17. Describe how the MCP will determine local misinformation trends and root causes for low vaccination rates/vaccine hesitancy. Character limit: 2,500 characters.

PHC has been conducting outreach campaigns to homebound and medically fragile individuals since vaccines first became available. As we encounter members who do not wish to be vaccinated, we have gathered details on the reasons for declining vaccination, and categorized these reasons. We continue to gather this information over time, summarizing the information for our internal COVID vaccine steering group, which uses this information to educate staff doing outreach calls on how to respond to these concerns or misinformation, as well as posting material to our website and social media sites to point members to more authoritative sources of information.

Our local county health officers are also tracking common sources of misinformation and preparing materials to respond. For example, see the statement by RANCHO (Rural Association of Northern California Health Officers) concerning vaccinations posted on July 14, 2021: https://www.trinitycounty.org/covid19-vaccine which responds to the most common misinformation in the rural northern counties.

Finally, we will be exploring the publicly available Google Health COVID Vaccine Search Insights tool to better categorize the different patterns of vaccine hesitancy in our region.

18. Describe the MCP's plan for administrative oversight of the coordination activities (including controls to ensure no duplicative member incentives). Character limit: 2,500 characters.

With PHC administering activities across 14 counties in California, a comprehensive plan for implementation, execution and oversight is extremely important. The structure includes:

Executive Committee: Provides guidance and approval for selection, funding and execution of interventions.

Project Management Team: This team provides centralized management of all vaccination response activities. Members of this team are tied into all core activities of planning, selection and implementation of interventions. Also responsible for the internal and external vaccine response communication plan.

Regional Management Team: PHC Regional Managers serve as the central resource for their respective counties in the following areas – Connecting with county stakeholders to identify and determine the high-impact interventions to recommend for implementation, coordinate with local county community organizations, engage local PHC staff to execute selected interventions and interact with all vaccine plan response teams to be informed and to inform of activities, issues, changes, successes and maintains effective communications with community partners.

Workgroup Teams: Larger groups of activities are assigned to the following workgroups, to plan and execute interventions. 1) Member outreach, incentives and disparities; 2) Communications; 3) Community and Provider Grants, including grant management that includes external stakeholders for the decision and review process 4) Provider Incentives – by Pay for Performance team; 5) Pediatric/Schools, to target this population, and 6) Data/Reporting. These workgroups will ensure the major components of the plan are executed in a timely way.

Execution Teams / Regional Resources: Geography-specific task force teams will partner with local agencies to execute identified community event interventions.

Controls to Ensure No Duplicative Member Incentives: Member incentives will be distributed to members only after verifying the member's date/site/lot number/body part/dose number of vaccination given. This validation will either be provided by a PHC staff witness at a vaccination event or by a trusted event partner's documentation of vaccination. Each incentive distributed will be tracked within PHC's campaign management tracking system, and may be audited against the CAIR data base. The member incentive system will also ensure that the total value of member incentives provided by PHC does not exceed $50 per member.

19. Describe the MCP's intentional efforts to avoid negative unintended consequences, including but not limited to vaccine coercion. Character limit: 2,500 characters.

PHC's efforts to increase vaccine uptake in the Medi-Cal population include a priority focus on individuals who have not been vaccinated either because they have not felt a compelling need to get vaccinated, those who are considering vaccination but have concerns/questions that remain to be answered, and parents of adolescents who have not been vaccinated. PHC's focus will not include those who are actively opposed to COVID vaccination.

A core value of PHC is Honest, Direct and Respectful communication with each other, our community partners, and our members. As a reflection of this, our staff will be instructed on communication protocols to not threaten or imply to members that they will lose Medi-Cal coverage, have decreased

service from PHC, or any other service related to PHC coverage decisions as a result of choosing not to be vaccinated.

Given these priority populations, PHC's efforts will be focused on addressing the barriers these populations face to vaccinations including:

- Providing scientifically accurate yet accessible education materials and through multiple means including - online and traditional mail, through means recommended by local public health entities, through to local Medi-Cal providers, via person-to-person conversations at vaccine sites, and through community based organizations that are trusted messengers
- Maximizing ease of access to vaccinations by assisting and encouraging primary care clinics and providers to routinely discuss COVID vaccination with unvaccinated or partially vaccinated patients, and to provide vaccination during routine patient visits rather than only on certain days/times
- Provision of member incentives with vaccination

PHC's focus on providing accurate and accessible education, increasing ease of access, and a limited use of small monetary incentives at the point of vaccination, are designed to address reasons for delay in persons who are not opposed to vaccination and will be provided through trusted local entities. These approaches are designed to persuade rather than coerce. Materials provided to the community and local providers will be designed to address patient concerns and questions in a manner that is helpful. PHC will leverage existing accurate and successful educational materials such as those from the CDC and the California Department of Public Health. Providers will be offered training and tools regarding how to address vaccine hesitancy with their patients.

20. Describe the MCP's plan to partner with Subcontractors (i.e., delegated health plans) to increase vaccination rates, coordinate strategies, and implement this Vaccination Response Plan. Character limit: 2,500 characters.

PHC is committed to working with its subcontractor partner, Kaiser Health Plan, Northern California, to improve vaccination rates of its delegated Medi-Cal members, via a number of activities including standing up the direct member incentive program outlined by DHCS. Kaiser's plan will be attached to PHC's plan to reflect activities Kaiser is planning. Here are some of the elements of Kaiser's plan:

A communications campaign will be directed to members who are not yet vaccinated, advising them of the availability of up to $50 worth of incentives for receiving their vaccination. Potential communications modalities include; social media campaigns, email, flyers, mailings, text, phone calls, or robocalls. The campaign will provide members with information on how and where to get vaccines. Gift cards will not be redeemable for cash (except for balances under $10, according to CA law), will be offered for grocery or fitness retailers, and will have the same value for all members (up to $50 per member). PHC will include a statement that restricts the use of the gift card for tobacco, alcohol, or firearms.

The following safeguards will be met: (1) the gift card will be furnished in connection with receiving a required dose of a COVID-19 vaccine (2) the vaccine must be authorized or approved by the FDA as a COVID-19 vaccine, and administered in accordance with all other applicable Federal and State rules and

regulations and the conditions for the provider or supplier receiving vaccine supply from the Federal government; (3) the gift card is not contingent upon any other arrangement or agreement between PHC and the member; (4) the gift card is not conditioned on the member's past or anticipated future use of other items or services that are reimbursable, in whole or in part, by Federal health care programs; (5) the gift card will be provided during the COVID-19 public health emergency.
Kaiser will notify PHC of members they believe qualify for these member incentives. The Population Health Department will confirm qualification and the related gift cards will be mailed directly to the member (see details in question 21).

21. Are direct member vaccine incentives a planned strategy? If so, please explain the strategy. Character limit: 2,500 characters.

Yes, PHC will support its overall COVID vaccination plan with direct member vaccine incentives. PHC intends to collaborate with community-based organizations and pop-up clinic organizers to reach local population pockets that have not responded to mass vaccination efforts. We will collaborate with local organizers to promote events. PHC staff will attend events with vaccination cards in hand. As individuals complete their vaccinations, PHC staff will gather demographic data, capture clinic location/date/vaccination maker, lot number, dose number, confirm body site of injection, and track this into our member campaign tracking system. After this information is recorded, we will hand the member an incentive worth no more than $50. If we run out of incentive cards at an event, we will mail a gift card on the next business day. Incentives are thus issued by the MCP directly, and not through subcontractors, network providers, or non-contracted providers. Any proposed change in this process, will be submitted to DHCS for approval.

While only gift card incentives are currently planned, we will ensure that the value of member incentives is reasonable for any "in-kind" incentives (i.e., non-cash-equivalent) that may be substituted in the future.

If PHC staff are unable to attend a planned vaccination event where we have already established a relationship with event organizers, we will ask the organizers to capture the same information and send it securely to PHC, after which we will distribute incentives directly to the members. It is our preference to attend each event in person, both to perform immediate validation of the vaccination and to establish face-to-face contact with our membership. In certain cases (e.g. when organizers will not agree to asking for insurance status before vaccination), PHC may use other funding sources to distribute incentives to non-PHC members who attend vaccination events where PHC members are offered incentives.

Member incentives earned through vaccination in PCP sites or by our delegate, Kaiser, will be distributed to members by mail. These mailings will be based submitted lists of vaccinated members by the PCPs as part of the PCP incentive program and tracked using PHC's campaign management tracking system. Member incentives will be provider agnostic, and on equal terms for all vaccinations administered by all participating Medi-Cal-enrolled providers, regardless of their network provider status or relationship with PHC.

a. If direct member vaccine incentives are used as a vaccination strategy, demonstrate how the MCP will meet DHCS guidelines for member incentives

below and verify member incentives do not exceed $50 per member (single or multi-dose). Character limit: 2,500 characters.

Controls to ensure member incentives are only available for medically-necessary vaccinations, and to verify member incentives do not exceed $50 per member (single or multi-dose) and that the value of member incentives is uniform and standardized: PHC staff examine the member's CDC card and gather additional member identifiers. These data are entered into PHC's member campaign tracking software, and weekly reports may be generated to track incentive distributions at the member level. Our intent is that by distributing incentives at vaccination sites, we will ensure each member qualifies for the incentive and only receives the appropriate dollar amount of the incentive.

Members vaccinated at non-PCP based clinic locations where PHC staff are unable to attend may qualify for incentives offered directly by the clinic provider (possibly through grant funding) or by sending adequate documentation of member vaccinations securely to PHC, and PHC will send the incentive directly to the member.

PHC will prevent duplication of incentives to members vaccinated at PCP sites through record keeping of incentive provision using PHC's campaign management tracking system. Duplicate incentives will not be mailed to members shown on the list as already receiving an incentive equal to $50. This will also demonstrate that 100% of funding communicated to DHCS on member incentives were actually paid to PHC members.

The incentives will meet the six safeguards set forth in the U.S. Department of Health and Human Services Office of the Inspector General guidance. Specifically, the following safeguards will be met: (1) the gift card will be furnished in connection with receiving a required dose of a COVID-19 vaccine (2) the vaccine must be authorized or approved by the FDA as a COVID-19 vaccine, and administered in accordance with all other applicable Federal and State rules and regulations and the conditions for the provider or supplier receiving vaccine supply from the Federal government; (3) the gift card is not contingent upon any other arrangement or agreement between PHC and the member; (4) the gift card is not conditioned on the member's past or anticipated future use of other items or services that are reimbursable, in whole or in part, by Federal health care programs; (5) the gift card will be provided during the COVID-19 public health emergency.

II. Direct member Vaccine Incentives

There will be a a pool of funds available for MCPs to utilize for direct member vaccine incentives. In order to draw funds from the direct member incentive pool, MCPs must attest to meeting the following requirements and include their direct member vaccine incentive strategy in their Vaccination Response Plan:

- Institute controls to ensure member incentives are only available for medically necessary vaccinations (i.e., MCPs have controls in place to track vaccinated members to ensure no duplicative member incentives).
- Ensure that the value of member incentives is reasonable for "in-kind" incentives (i.e., non-cash or cash-equivalent).
- Verify member incentives do not exceed $50 per member (single or multi-dose).
- The value of member incentives must be uniform and standardized.

- Member incentives must be provider agnostic, and on equal terms for all vaccinations administered by all participating Medi-Cal enrolled providers, regardless of their Network Provider status or relationship with the MCP.
- Ensure member incentives are issued by the MCP directly, and not through Subcontractors, Network Providers, or non-contracted providers, unless DHCS grants prior approval for an exception from this requirement. MCPs can use a vendor for member incentives with prior approval from DHCS.
- Demonstrate that 100% of applicable MCP incentive payments for direct member vaccine incentives are expended on direct incentives to members.
- The incentive meets the six safeguards set forth in the U.S. Department of Health and Human Services Office of the Inspector General guidance to ensure sufficiently low risk under the Federal anti-kickback statute and Beneficiary Inducements Civil Monetary Penalty.1

I hereby attest that all information provided in this plan is true and accurate to the best of my knowledge, and that this plan has been completed based on a good faith understanding of the Medi-Cal COVID-19 Vaccination Incentive Program participation requirements.

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Signature of MCP Representative & Date

1 See Frequently Asked Questions – Application of the Office of Inspector General's Administrative Enforcement Authorities to Arrangements Directly Connected to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency at: https://oig.hhs.gov/coronavirus/authorities-faq.asp.