NYC Department of Health & Mental Hygiene: COVID-19 Mass Vaccination

Logistics Plan



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**Preface**

The World Health Organization declared COVID-19 a pandemic on March 11, 2020. ​1​ This declaration came exactly two months after the WHO advised countries of a novel disease outbreak and provided guidance on case definitions for surveillance and a review tool for determining national capacities to manage COVID-19.​1​ On March 13, 2020, the United States declared a national emergency as New York City along with 34 other states reported a tally of 500 cases and 19 deaths attributed to COVID-19 disease. ​2,3​ The pandemic raged through New York City with peaks of up to 6300 cases and nearly 800 deaths reported daily .​4​ The New York City Department of Health and Mental Hygiene (NYC DOHMH), through its strategies of case investigation and contact tracing, testing, risk communication and community engagement, has seen a reduction in that tally to approximately 300 reported cases per day since September 2020.​4​ Based on its strategic plan for 2020-2021, the next priority in its three-pronged strategy for COVID-19 control and prevention is the mass immunization of city dwellers in its jurisdiction.5​

The New York City Department of Health and Mental Hygiene is one of the largest and oldest public health entities in the US, serving a population of approximately 8.3 million persons.​6,7​ The NYC DOHMH has oversight responsibilities for the five New York city boroughs: Manhattan, Bronx, Queen, Brooklyn and Staten Island.​6​ Brooklyn is the largest borough with a population of approximately 2.55 million persons.​7​ In New York City, 14.1 % of the population is 65 years and older and this segment of the population is at increased risk for contracting COVID-19 disease particularly in those persons with underlying medical conditions.​7​ Twenty nine percent of the city’s population identify as Hispanic or Latino and another 21% as Black or African American. The incidence of COVID-19 disease has been disproportionately high in these segments of the population. ​9​ The city boasts a diverse community with 37% foreign born individuals and, according to the US Census Bureau, as much as 48% of the population speak languages other than English at home.​9​ Effective risk communication messaging from the NYC DOHMH must include languages other than English to reach these sections of the population.

With an annual budget of $1.6 billion, the NYC DOHMH must allocate this across its varied public health programs.​6​ In recognition of the vast undertaking the Department faces in trying to implement an effective COVID-19 vaccination program, the CDC recently announced that New York City will receive an allotment of $6.6 million under the CARES (Coronavirus Aid, Relief and Economic Security) Act, one of only 64 jurisdictions to receive additional funding to update vaccination plans for COVID-19.​8​ As of September 26, 2020, NYC DOHMH has reported that NYC has had 237,628 cases and 23,795 deaths attributable to COVID-19.​9

**Signature Page**

The following personnel hereby concur with the features of the following COVID-19 Disaster Plan and agree to assume administrative roles.

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NYC DOHMH Commissioner Date

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Deputy Commissioner Disease Control Date

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Deputy Commissioner Epidemiology Date

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Deputy Commissioner Emerg. Preparedness & Response Date

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NYC Health + Hospitals Chief Medical Officer Date

**Mission**

The New York City Department of Health and Mental Hygiene (DOHMH) acts as an oversite agency to monitor various healthcare-related operations within New York City and its primary mission *is to protect, improve and promote the health, productivity and well-being of all New* *Yorkers*​.

The DOHMH envisions *New Yorkers will be the healthiest people in the world- living in*​ *communities that promote health, protected from health threats, and having access to quality, evidence-based, cost effective health services*​.

The Core values of DOHMH include:

*Dedication to public good, Innovation, Excellence, Integrity, Teamwork, Efficiency*

**Statement of Purpose**

This plan serves as a guidance for the organization and implementation of mass COVID-19​ vaccination strategies in New York City. The plan aims to minimize the threat of the pandemic through the ease of access to vaccinations, quick dispensing of vaccinations to the communities and enhanced continuity of operations between the healthcare delivery systems and local emergency partners.

**Authorities**

The New York City Department of Health and Mental Hygiene (DOHMH) is under the direction of the Deputy Mayor of Health and Human Services Dr. Raul Perea-Henze ​and led by​ Commissioner Dr. Dave A. Chokshi. This COVID-19 Mass Vaccination Logistical Plan establishes full compliance with the Department of Health Prevention Agenda 2019-2024: ​

Prevent Communicable Diseases Action Plan Focus Area 1. Vaccine Preventable Diseases. Objectives: By December 31, 2024 to increase the rates of immunization and reduce disparities between communities in vaccine adherence. It complies with the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013.

Regulations (NYCRR) Title 10, Subpart 66-1. NYS Public Health Law Section 2165 and NYCRR Title 10, Subpart 66-2 require vaccinations for highly communicable diseases for school age children and college students. Public Health Law: Article 21, Title 6, Section 2168 - Statewide Immunization Registry requires the security and standardized reporting of immunized persons and dosing. 1905 U.S. Supreme Court decision in Jacobson v. Massachusetts upholds the authority of states to enforce compulsory vaccination laws. It is also the policy of the New York City Department of Health and Mental Hygiene to comply with all other applicable laws including but not limited to, the Americans with Disabilities Act (ADA), the Rehabilitation Act, the New York State Human Rights Law and the New York City Human Rights Law. NYC DOHMH does not discriminate based on disability in the operation of its programs, services, and activities.

**Definitions**

CIMS: NYC Citywide Incident Management System, standardized approach to establish roles​ and responsibilities and designates authority for city, state, other government entities, and nonprofit and private sector organizations performing and supporting emergency response.

DOHMH:​ Department of Health & Mental Hygiene

MCM:​ Medical countermeasures; countermeasures, such as vaccines, antiviral drugs, antibiotics, antitoxins, and chemical antidotes, used to prevent, mitigate, or treat adverse health effects of a public health emergency.

PODs:​ Points of dispensing; community locations in which state and local agencies dispense​ MCMs to the public during a public health emergency.

SNS:​ Strategic National Stockpile; the United States national repository of MCMs​

PPE:​ Personal Protective Equipment (gloves, goggles, facemasks, etc.)

**Communications Plans**

Internal Communication

The current pandemic has created a high demand for information from internal employees of the NYC Department of Health and Mental Hygiene. Multiple channels such as e-mail, newsletters, intranet and an electronic staff directory are directly available for all staff members. Messages and communications from management will be frequently delivered to increase awareness of any new developments. The primary means of communication during non-emergency situations, will be through emails and landline phones that will be distributed across all departments within the NYC Department of Health and Mental Hygiene. In the event of an emergency, communication will be escalated accordingly to all members and prompt responses from the Commissioner, Chief of Staff and current General Counsel. In the case that primary means of communication fails or become compromised, backup two-way radios will be implemented to keep an active communications system between all employees.

External Communication

In the event of an emergency, communication between external agencies and the NYC

Department of Health and Mental Hygiene will be carried out by the Chief Communications Officer. The Chief Communications Officer will advise the Commissioner on any external matters that are impacting the agency and advise the Bureau of Communications on crisis response. Furthermore, in liaison with the Department’s Office of External Affairs Division, proper outreach to other agencies, organizations and the public will be made. Emergency Operations will emit an organizational crisis alert sending both emails and phone messaging to all employees. The Health Alert Network (HAN) will also emit health alerts and advisories and contain public health information for medical providers by sending up-to-date health alert information and online document library on public health topics.10​ ​Furthermore, advisory alerts will also be sent out regularly when subscribed to HAN and will also be made available to the public to view on the advisory bulletin.

**Mutual Aid Agreement**

1. Athletic Facilities
2. Local Community Centers
3. Retail Pharmacies
4. The Jacob K. Javits Convention Center
5. New York City Public Schools
6. Hospitals and Health Care Facilities
7. Nursing Homes and Long-Term Care Facilities
8. Pharmaceutical Companies and Drug manufacturers
9. Shipping and Logistics Companies
10. The Strategic National Stockpile
11. Nurses and Social Workers
12. Local Law Enforcement
13. The National Guard
14. NYC Emergency Management
15. NYC Governor’s Office
16. Center for Disease Control and Prevention
17. The U.S. Department of Health and Human Services
18. Office of the Assistant Secretary for Preparedness and Response

**Concept of Operations (CONOPS): Mass immunization plan for NYC DOHMH**

**Description of organizational structure**

The incident command structure under the existing [NYC Citywide Incident Management Syste](https://www1.nyc.gov/site/em/about/citywide-incident-management-system.page)​ [m](https://www1.nyc.gov/site/em/about/citywide-incident-management-system.page)

(CIMS) should be utilized. Key authoritative roles will include NYC DOHMH Commissioner,

Deputy Commissioner Emergency Preparedness & Response, Deputy Commissioner

Epidemiology, Deputy Commissioner Family and Child Health, Deputy Commissioner

Disease Control. It is up to the discretion of each Points of Dispensing (POD) jurisdiction to designate an incident commander.

**Population needs assessment**

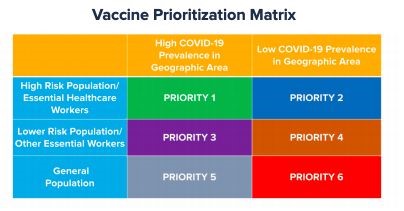
As of this writing, discussions on prioritization for a COVID-19 vaccine are ongoing. [Th](https://www.nap.edu/read/25917/chapter/1#iii)​[e National Academies of Science, Engineering and Medicine (NASEM)](https://www.nap.edu/read/25917/chapter/1#iii) has released a five-phase​ tiered approach to guide distribution based on vulnerability. Phase 1 will include health care workers and first responders, Phase 2, those with underlying health conditions and elderly people in densely populated housing, Phase 3, essential workers, teachers, people experiencing homelessness, prison populations, and older adults who are at moderate risk of complications from COVID-19 infection. Phase 4, will include people with increased risk of exposure (essential service workers), and Phase 5 will be the remaining population. Although the needs of specific communities within New York City will differ, the Department of Health and Mental Hygiene can use these guidelines as a reference to tailor their own prioritization plans.

**Anticipated Operational Activities, Agency’s Responsibilities and Deployment Matrix**

1. Deployment of the Vaccine Distribution and Implementation Task Force established by Governor Cuomo on September 24. The Task force is composed of experts in public health, immunizations, government operations, data and other fields relevant to vaccine distribution and administration. Their task is to advise the launch and operations of the state’s COVID-19 vaccination program

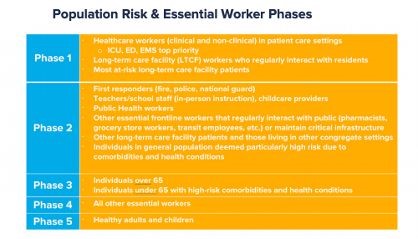
B. Operational and prioritization decisions will consider evolving surveillance data and closely monitor the clinical efficacy of the vaccination program C. Prioritization will be made to consider the disproportionate impact of COVID-19 on communities of color and health disparities present in underrepresented and marginalized communities

* 1. Operational and Prioritization Strategies
     1. Designed to ensure early vaccination of most vulnerable New Yorkers as well as essential frontline workers, with distribution potentially directed to communities with highest prevalence
     2. Designate 6 Priority Levels according to National Academies of Sciences, Engineering and Medicine Prioritization Matrix



* + 1. New York State in conjunction with NYC DOHMH will use up-to-date data to determine geographic area prioritization

4. NYC DOHMH Responsibility to create Population Risk and Essential Worker Phases:



5. Micro-Level Prioritization will be identified based on vaccine availability and vaccination rates

6. Main responsibility of NYC DOHMH will be to prepare detailed allocation scenarios based on data and variables for vaccine allotment amounts and vaccination rates within priority populations.

7. In coordination with other agencies, NYC DOHMH will utilize their logistical expertise in assigning management of critical tasks to distribute and deliver enough vaccines to administer two doses to every New Yorker.

8. NYC DOHMH will input on management of vaccine storage and inventory management

* 1. The New York City Medical Reserve Corps will be activated to strengthen community health and build community resilience. The trained corps will be rapidly mobilized and deployed to respond to vaccination strategies in regards to storage and management of the vaccine.
  2. Depending on the requirements for vaccine storage and inventory, certain locations will be determined best suited to keep the vaccine viable.

9. Providers of all types will need to enroll with the NYC DOHMH Vaccine Program

**Surge Capacity**

Based on local capacity, jurisdictions will define management of distribution. Expected outcome - 250 DOHMH and volunteer staff and 50 Medical Reserve Corps volunteers for each borough will all be assigned to one of the 100 NYC DOH POD sites. They must check in and out at the site’s dedicated personnel station at the start of their shift (7AM or 1PM shift) for tracking purposes. Rotational 6-hour shifts will be assigned based on ranked preferences, and each worker will have four consecutive days on site. Patient information and location of treatment should be documented. Paying DOHMH overtime pay will help to secure attendance. POD staff should be identified, and training systems implemented immediately. Limitations meeting demand for trained staff on each day of operation may prove difficult. Staff may be late or no-shows due to a myriad of reasons. If patient information, location of visit, and staff attendance is not recorded, data collection and reporting will be inaccurate. To avoid this issue, DOHMH should utilize volunteers from the volunteer database. DOHMH should aim to enlist as many volunteers to collect and record patient information data as needed to fulfill the 300 person staff requirement as noted previously.

Internal agency surge capacity: Expected outcome - each site should be prepared to serve at least 5000 patients each day of operation. Limitations - if the rate of treatment is not equal to or greater than the rate of patient arrival the site may become overcrowded.

Higher order support: Expected outcome - assistance should be requested at least two hours before the day’s supplies are projected to be exhausted, or when customer service, data collection, POD site leadership structure become compromised beyond what is possible to recover within the 4-hour time frame. Limitations - if additional supplies are not requested in time, patients may be turned away after they have already begun the walk-through process.

Outside/jurisdictional assistance: Expected outcome - agencies can manage with present human and physical resources for 4 hours before requesting outside assistance. Limitations - if staff are not adequately trained prior to the start of operations they may waste money, time, and cause harm to patients and other staff members. Volunteers & DOHMH staff should begin training protocols (example in Annex 3) immediately to ensure a smooth/quick transition upon receipt of accepted vaccinations.

State present capabilities: Expected outcome - the state may not be able to coordinate same day vaccination deliveries to all PODs in the event of shortages. If this occurs,

DOHMH should request assistance from the Army National Guard and/or a Disaster Medical Assistance Team (DMAT) through the National Disaster Medical System (NDMS). Densely populated underserved locations will be preselected and prioritized. Limitations - external logistics factors such as traffic flow, human error, and packaging must be considered and monitored to ensure efficiency, accuracy, and effectiveness. Emergency preparation plans for inclement weather, mass casualty, and overcrowding situations must be readily available to staff and include comprehensive instructions for all diverse visitors to understand and comply.

**Command and Control**

Activation of NYC DOHMH’s mass prophylaxis and immunization protocols (mass dispensing protocols) and the Incident Command System in accordance with the National Incident Management System (NIMS) will be instituted.

*NYC’s Emergency Management Department & NYC DOH:* ​ Will determine objectives, standard operating procedures and identify Local distribution sites which will function as collection and distribution sites to vaccine dispensing sites (point of dispensing).

Local Distribution site command systems & Point of Dispensing sites command systems and responding medical personnel and administrators.

**Communication**

*Tactical communication:* ​ Redundant communication networks and back-up systems to support command and control (phone, fax, e-mails, types of radio, satellite phones etc.).

*Internal communication*​: communication systems used on-site at the distribution center (runners, cellphones, radios, flags etc.)

*External communication*​: NYC DOHMH will communicate with other state and local departments and partners.

**Risk Communication & Health Education**

NYC DOHMH will undertake immunization advocacy initiatives and other public information communications.

**Local Resources, State Resources & Strategic National Stockpiles (SNS)** NYC DOHMH will maintain the required supply of PPE kits, gloves, biohazard disposal, syringes, masks, gowns, and other medical material. The local department will also partner with local hospitals, public health agencies and pharmacies for the resources. Requisition of state resources and SNS will be carried out by the emergency department in agreement with CDC criteria. The state will be responsible for responding to & funding needlestick injuries should they occur. Thorough reporting of each incident, including time, date, chronology of events, involved personnel, and other pertinent information must be recorded and stored in an injury reporting database.

**Medical Material Handling, Management, Storage, Transport and Site Operations**

Standing orders, storage, handling and management procedures will be outlined by NYC DOHMH. Inventory tracking through the Inventory Management System and the chain of custody form with medical material and pharmaceutical assets as they are transferred from one party to another to be provided by the DOHMH.

**Security & Staffing**

Identify and verify licensed personnel and volunteers prior to the operation through NYC DOHMH citywide immunization Registry.

Training for staff including communications procedures, handling of medical supplies, chain of custody and other standard operating procedures and emergency response.

Health and Hygiene procedures/ Personal Protective measures will follow general precautions and specific guidance at the time of the event by NYC DOHMH.

Security staff and local police officers on standby for security purposes at immunization sites.

**Priority Prophylaxis:**

POD personnel: volunteers, first responders, medical personnel, law enforcement and concerned government officials will be immunized as priority 1 as per vaccine prioritization matrix before dispensing to the population. This medical supply will come out of the local and regional supplies. Hospital workers employed through NYC HHS will receive vaccine as per mandatory influenza protocol at their respective hospitals but will have the option to opt up since the vaccine will be under Emergency Use Authorization (EUA).

### Demobilization

The distribution and/or termination of the site will take place as determined by NYC DOHMH in collaboration with NYC Health + Hospitals when the desired outcome is achieved or when the resources (medications/vaccinations) have been depleted.

**Evaluation of the Mass Immunization Event**

The final evaluation report must be completed within five days of the completed mass immunization event. The POD coordinator/supervisor will be responsible for completing the report which will be forwarded to the Deputy Commissioner-Disease Control for signature. The report will follow the format of the after-action report (AAR) template from the​ [H](https://emergency.cdc.gov/training/ERHMScourse/pdf/127961885-Hseep-AAR-IP-Template-2007.pdf)​[omeland Security Exercise and Evaluation Program](https://emergency.cdc.gov/training/ERHMScourse/pdf/127961885-Hseep-AAR-IP-Template-2007.pdf) ​ and will include primary areas for improvement and recommendations.

As it is expected that the mass immunization event will occur over a time span of several weeks to months, an interim report can be generated from information derived from completed copies of [the daily checklist of best practices for vaccination clinic](https://www.izsummitpartners.org/content/uploads/2017/02/NAIIS-Vaccination-Clinic-Checklist_v2.pdf)​[s](https://www.izsummitpartners.org/content/uploads/2017/02/NAIIS-Vaccination-Clinic-Checklist_v2.pdf) ​ developed by the NAIIS.

Any clinically significant adverse event occurring during the POD must be reported in VAERS [(Vaccine Adverse Event Reporting System)](https://vaers.hhs.gov/) ​ and documented in the post clinic evaluation report as part of the target capabilities list. Any issues regarding worker safety (examples include needlestick injuries, attacks on personnel) must also be documented in this report.

The signed evaluation report will be shared with:

1. Incident Command – Emergency Operations Center
2. Medical Supplies Management and Distribution (Deputy Commissioner-Emergency Preparedness and Response and/or Logistics Section of CIMS) iii. Deputy Commissioner Epidemiology
3. Deputy Commissioner Maternal and Child Health
4. Emergency Public Safety and Response (NYPD, FDNY under CIMS)

**Liability Immunity**

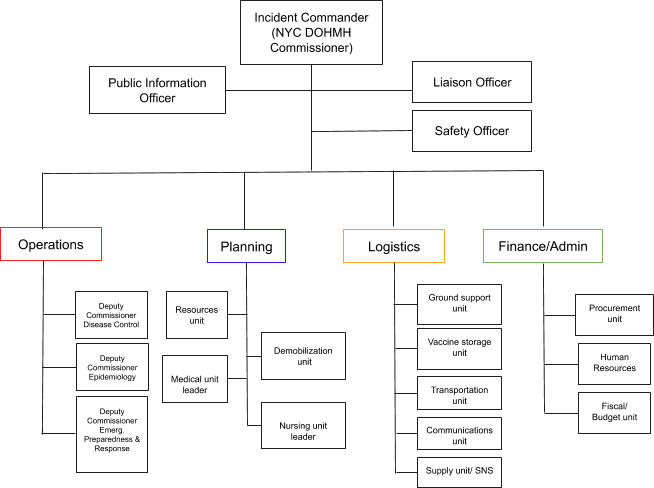
Vaccine administrators will be immune from liabilities under the Declaration Under the Public​

Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 as covered persons. Signed standing orders will also be in effect.

**Annex 1. Threat and Hazards Assessment Table: NYC Department of Health and Mental Hygiene-New York City, New York**

|  |  |  |
| --- | --- | --- |
| **Natural** | **Technological** | **Human-caused** |
| Resulting from acts of nature | Involves accidents or the failures of systems and structures | Caused by the intentional actions of an adversary |
| * **Outbreak/Pandemic:** Based on the 2019 National THIRA by FEMA and the2019 NYC Measles Outbreak, contagion by existing and emerging pathogens remains a credible threat to NYC residents.1 NYC has a high population density of 27,000 persons per square mile while the largest hospital has 2650 staffed beds.2,3 Even with surge capacity, the health care system is likely to be overwhelmed by novel infections without known treatments or vaccines. * **Winter Storm**: Winter storms are common in the northeast every year and may lead to disruptions in air and ground transportation, interruptions in electricity supply with risk of exposure to the vulnerable homeless population. Multi-agency responses may be required to address these issues as they arise. * **Flood**: Due to its geographical location adjacent to the Atlantic Ocean, all structures are vulnerable to flooding. The New York Bight, or the right angle formed by Long Island and New Jersey make NYC and subsequently all Department of Health locations vulnerable to flooding.7 Consequential to the bight, water is easily funneled into the New York Harbor threatening the infrastructure of the DOHMH, & in particular it’s Brooklyn & Queens locations. | * **Power Outage:** In the past ten years, NYC has had a few major power outages which led to disruption to supply in residential homes but also affected commerce, major railways and caused traffic disruption. While there were no major injuries or crime during the last major incident in 2019, the police and fire department are stretched thin to respond to major disruptions in electricity.4 * **Mass Transit Malfunction:** On average, 5.7 million persons ride the subway daily. With its dependence on steady electricity supply and the fact that some 60% of its stations are underground, NYC’s MTA is vulnerable to malfunction.6 Electrical outages and flooding have been major contributors to service disruption in the recent past which required involvement of communications systems to issue warnings to its customers. * **Airline Disaster:** As one of the international travel hubs in the US, NYC has experienced a number of airline disasters in the past. The sheer volume of arriving and departing flights into any of the three NYC airports increases likelihood for calamitous disasters. Notably, the 1960 LaGuardia mid-air collision, 2001 Queens crash, 2001 September 11 attacks, and 2009 Hudson River landing are all prime examples of airline disasters affecting NYC. NYC DOHMH should be prepared for direct impact from such disasters as well as a surge in volume of injuries and fatalities. |  **Civil Unrest:** Protests in NYC are common including Occupy Wall Street and the more recent George Floyd protests. As emotions flare, police, fire and sanitation departments are usually engaged in response. Damage in the wake of George Floyd riots is likely to be the costliest civil unrest in US history but such unrests usually result in injuries and arrests with minimal deaths.5   **Active Shooter:** Health care settings and/or departments of health are often not considered as targeted sites for active shooter scenarios, however the second largest hostage situation in recent history occurred in a large public hospital.8 This has implications for any DOH, but especially a DOH in the country’s largest metropolis. In 2016 alone there were 308 active shooter cases, of which 32% were targeted towards the attacker’s workplace.9 |

**Annex 2: Incident Command System Organizational Chart for NYC DOHMH Mass Vaccination Program**



**Annex 3: Community Training for NYC DOHMH Mass Vaccination Program**

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| --- | --- |
| **Training Seminar Title:** ​COVID-19 Mass Vaccination Clinic Training | |
| **Objectives of your Training Seminar (What mitigation strategy are you advocating?)** | 1.​ Provision of COVID-19 vaccine to community members​ in a safe and efficient manner  2. Maintain the integrity of vaccines through maintenance​ of the cold chain during the POD exercise |
| **Estimate Length of Training** | Two hours |
| **Target Audience and max size of audience.** | Providers, POD volunteers, Medical Reserve Corps |
| **Who would be a good candidate as Facilitator of this session? Why?** | Senior personnel from the NYC DOHMH Family & Child Health and/or Disease Control Departments with prior experience executing POD exercises for influenza immunization (nurses, pharmacists, etc.) |
| **What do you want community members to**  **do as a result of their attending this session?** | Inquire about when they will be eligible for the walk-through vaccination clinic, submit outstanding necessary documentation regarding licensure. Schedule a time to be vaccinated in the prioritized first phase of frontline health workers. Confirm which POD location they will be working in. Arrive two hours prior to their first shift for training. |
| **Strategies to increase community uptake of your mitigation** | Strategies to increase pool of volunteers:  1. Incentivize attendance for training by providing continuing education credits for future licensure (eg: CMEs for physicians, CE for nurses)  2. Approach cadre of students in healthcare professions at local colleges and universities and arrange incentives for attendance (service hours, discounts at local shops, gift cards)  Materials for training: Mass vaccination training video (drive through clinic scenario) https://mediazilla.com/FjPsn8wtYZ​ |

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