Testimony

of

Dave A. Chokshi, M.D., M.S.c.
Commissioner
New York City Department of Health and Mental Hygiene

before the

New York City Council

Committee on Health

and

Committee on Hospitals

on

COVID-19 Vaccine Distribution & Accessibility in NYC

January 12, 2021
Virtually
New York, NY

Good morning Chairs Levine and Rivera, and members of the committees. I am Dr. Dave Chokshi, Commissioner of the New York City Department of Health and Mental Hygiene. Thank you for the opportunity to testify today and provide an update on the City's distribution of COVID-19 vaccine to New Yorkers. I am joined today by First Deputy Commissioner and Chief Equity Officer, Dr. Torian Easterling, and Dr. Andrew Wallach, Ambulatory Care Chief Medical Officer for NYC Health + Hospitals and Chief Medical Officer for NYC Test and Trace Corps.

I would like to start by recognizing how far we have come in the last year. This pandemic has uprooted our lives – it has taken too many family and friends, destroyed beloved businesses, fundamentally changed our education system, and has kept us physically apart from loved ones for far too long. We are elated to have a vaccine available to New Yorkers, and the beginning of distribution is exciting and provides hope for the coming year. However, we are still in a state of emergency and COVID-19 cases are increasing throughout the country as well as here in New York City. New Yorkers need to remember what we are fighting for, and what helped us to flatten the curve during the Spring and Summer. In a ship during a storm, you would not throw away your oars upon seeing the shore, you would paddle until you reach land. And that is what we all must do here – we are still in the center of the storm. Everyone must continue getting tested regularly and sticking to the public health prevention measures we know work: stay home if you're not feeling well, wash your hands regularly, wear a mask or face covering, and maintain physical distance. Together we can help save lives as we continue to accelerate our vaccination efforts.

As of now, there are two COVID-19 vaccines authorized for emergency use by the FDA, manufactured by Pfizer/BioNTech and Moderna. Extensive clinical studies have shown these vaccines to be safe and highly effective. There is currently a limited supply of vaccines, and to ensure the available vaccine is allocated in the most equitable manner, it is being prioritized for administration to certain groups. As many of you know, New York State is establishing phases of distribution based on federal recommendations, with the intention of prioritizing people who are at greatest risk for exposure to COVID-19 or severe illness from COVID-19. Initially, only high-risk healthcare workers and long-term care facility staff and residents were eligible to get vaccinated. The State then opened up eligibility to other healthcare workers, including emergency medical services and ambulatory care workers, as well as public health workers who have direct contact with patients, and home care and hospice workers. We are pleased that the State has responded to our strong recommendation to expand beyond these initial populations to ensure vaccines are utilized to the fullest and that all vulnerable New Yorkers are reached. As of this week, additional populations, including seniors seventy-five years and older are eligible to receive the vaccine. It is particularly important that elderly New Yorkers who are much more likely to experience complications from COVID-19 receive vaccines immediately. We continue to prepare for State authorization for additional populations to become eligible. We have further called on the federal government to support our efforts through advance planning and increased vaccine manufacturing.

To coordinate New York City's multifaceted efforts to promote and distribute the vaccine, Mayor de Blasio created the Vaccine Command Center, or the "VCC." The VCC is an interagency effort co-led by Deputy Mayor Melanie Hartzog and me, bringing together experts and doers from across City government. This reflects a whole of government approach that includes many city agencies including the Health Department, NYC Health + Hospitals, Emergency Management, the Mayor's Office, and the Task Force on Racial Inclusion and Equity. Leveraging existing relationships across the city, and using data-driven decision-making, the VCC is streamlining our planning and outreach surrounding the vaccine distribution in order to turn vaccines into vaccinations. The VCC team, in partnership with the Health

Department and Health + Hospitals, and in accordance with the guidance issued by State officials, is implementing plans to distribute our allocated vaccine doses across the city.

The City is collecting and sharing data in real time on the number of vaccine doses reserved by the federal government for the city, delivered to the city, and administered to New Yorkers. This is all available on the Health Department's website, making us one of the most transparent jurisdictions in the world with respect to our vaccination campaign. As of today, New York City has been allocated 885,325 vaccine doses, 668,175 doses have been delivered to the City, and 216,014 first doses and 23,310 second doses have been administered in the City. The Mayor has set an ambitious goal to administer one million doses of the vaccine by the end of this month, and we are laser focused on ramping up our operations to meet this goal. Keeping track of and being transparent about all of this information allows us to map our progress, stay accountable, and most importantly, identify where we need to direct resources to ensure all New Yorkers have the information they need and access to vaccinations.

To ensure vaccine is widely available, the City is scaling up distribution sites for vaccine to ensure equitable access as supply increases. Sites are being established in all five boroughs where New Yorkers who are eligible can get vaccinated. We just opened two 24/7 mass vaccination sites at the Brooklyn Army Terminal Annex Building and the Bathgate Industrial Park in the Bronx, as well as three COVID-19 Vaccine Hubs in Brooklyn, Queens, and the Bronx that are open seven days a week from 9am to 7pm. Our plan is to launch an additional twelve COVID-19 Vaccine Hubs, and 3 additional 24/7 sites – making one in each borough – by this Saturday to reach our goal of administering one million doses by the end of this month. New Yorkers can make appointments for vaccination on our website, via nyc.gov/VaccineFinder, or call 1-877-VAX4NYC. We will continue to expand vaccine offerings – and refine the user experience through continuous improvement – to ensure all New Yorkers who are able to get vaccinated are vaccinated.

Underlying these operations is our unwavering commitment to equitable distribution, access, and uptake of vaccines. We know the context of our vaccine efforts: persistent, systemic and intergenerational racism faced by people and communities of color that manifests in the form of inequitable access to basic resources including employment, housing, food, green spaces and health care. This, combined with explicit and implicit interpersonal racism, has led to greater burden of chronic disease and increased the risk of morbidity and mortality for Black and Hispanic/Latino New Yorkers throughout the pandemic. We also know that people of color are more likely to experience racism within the health care system, exacerbating health burden for individuals who require hospitalization or other care. These factors have also created circumstances where Black and Hispanic/Latino people are more likely than White people to be employed in roles that are considered essential during this outbreak, and therefore less able to avoid exposure.

With this in mind, we have developed a Vaccine Equity Strategy that focuses on ensuring access and uptake of the COVID-19 vaccines by all New Yorkers and holds us accountable to monitor vaccine uptake by race and ethnicity as well as by neighborhood.

We will support access to the COVID-19 vaccines by ensuring that we have enough vaccination locations in neighborhoods that have experienced ongoing disinvestment and inequities as well as high rates of COVID-19 infection and death. We are also working to ensure that our messaging reaches and is heard by these neighborhoods by hosting Community Conversations, listening to and working with trusted messengers to reach more New Yorkers with our message than ever before. In addition, our vaccine site planning includes eliminating barriers for people with disabilities, people who do not read or speak English, people who are undocumented, people with mental illness, people with substance use disorders, and people who are homeless. From my own clinical experience, I know how important it is to hold individuals in each of these groups, and many more, in mind if we are to truly reach those most marginalized and at risk.

In addition to advancing widespread accessibility of vaccination sites, our equitable approach to vaccinations is rooted in engaging directly with New Yorkers to strengthen vaccine confidence and public trust. In partnership with our colleagues at the VCC and other City agencies, including the Taskforce on Racial Inclusion and Equity, we are undertaking broad scale efforts with community members. We are working with community organizations to disseminate anti-racist and culturally and linguistically appropriate vaccine communications. We are also working with community and faith-based organizations to engage residents in conversations about vaccine safety and efficacy, addressing vaccine hesitancy with empathy and humility. We are further building capacity through training of health care providers, community and faith-based organizations, and other agencies to partner on vaccine information dissemination to communities by trusted messengers. We have already shared messaging with thousands of community partners, hosted dozens of engagement events, and are deploying experts to community forums citywide. These plans are evolving daily as we receive feedback from partners and incorporate lessons learned from the first several months of the pandemic. We look forward to further ramping up these community engagement efforts as vaccine rollout continues.

Throughout our work to ensure that New Yorkers can access the vaccine and have the information they need to decide to get the vaccine, we must also pay close attention to vaccination rates and be ready to respond quickly if we see different rates of vaccination across neighborhoods or across racial or ethnic groups. We are also monitoring safety trends that are formally reported to the federal Vaccine Adverse Event Reporting System as well as informal reports of vaccine side effects – as well as misinformation – on social media and will be prepared to act if we begin to see worrying trends.

Finally, we are using opportunities created by our unprecedented vaccination efforts to dismantle systems that have oppressed people of color, LGBTQIA+ people, people with disabilities, people who are undocumented, people who have had contact with the criminal justice system, and older adults. We are educating vaccinators about the importance of collecting demographic information, particularly race and ethnicity, so that we can ensure that our resources reach communities that need them most. Finally, we are building on vaccine education to increase overall health literacy so that all New Yorkers are able to make informed decisions about their health and wellness.

It was almost a month ago when I had the privilege of administering one of the first COVID-19 vaccinations to Veronica Delgado, a physician assistant in the emergency department at Elmhurst Hospital. Her words about what it felt like have stayed with me: “Like that first bit of sunlight in the morning after a very long, dark, and frightening night.” Indeed, there is a light at the end of the tunnel, but even as we look forward, we must look back – and recommit ourselves to the core public health tools that work to curb the spread of this vicious virus.

Thank you again to Chairs Rivera and Levine for holding this hearing today and for your support in amplifying important, science-based information about COVID-19 and vaccines. I am happy to answer any questions.

Testimony of Brooklyn Borough President Eric Adams before the Joint Hearing of the Committee on Health and the Committee on Hospitals
January 12, 2021

I would like to thank Chair of the Committee on Hospitals, Carlina Rivera, and Chair of the Committee on Health, Mark Levine, for inviting me to testify today. Since the first cases of COVID-19 were diagnosed a year ago, the goal has been to develop and distribute a vaccine. Over that same time period, we have seen the damage that the lack of clear information from government officials and others can do. We have also seen the effects of inequity in testing and PPE distribution. These facts make it all the more important that New York City has a clear, equitable, and transparent plan for vaccine distribution. Unfortunately, that has not been the case.

In the weeks since the vaccines were released, cases and deaths have continued to rise. And yet, we still do not have a clear, equitable, and transparent distribution plan. Instead, we have intergovernmental finger-pointing and vaccines sitting in wait. New York has been economically and emotionally devastated by this pandemic. We must do better to honor the sacrifices we have all made over the past year.

To start, we must have a real-time demographic data vaccination reporting system to track test positivity rates, death rates, and hospitalizations so that we do not see the same disparities that we saw in testing. In addition to tracking, and the steps that have already been taking in terms of a hotline and the mobilization of volunteers, there remain several steps we must take to improve the distribution of vaccines in New York City.

1. The State must expand eligibility now to speed up vaccination implementation, using criteria that gets the first dose to the New Yorkers most likely to contract or transmit the virus. That criteria should include:
    - Non-health care essential workers such as workers in high-risk industries, for example home health care, food delivery, supermarket, and transit workers
    - New Yorkers with medical conditions that make them susceptible to the virus
    - Residents of the most impacted ZIP codes
    - New Yorkers over the age of 65 (as per updated Centers for Disease Control guidance as of January 12, 2021)
2. The New York State Department of Health (DOH) should create a transparent three-tier color-coded system to define each level of eligibility for those who still need to receive vaccines:

- Red – People with the highest level of need, such as frontline workers and first responders
- Yellow – All of the red group, plus the ZIP codes most impacted by the virus, those with medical conditions that make them susceptible, those in high-risk industries, and all New Yorkers over 75
- Green – All of the red and yellow groups, plus all in the public who have not already been vaccinated
- Regardless, of tiered status, the City and State should ensure that all doses are used each day by creating an open call for residents when the day's appointments are complete

3. To ensure immigrants and other at-risk communities who are eligible get connected with the vaccination program, the City and State must work with advocacy organizations and those groups on the ground that can help them prove eligibility and to build the queue for the next round of dosages. For example, the City and State should work with groups such as the Biking Public Project to ensure delivery workers are educated and informed about eligibility.
4. To set up the distribution hubs, the City must immediately provide a map of the 250 locations it says will be used so that we can ensure they can cover the most at-risk populations. These locations should be open 24 hours a day and include:
    - Schools without student population currently doing in-person learning
    - Schoolyards
    - Houses of worship
    - Senior centers

At my request, Council Member I. Daneek Miller is introducing a resolution to call on the State to implement the outstanding items in our seven-point plan. I urge the City Council members of this committee to co-sponsor and send a message to Albany that we must act now with clear-cut communication, guidance, and urgency.

New York City is resilient, and we must not waste the precious resource of vaccines, but we need a plan that provides clarity and transparency to help us get through this crisis. Thank you.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

**TESTIMONY OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS
TO THE COMMITTEE ON HEALTH AND COMMITTEE ON HOSPITALS -
JANUARY 12, 2021**

Good morning,

My name is Jumaane D. Williams, and I am the Public Advocate for the City of New York. I thank chair Mark Levine and chair Carlina Rivera for holding today's timely and vital hearing.

Last year was one of the most challenging years in the City's history. Over 25,000 people lost their lives to COVID-19, and it is a reminder of the virus' devastating impact. This year is looking better with news of vaccines available for the public. There are several challenges with that, and I welcome today's hearing to highlight some of them.

Before that, I thank the Governor for recently loosening vaccine distribution restrictions. Vaccines for a virus as dangerous as COVID-19 should not be wasted. Unfortunately, because of the inability of our Mayor and our Governor to come to an agreement, vaccines were thrown out. This can greatly affect public confidence in the vaccine if our political leaders are disorganized and aimless. We need to do what is right, and I repeat my previous call to the Mayor to distribute vaccines regardless of state fines and restrictions.

However, vaccine hesitancy is a serious challenge for our health campaign. While the time to create this vaccine is miraculous, we cannot dismiss concerns from communities of more color. These fears are justifiable with the disparate health outcomes. For example, doctors are less likely to treat pain for Black patients than White patients. The impact of racism is real, and fears should not be dismissed. Therefore, we must be transparent, we must be clear, and we must be responsive.

It cannot be forgotten that COVID-19 was more prevalent in communities of more color since the height of the pandemic last year. The hospitalization rate per 100,000 is nearly two times higher among Black and Latinx New Yorkers than white New Yorkers, according to January 6th data from New York City Department of Health and Mental Hygiene. This demonstrates, amid a resurgence of COVID-19, that communities of more color are hit harder again. We cannot have disparity in vaccinations that leaves communities of more color behind.

Another issue will be our infrastructure. I am worried that our infrastructure may not be prepared for an inevitable rollout that includes a larger eligible population. I understand that our federal

government, once again, refuses to take responsibility and lead vaccination efforts. This is shameful to see during a pandemic. This forces states and localities to scramble in distribution. I am thankful that a change in administration on January 20th will help our efforts with a boost in vaccines.

At the same time, this is no time for complacency. I recall the City's test and tracing program last summer experienced some issues with delays. Preparation is key to ensure a quick rollout of the vaccine. Everyone who registers and wants a vaccine should not wait weeks or be turned away. An adequate number of staffers are needed at hubs and other places. Any serious mistake would be consequential.

Our infrastructure must also make sure people with disabilities are included. At the beginning of the pandemic, this group was overlooked. See-through masks were not accessible at hospitals, and initial government addresses did not include an ASL translator. Things have improved since then, and it is imperative that they are not left behind as well. For example, people with developmental disabilities who have COVID-19 are two to 10 times more likely to die than those who are not. This group must not be overlooked in priority lists.

It will be vaccinations, not vaccines, that will save lives. Our vaccination campaign will work only based on the effectiveness of distribution and accessibility. Thank you to the chairs, and I look forward to today's hearing.

NEIGHBORHOOD DEFENDER SERVICE
OF HARLEM

New York City Council

Committee on Health (Jointly with the Committee on Hospitals)

Hearing re: Oversight of COVID-19 Vaccine Distribution & Accessibility in NYC, January 12, 2021

Written Testimony of the Neighborhood Defender Service of Harlem[1]
By Meghna Philip, Staff Attorney, Criminal Defense Practice

This week, Phase 1B of the vaccine distribution has begun in New York, targeting several at-risk groups including police, court officers, corrections officers, and individuals living in homeless shelters (who the state has specifically identified as vulnerable because they must sleep, bathe, and eat in accommodations with other individuals who are not part of their household). But one extremely vulnerable population that intersects with all these groups is notably missing from the Phase 1B list: our incarcerated clients.

Neither the state nor the city have provided any clear statement as to when or how incarcerated people will be vaccinated. We were encouraged to read reports that Correctional Health Services has received approval to offer the vaccine to its "highest risk patients". But the city must do more—it must urgently prioritize vaccinating *all* people incarcerated in its jails. We request that the City Council do all it can to push both the Mayor's Office and Governor Cuomo to coordinate clear and transparent plans to promptly vaccinate people housed in New York's jails and prisons.

The total population in New York City Department of Corrections (DOC) custody is now close to 5000. 59% of that population is Black, and 27.7% of that population is Hispanic. Our incarcerated clients come from precisely the Black, brown, and low-income communities hardest hit by the pandemic, and whom the Governor has pledged to prioritize in vaccination efforts. And as has now been well documented, people in jail or prison are four times as likely to be infected with coronavirus as the general population and twice as likely to

[1] Neighborhood Defender Service of Harlem (NDS) is a community-based public defender office. Since 1990, NDS has been working to improve the quality and depth of criminal, family, and civil defense representation for those in Harlem and Northern Manhattan who would otherwise be unable to afford an attorney.

die from it. Clusters of infections in jails and prisons inevitably end up triggering broader community spread. Yet Governor Cuomo's priority phases have been silent as to when incarcerated individuals will be vaccinated.

The custodial population has been increasing steadily since the late summer, and numbers are now nearly back to pre-pandemic levels. Police and district attorneys are behaving as though the pandemic has already run its course, playing with both our clients' safety and public health generally. Since the pandemic began, the City has also closed multiple DOC facilities, including the Manhattan Detention Center, the Otis Bantum Correction Center, and the Eric M. Taylor Center. Therefore, as the Board of Corrections has documented, housing density inside city jails has steadily increased alongside the jail population in recent months. The majority of the jail population is now housed in an area that exceeds 75% capacity. Social distancing under these circumstances is impossible.

As the pandemic's latest wave rages, with New York City's COVID positivity rate now at more than 9 percent, the state has two solutions before it, which must be pursued in tandem: vaccinate every incarcerated person and reduce the jail and prison population. The consequences of inaction would be catastrophic.

A lack of clarity, specificity, and urgency around when and how incarcerated people will be vaccinated will only prolong the serious risks of another large outbreak in city jails, similar to what happened last spring. We join our colleagues at other public defender organizations in requesting clear information on how many vaccine doses will be made available for incarcerated people, when those will be made available, and how incarcerated people will be educated to make informed decisions regarding vaccination. And we request that the City Council strongly advocate to the Mayor's Office and Governor Cuomo that all incarcerated people must be prioritized for vaccinations now.

Testimony of

Christopher Boyle

Director of Data Research and Policy

New York County Defender Services

Before the

Committee on Hospitals and Committee on Health

Oversight Hearing – COVID-19 Vaccine Distribution & Accessibility in NYC

January 12, 2021

My name is Christopher Boyle and I am the Director of Data Research and Policy at New York County Defender Services (NYCDS). We are a public defense office that represents New Yorkers in thousands of cases in Manhattan's Criminal and Supreme Courts every year. I have been a New York City public defender for more than twenty years. Thank you to Chairs Rivera and Levine for holding this hearing on the city's plan to distribute COVID-19 vaccinations.

COVID-19 in City Jails

New York City's jails are a coronavirus hotspot. At least three incarcerated people have died following documented COVID-19 infections.[1] At least 13 DOC and CHS staff have died from COVID-related illness; the correctional officers' union has asserted that another of their members who died from COVID-19 was not included in that tally.[2] As of January 10, 2021, 748 incarcerated

[1] New York City Board of Correction Weekly COVID-19 Update, Week of December 26, 2020 – January 1, 2021, *available at* https://www1.nyc.gov/assets/boc/downloads/pdf/covid-19/BOC-Weekly-Report-12-26-20-01-01-21.pdf (this is the most recent BOC Weekly COVID Update currently available) (hereinafter "BOC Weekly COVID Update, December 26–January 1").

[2] Jan Ransom, "Virus Raged at City Jails, Leaving 1,259 Guards Infected and 6 Dead," THE NEW YORK TIMES, May 20, 2020 (updated June 16, 2020), *available at* https://www.nytimes.com/2020/05/20/nyregion/rikers-coronavirus-nyc.html.

people have tested positive for COVID-19 while in custody;[3] 133 of those positives tests among incarcerated people have occurred since December 1, 2020. Twenty-seven incarcerated people have been hospitalized for COVID-related illness while they were held in NYC jails, including one incarcerated person who was hospitalized recently.[4] It is no surprise that the *Wall Street Journal* called Rikers Island "among the most-infected workplaces in the U.S."[5]

Despite the known dangers of increased density and a lack of social distancing in congregate settings, our city jail population has increased swiftly and significantly over the past several months. As of January 1, 2021, the jail population has risen from a daily low of 3,832 on April 29 all the way to 4,967.[6] As a result, approximately 70% of the jail population—more than 3,300 people—are housed in units that are more than half-full.[7] The Department of Correction has long used the number of units filled to more than half of their capacity as a measure of whether the population density in NYC jails is safe.[8] More than 20% of all available housing units are filled between 76% and 100% of their designed capacity.[9]

The City needs to urgently release a vaccination plan for the nearly 5,000 people incarcerated in city jails. Such a plan must be implemented swiftly and efficiently, but so far, defenders are in the dark.

The City's Vaccination Plan for Incarcerated People

On January 3, 2021 *The City* published an article stating that Correctional Health Services, the city agency that cares for incarcerated people in city jails, has been authorized to begin the process of classifying incarcerated people in categories for vaccine distribution.[10]

As a public defender office, we are eager to see our incarcerated clients vaccinated to protect them from the spread of COVID-19 in city jails. But we were deeply dismayed to have to learn this information from a news publication. This announcement should have been made directly to

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[3] Correctional Health Services COVID-19 Snapshot, data as of January 10, 2021, *available at* https://hhinternet.blob.core.windows.net/uploads/2021/01/CHS-COVID-19-data-snapshot-20210111.pdf (this is the most recent CHS COVID-19 Data Snapshot currently available; a new Snapshot is currently being published on CHS's website every business day, *see* https://www.nychealthandhospitals.org/correctionalhealthservices/).

[4] Correctional Health Services Local Law 59 Report, Report for Week of December 14, 2020 – December 20, 2020, *available at* https://hhinternet.blob.core.windows.net/uploads/2021/01/report-for-the-week-of-december-14-2020-to-december-20-2020.pdf (this is the most recent CHS Local Law 59 report currently available).

[5] Deanna Paul & Ben Chapman, "Rikers Island Jail Guards Are Dying in One of the Worst Coronavirus Outbreaks," *Wall St Journal*, April 22, 2020, *available at* https://www.wsj.com/articles/rikers-island-jail-guards-are-dying-in-one-of-the-worst-coronavirus-outbreaks-11587547801.

[6] BOC Weekly COVID Update, December 26–January 1(note 6, *supra*).

[7] *Id*.

[8] *See* Archived copy of DOC COVID-19 Action Plan, Social Distancing Guidelines for Staff and People in Custody, captured October 20, 2020, *available at* https://web.archive.org/web/20201020183222/https:/www1.nyc.gov/site/doc/media/socialdistancing.page (last accessed November 29, 2020); DOC COVID-19 Action Plan, Social Distancing Guidelines for Staff and People in Custody, *available at* https://www1.nyc.gov/site/doc/media/socialdistancing.page (last accessed November 29, 2020).

[9] *Id.*

[10] Reuven Blau, "COVID-19 Vaccines Headed to Rikers Island and Other City Jails," *The City*, Jan. 3, 2021, *available at* COVID-19 Vaccines Headed to Rikers Island and Other New York City Jails - THE CITY.

defenders and other agencies that serve incarcerated people in a way that invited us to collaborate and support the city's vaccination efforts. Sadly, as in every other way that the city has approached COVID-19 in city jails, the city's actions once again fall short.

The city's announcement raises many questions that the Committee on Health and the Committee on Hospitals should also be looking for answers for from city officials. Last week, I sent a letter to DOC Commissioner Cynthia Brann, CHS Senior Vice President Dr. Patsy Yang, BOC Chair Jennifer Jones Austin and MOCJ Acting General Counsel Deanna Logan asking for specifics on the city's vaccination plan. I posed the following questions:

1- How many doses of the vaccine will CHS have available for its first distribution?

2- Will this allotment be replenished to account for the high degree of turnover within the city jail population?

3- Which vaccine will be made available?

4- Will persons who are vaccinated be housed with those that aren't vaccinated and will there be some segregation between the first and second shots?

5- Who will be designated "high risk" to get the vaccine? The defender organizations have received dozens of letters from CHS explaining that there are many clients labeled "high risk" Will every inmate who received a letter get access to the vaccine?

6- If the highest risk inmates exceed the number of shots available how will the shots be rationed?

7- If an incarcerated person gets the first does while within jail custody and then is subsequently released how will they received their second dose?

8- What type of outreach has DOC done or considered to alleviate the obvious fears this particular vulnerable population may have as to even taking he vaccine? Has CHS conducted any education efforts among the first inmates who may receive a vaccination?

This last point is perhaps the most serious. There is every indication that many incarcerated people may be fearful of accepting the vaccine. As you know, Rikers Island is a dangerous place for our clients and DOC has failed to engender trust between incarcerated people and corrections officers. Without any real efforts to alleviate those fears by CHS or other city agencies, we may see far lower numbers of vaccinations in our jails than are necessary to end the outbreak and protect incarcerated people, staff and the surrounding communities.

We still have not heard directly from city officials further details of their plan, though we were informed yesterday that a plan would be released at today's Board of Correction hearing. We urge City Council to call on MOCJ, DOC and CHS to work with public defenders as partners so that we can accomplish our shared goal of stopping the spread of COVID-19 as quickly as

possible. We can help to facilitate the flow of information so that our clients and their families can have their questions answered and any fears assuaged about the vaccination process.

If you have any questions about my testimony, please email me at cboyle@nycds.org.

Legislative Affairs
One Whitehall Street
New York, NY 10004
212-607-3300
www.nyclu.org

Testimony of Allie Bohm
On Behalf of the New York Civil Liberties Union
Before the New York City Council Committees on Health and Hospitals
Regarding *Oversight - COVID-19* Vaccine Distribution & Accessibility in NYC

January 12, 2021

The New York Civil Liberties Union (NYCLU) is grateful for the opportunity to submit the following testimony regarding oversight of COVID-19 vaccine distribution and accessibility in New York City. The NYCLU, the New York state affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices across the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution through an integrated program of litigation, legislative advocacy, public education, and community organizing.

The U.S. has long pinned its hopes of emerging from the coronavirus pandemic on the development and distribution of an effective vaccine.[1] And yet, New York City's initial vaccine rollout has been slow. As of last week, the City had distributed just 25% of the COVID vaccines it had received since mid-December, and only around 110,000 New Yorkers have received their first dose of the vaccine.[2] The City Council must do everything in its power to ensure that all New Yorkers who want to be vaccinated can get the COVID-19 vaccine and that all New Yorkers both are and feel safe doing so. This testimony will focus on three areas where the need for timely, equitable vaccine is particularly acute – congregate care, public schools, and carceral settings – and articulate three challenges the City Council must keep front of mind: vaccine distribution mechanisms; equitable, culturally competent vaccine distribution; and vaccine confidentiality.

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[1] *E.g.* David Paul, *Wall Street's Rosy Scenario is About to Come Crashing Down*, MEDIUM, July 21, 2020, https://davidapaul.medium.com/wall-streets-rosy-scenario-is-about-to-come-crashin-46d96880dfca; *cf. Waiting for a vaccine fairy is for children, not leaders*, SUNDAY INDEPENDENT, Oct. 18, 2020, https://www.pressreader.com/ireland/sunday-independent-ireland/20201018/282282437780731.

[2] Kay Dervishi, *Why can't NYC vaccinate like it's 1947?*, CITY & STATE, Jan. 5, 2021, https://www.cityandstateny.com/articles/policy/health-care/why-cant-nyc-vaccinate-its-1947.html.

Vaccine Rollout in Congregate Care Settings

Although individuals living in congregate care settings, including the disabled, were rightly prioritized to receive vaccines, there has been a complete failure to exercise centralized and uniform control over the rollout of the available vaccines to these priority populations. The state appears to have left it to the various Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), and Office of Addiction Services and Supports (OASAS) congregate care providers in the 1a priority pool to make their own arrangements for their residents and staff to be vaccinated.[3]

Where nursing home residents are not vaccinated "at home" and workers are not vaccinated at work, they are left to navigate a confusing array of barriers to determine whether they are eligible for the vaccine and, if they are eligible, they must traverse the internet to identify a vaccine location and make an appointment. This is true despite the fact that individuals with developmental disabilities are traditionally the group least likely to be digitally literate.[4] And, 46% of New York City households living below the poverty line – a category that both home health aides and people with developmental disabilities disproportionately fall into – do not have home internet access.[5]

The challenges these individuals face obtaining vaccines are only likely to increase as New York opens vaccine eligibility to the 1b population without any concomitant increase in the number of doses allocated to the state.[6] Although Governor Cuomo insists that the 1a populations will remain top priority for vaccination,[7] in practice the developmentally disabled and others in congregate care settings are likely to lose vaccination slots to the more able and digitally literate individuals in category 1b who will be better able to navigate the online appointment scheduling system, more likely to have the ability to travel to far flung vaccination sites,[8] or who may be vaccinated at their workplaces.[9]

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[3] Guidance for the NYS Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), and Office of Addiction Services and Supports (OASAS) Prioritization of Essential Healthcare and Direct Support Personnel as well as High-Risk Populations for the COVID-19 Vaccination, New York Dep't of Health 2 (Jan. 2021).

[4] Darren Chadwick, Caroline Wesson, & Chris Fullwood, *Internet Access by People with Intellectual Disabilities: Inequalities and Opportunities* 5 FUTURE INTERNET 376, 379 (2013).

[5] *Mayor de Blasio and Taskforce on Racial Inclusion and Equity Announce Accelerated Internet Master Plan to Support Communities Hardest-Hit by COVID-19*, NYC, July 7, 2020, https://www1.nyc.gov/office-of-the-mayor/news/499-20/mayor-de-blasio-taskforce-racial-inclusion-equity-accelerated-internet-master.

[6] *See* Jeanmarie Evelly, *City Pushes Feds to Deliver More Vaccines to NYC*, CITY LIMITS, Jan. 5, 2021, https://citylimits.org/2021/01/05/city-pushes-feds-to-deliver-more-vaccines-to-nyc/.

[7] Matt Troutman, *Coronavirus Vaccine Expands to NY Elderly, Teachers*, PATCH, Jan. 8, 2021, https://patch.com/new-york/new-york-city/cuomo-expands-coronavirus-vaccine-eligibility-1-5m-nyc.

[8] *See infra* pp. 6 – 7.

[9] *See* Press Release, Gov. Andrew Cuomo, Governor Cuomo Updates New Yorkers on COVID-19 Vaccine Distribution Efforts (January 5, 2021) (https://www.governor.ny.gov/news/governor-cuomo-updates-new-yorkers-covid-19-vaccine-distribution-efforts) ("To prepare for the next phase of eligibility, the Governor is encouraging essential worker groups such as police departments, fire

Compounding these challenges, there is no public tracking of how many people living in congregate care settings and how many of the staff supporting them have received vaccines, refused vaccination, or are medically counter-indicated. This tracking is necessary to ensure that everyone in these highly vulnerable populations who can tolerate the vaccine and wants to receive a vaccine is able to do so expediently. Governor Cuomo has indicated that all nursing home residents and staff will be vaccinated by the end of the week,[10] and transparent nursing home data is integral to ensure for accountability for meeting this milestone.

The Impact of Vaccines on Public Schools

We are grateful that teachers and education workers are included in Phase 1b of vaccine rollout, which began yesterday.[11] The vast majority of New York City public school students (approximately 700,000) still attend classes remotely, and even those who participate in hybrid learning only spend two or three days per week in the classroom. These students also face frequent school closures because of COVID rates in school buildings. For these reasons, the plan for vaccine distribution across New York City must include a thoughtful focus on the needs of public school communities, and vaccination in school communities must be timely and equitable.

The vaccination plan must be crafted to ensure vaccine distribution is used as a tool to bring students back *into* learning environments, not to exclude them unfairly. For example, students should be able to move from virtual to in-person instruction with *reasonable* notice to the school. The current system of one-chance deadlines puts undue pressure on parents to "opt in" to in-person learning even when they are not sure it is safe.[12]

Additionally, the Department of Education (DOE) must improve its school-related COVID data so teachers and families can make smart decisions and vaccines can be directed where they are most needed. Right now, the data available through the DOE's COVID "situation room" are not reliable or granular enough to be useful, are updated at different times on different days, and do not give complete information.[13]

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departments, educators, and public transit organizations to begin developing plans to vaccinate their workforce.").

[10] Press Release, Gov. Andrew Cuomo, Governor Cuomo Updates New Yorkers on COVID-19 Vaccine Distribution Efforts (January 5, 2021).

[11] *Phased Distribution of the Vaccine*, NEW YORK STATE DEP'T OF HEALTH, https://covid19vaccine.health.ny.gov/phased-distribution-vaccine (last visited Jan. 11, 2021).

[12] *See* Elizabeth Kim, *In Major Shift, NYC Will Offer Public School Families Only One More Chance To Opt Into In-Person Learning*, GOTHAMIST, Oct. 26, 2020, https://gothamist.com/news/major-shift-nyc-will-offer-public-school-families-only-one-more-chance-opt-person-learning.

[13] *Daily COVID Case Map*, NYC DOE, https://www.schools.nyc.gov/school-year-20-21/return-to-school-2020/health-and-safety/daily-covid-case-map (last visited Jan. 14, 2021); *See also,* Jillian Jorgenson Twitter post, Jan. 6, 2021, 11:33 a.m., https://twitter.com/Jill_Jorgensen/status/1346857310019325954?s=20 (The "situation room" provides the current day's citywide totals, as well as a cumulative total since the first day of school).

Importantly, the school vaccine plan must ensure that students who not vaccinated are not unfairly and pointlessly excluded from virtual education. At the beginning of this school year, we were contacted by parents whose children were shut out of remote learning because they did not have updated vaccination records on file. Vaccines are an essential public health tool, but in a year when families were advised to avoid leaving the home (including for non-urgent visits to the family doctor) and classes were available online, this denial was pointless and cruel. We urge the City to utilize remote learning capabilities as a tool to make educational opportunities more widely available, not less. While we do not object to traditional mandatory vaccination requirements for school children, we hope that the existence of online learning could at least grant families more leeway to meet deadlines. In the state of New York, education is a right, not a reward for filing the proper paperwork.

Finally, creating an environment where all students feel safe to return to school is essential, but at the same time, it would be a mistake to ignore or deprioritize remote learning simply because a vaccine exists. For some students (who have a space to work, access to high-speed internet, and adequate devices) online learning can be as good or even better than the traditional classroom,[14] and even for students who return to physical classrooms, the need to complete work online and maintain email communication with teachers will only grow. For these reasons, New York City must improve remote learning capabilities and close the digital divide.[15]

Vaccine Distribution in Carceral Settings

There is substantial confusion over whether individuals who are incarcerated are included in vaccine priority tier 1b. Zack Fink of NY1 reported on January 5th that Governor Cuomo, Dr. Howard Zucker, and Larry Schwartz told "legislators that inmates . . . are in the next tranche of vaccinations, listed as 1B, along with Corrections Officers,"[16] but Senate Minority Leader Robert Ortt refuted this report, saying that "no decision had been made."[17] New

[14] *See* Elizabeth Harris, *Not Everyone Hates Remote Learning. For These Students, It's a Blessing*, N.Y. TIMES, May 2020, https://www.nytimes.com/2020/05/20/nyregion/coronavirus-students-schools.html.
[15] There is promise in high-quality virtual education for reaching certain student populations (for example, those with serious health challenges) and delivering education more equitably (for example, allowing students to take advanced courses that are not provided in their home school). The City must invest in building a permanent, 21st-century virtual learning infrastructure to make education more flexible, more meaningful, and to close the homework gap. This means not only putting devices in students' hands, but actually closing the digital divide, adapting curriculum and graduation requirements for virtual learning, and ensuring that student privacy is protected when learning virtually.
[16] Zack Fink (@ZachFinkNews), Twitter (Jan. 5, 2021), https://twitter.com/ZackFinkNews/status/1346560285428113410?s=20.
[17] Morgan McKay, SPECTRUM NEWS NY1, Jan. 6, 2021, https://www.ny1.com/nyc/all-boroughs/ny-state-of-politics/2021/01/06/confusion-over-when-new-york-inmates-will-be-vaccinated.

York's Phased Distribution website is ambiguous at best on this point.[18] Both Brooklyn Defender Services and New York County Defender Services testified at this hearing that they have been informed that the City will vaccinate high-risk individuals who are incarcerated.[19]

Because social distancing is impossible in prisons and jails, the COVID-19 infection and death rates on City jails have been staggering.[20] While New York City should work to decarcerate as an important pandemic mitigation measure, it must also prioritize those who are incarcerated in the city jails for informed, consensual vaccination, and their counsel should be involved in conversations about vaccination and vaccine prioritization within the City jails.[21]

At the same time, many questions remain about how vaccination in City jails will function, and the City Council should seek answers to these questions: how is Correctional Health Services (CHS) determining who is high-risk? If the number of high-risk individuals exceeds CHS's allotment, how will vaccines be rationed? When will the vaccine be available to everyone in custody? How will the City ensure that individuals receive both doses of the vaccine if they are released between doses? How are the Department of Correction and CHS educating individuals who are incarcerated about the vaccine and alleviating any fears they may have about it?[22] This is particularly important given the U.S.'s long history of medical experimentation on incarcerated populations.[23]

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[18] *Phased Distribution of the Vaccine*, NEW YORK STATE DEP'T OF HEALTH, https://covid19vaccine.health.ny.gov/phased-distribution-vaccine (last visited Jan. 11, 2021). ("describing category 1b as including "Local Correctional Facilities, including correction officers.").

[19] TESTIMONY OF KATHLEEN MCKENNA, BROOKLYN DEFENDER SERVICES, NEW YORK CITY COUNCIL COMMITTEES ON HEALTH AND HOSPITALS ON OVERSIGHT - COVID-19 VACCINE DISTRIBUTION & ACCESSIBILITY IN NYC (2021); TESTIMONY OF CHRISTOPHER BOYLE, New York County Defender Services, NEW YORK CITY COUNCIL COMMITTEES ON HEALTH AND HOSPITALS ON OVERSIGHT - COVID-19 VACCINE DISTRIBUTION & ACCESSIBILITY IN NYC (2021).

[20] *See generally* MICHAEL REMPEL, COVID-19 AND THE NEW YORK CITY JAIL POPULATION (Center for Court Innovation, Nov. 2020).

[21] It is not clear that consent can ever be truly voluntary when an individual is incarcerated, though incarcerated populations are among both the highest risk and the least likely to have access to adequate medical care. *Cf.* Camila Strassle, E. Jardas, Jorge Ochoa, Benjamin E. Berkman, Marion Danis, Annette Rid, & Holly A. Taylor, *Covid-19 Vaccine Trials and Incarcerated People – The Ethics of Inclusion*, 383 N. ENGL. J. MED. 1897 (2020).

[22] *See, e.g.*, *infra* pp. 10 – 12.

[23] *See generally* Greg Dober, *Cheaper than Chimpanzees: Expanding the Use of Prisoners in Medical Experiments*, PRISON LEGAL NEWS, Mar. 15, 2008, https://www.prisonlegalnews.org/news/2008/mar/15/cheaper-than-chimpanzees-expanding-the-use-of-prisoners-in-medical-experiments/.

Vaccine Distribution Mechanisms

Both for prioritized populations and as vaccines become more widely available, New York must focus on ensuring that its vaccine distribution mechanisms are robust and reach all of our communities.

The federal government has announced that it will use the traditional private health infrastructure that delivers the flu vaccine (major pharmacy chains, doctors' offices, and hospitals) to distribute COVID-19 vaccines.[24] Unfortunately, the traditional private health infrastructure does not serve all communities equally. In fact, this network is woefully inadequate in the neighborhoods hardest hit by COVID-19. This is unsurprising, given that the pandemic has disproportionately impacted New York City's lower income neighborhoods that are home to a high percentage of essential workers and individuals who cannot work from home.[25] For example, Manhattan has nearly *four times* as many traditional vaccination sites as the Bronx – despite comparable borough populations.[26] Particularly galling, there is only *one* lonely vaccination site in East Elmhurst, Queens,[27] which is home to more than 23,000 people.[28]

New York City's newly released COVID-19 vaccine finder paints an even starker picture than the traditional vaccine network map.[29] Entire neighborhoods – like Woodside, Corona, Fresh Meadows, Bayside, Queens Village, South Richmond Hill, and Ozone Park in Queens; Brownsville and Fort Hamilton in Brooklyn; Parkchester, Throgs Neck, and Hunts Point in the Bronx; Washington Heights and Inwood in Manhattan; and Willowbrook and Woodrow on Staten Island – lack a single COVID-19 vaccination site.[30]

The paucity of traditional vaccination sites in lower income communities that have been devastated by the pandemic is likely to be exacerbated by the extremely cold storage required for the two vaccines that have so far been granted emergency use authorization (EUA). Pfizer's vaccine must be stored at -70 degrees Celsius and will go bad if not injected within five days of thawing.[31] Moderna's vaccine must be stored at -20 degrees Celsius,

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[24] Press Release, Gov. Andrew Cuomo, Audio & Rush Transcript: Governor Cuomo Updates New Yorkers on State's Progress During COVID-19 Pandemic (Nov. 2, 2020) (https://www.governor.ny.gov/news/audio-rush-transcript-governor-cuomo-updates-new-yorkers-states-progress-during-covid-19-18).
[25] *See* Joseph Goldstein, *1.5 Million Antibody Tests Show What Parts of N.Y.C. Were Hit Hardest*, N.Y. TIMES, Aug. 19, 2020, https://www.nytimes.com/2020/08/19/nyregion/new-york-city-antibody-test.html.
[26] *Flu Vaccine*, NYC, https://a816-healthpsi.nyc.gov/NYCHealthMap/ (last visited Dec. 2, 2020).
[27] *Id*.
[28] U.S. Census Bureau, Census 2010, Table PL-P5 NTA: Total Population Per Acre New York City Neighborhood Tabulation Areas.
[29] *See COVID Vaccine Finder*, NYC, https://vaccinefinder.nyc.gov/locations (last visited Jan. 12, 2021).
[30] *Id*.
[31] *Deep-Freeze Challenge Makes Pfizer's Shot a Vaccine for the Rich*, BLOOMBERG, Nov. 10, 2020, https://www.bloomberg.com/news/articles/2020-11-10/deep-freeze-challenge-makes-pfizer-s-shot-a-vaccine-for-the-rich.

although it remains stable for 30 days at 2 – 8 degrees Celsius.[32] Extreme cold storage and transport procedures ("cold chains") are expensive, and to ensure that the vaccines that are now available via EUA are not solely options for the rich, appropriate cold chains will need to be established throughout the City.[33]

While we are grateful that the City and state have supplemented the traditional private health infrastructure by enlisting community-based providers to serve as vaccination sites, we have learned that these providers face myriad bureaucratic hurdles to effectively and efficiently distributing vaccines. In fact, the bureaucratic hurdles are so high – and the penalties for a mistake are so steep – that some medical providers were forced to throw out vaccine doses, because they simply could not find people to vaccinate who met all of the state's vaccination criteria.[34] In addition, we understand that community-based providers were told on January 3rd that they may be stripped of their vaccine supply[35] or denied subsequent vaccine allocations[36] if they did not distribute their entire initial supply of vaccines by Thursday, January 7th. Those that have used their entire vaccine supply do not know whether or when their doses will be replenished. Community-based providers are deeply integrated into their communities and are trusted sources of care for the populations they serve. They therefore have an integral role to play in ensuring that the vaccine reaches everyone.

The City Council must do everything in its power to ensure that the vaccine reaches all of our communities and to make sure that individuals do not have to traverse the city to receive vaccines, but rather can be vaccinated – without substantial wait times – within their neighborhoods. In addition to supporting vaccination programs within the existing community-based health care providers, this should include partnering with community-based organizations to establish additional vaccination sites that are local, culturally competent, and linguistically inclusive. The City should also ensure free and accessible transportation to existing vaccination sites, as well as guarantee job-protected time off work to get vaccinated, where necessary. And, the City should engage in a culturally competent and linguistically inclusive public education campaign to ensure that all of our communities know where they can receive vaccines.

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[32] Press Release, Moderna, Moderna Announces Longer Shelf Life for its COVID-19 Vaccine Candidate at Refrigerated Temperatures (Nov. 16, 2020) (https://investors.modernatx.com/news-releases/news-release-details/moderna-announces-longer-shelf-life-its-covid-19-vaccine).
[33] *Deep-Freeze Challenge Makes Pfizer's Shot a Vaccine for the Rich*, BLOOMBERG, Nov. 10, 2020, https://www.bloomberg.com/news/articles/2020-11-10/deep-freeze-challenge-makes-pfizer-s-shot-a-vaccine-for-the-rich.
[34] Dana Rubinstein, *After Unused Vaccines Are Thrown in Trash, Cuomo Loosens Rules*, N.Y. TIMES, Jan. 10, 2021, https://www.nytimes.com/2021/01/10/nyregion/new-york-vaccine-guidelines.html.
[35] Letter from Howard A. Zucker, M.D., J.D., Commissioner of Health, New York State Dep't of Health, to COVID-19 Vaccine Provider (Jan. 3, 2021) (on file with the author).
[36] Press Conference, Gov. Andrew Cuomo, (Jan. 8, 2021).

Equitable, Culturally Competent Vaccine Distribution

New York has articulated its first priority groups for vaccination.[37] In addition to the health care workers; those working at and those living in congregate settings, including the elderly and the disabled; teachers and other school staff; public transit workers; and pharmacy and grocery store workers; individuals living or working in homeless shelters with shared "sleeping, bathing or eating accommodations" who are already prioritized, New York must also prioritize those working at and those detained in prisons and jails; essential workers of all stripes; those with pre-existing medical conditions; and those whose racial, ethnic, and socioeconomic circumstances heighten their vulnerability; among others.

It is imperative that New York focus on those with the most need and that, within the prioritized groups, vaccines be distributed on an equitable basis. The City must also develop efficient, easily accessible, simple-to-use ways for New Yorkers to sign-up to be vaccinated. At present, while the City hosts a centralized vaccine finder website,[38] individuals must navigate to each provider's website to try to register for one of precious few vaccination slots, often filling out the same intake materials over and over again with each new attempt to obtain an appointment.[39] Comptroller Scott Stringer reports that "[t]hose seeking appointments [at DOHMH locations] must fill out a multi-step verification process to set up an account and face about 51 questions or fields to check off."[40] Although the City has developed a hotline for New Yorkers to make appointments, that phone line is often overwhelmed and, moreover, only accommodates English and Spanish speakers.[41] This is unacceptable. The City must ensure that all of our communities – particularly those who endure multiple burdens, including limited English language proficiency, digital illiteracy, and lack of connectivity – are able to easily schedule vaccination appointments.

And, the City must accommodate those who, whether for fear of deportation, criminalization, losing custody of their children, or any other reason, may be afraid to share intimate information with the government. This is particularly true when it comes to intake forms, like CVS's, that ask for a social security number, state identification number, or driver's license number for individuals who are uninsured;[42] there is no reason that vaccine providers should be soliciting this information.[43]

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[37] *Phased Distribution of the Vaccine*, NEW YORK STATE DEP'T OF HEALTH, https://covid19vaccine.health.ny.gov/phased-distribution-vaccine (last visited Jan. 8, 2021).
[38] *COVID Vaccine Finder*, NYC, https://vaccinefinder.nyc.gov/locations (last visited Jan. 12, 2021).
[39] Sydney Pereia, *New Yorkers Eligible for COVID Vaccine Report Frustrations With City Registration Websites*, GOTHAMIST, Jan. 11, 2021, https://gothamist.com/news/new-yorkers-eligible-vaccine-report-frustrations-city-registration-websites.
[40] *Id*.
[41] COUNCILMEMBER MENCHACA, NEW YORK CITY COUNCIL COMMITTEES ON HEALTH AND HOSPITALS ON OVERSIGHT - COVID-19 VACCINE DISTRIBUTION & ACCESSIBILITY IN NYC (2021).
[42] *COVID Vaccine Intake Consent Form*, CVS, https://info.omnicare.com/rs/095-VIX-581/images/COVID%2019%20Vaccine%20Intake%20Consent%20Form.pdf (last visited Jan. 12, 2021).
[43] *See infra* pp. 12 – 14.

In addition, the options on these vaccine sign-up forms must include individuals whose gender does not align with the gender binary and transgender people. We have heard reports that some intake forms inquire about a potential vaccine recipient's sex assigned at birth. We are aware of no reason these forms should include a question that is so likely to provoke fear and othering.

The City must also develop a mechanism for distributing vaccines to those for whom traditional identification documents present a problem, including undocumented individuals.[44] At a minimum, vaccination sites must accept a broad range of identity documents, including foreign IDs and documents besides photo identification, such as utility bills. The City must also establish ways for individuals who lack such documents to receive vaccines, because many low-income individuals and people experiencing homelessness do not have identification documents.[45]

In addition, we have heard reports of individuals who were denied vaccines because they are pregnant even though the EUA explicitly contemplates vaccination of pregnant people[46] and despite the fact that New York law proscribes medical providers from overriding a pregnant person's informed consent to receive a vaccine.[47] The City must ensure that pregnant people are in the position to decide whether to be vaccinated – which includes having access to the information they need to make the best decision for themselves[48] – without interference from paternalistic medical providers or paternalistic government actors.

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[44] Despite IDNYC and the state's Green Light law, which make identity documents available to undocumented New Yorkers, ID requirements continue to present unique challenges for undocumented people.

[45] *See* BRENNAN CTR. FOR JUSTICE, CITIZENS WITHOUT PROOF: A SURVEY OF AMERICANS' POSSESSION OF DOCUMENTARY PROOF OF CITIZENSHIP AND PHOTO IDENTIFICATION 3 (Nov. 2006), https://www.brennancenter.org/sites/default/files/legacy/d/download_file_39242.pdf ("At least 15 percent of voting-age American citizens earning less than $35,000 per year do not have a valid government-issued photo ID."); NAT'L LAW CTR. ON HOMELESSNESS & POVERTY, PHOTO IDENTIFICATION BARRIERS FACED BY HOMELESS PERSONS: THE IMPACT OF SEPTEMBER 11 13 (Apr. 2004) ("A total of 10.7% of clients lacked photo identification.").

[46] *E.g.* Letter to Elisa Harkins, Pfizer Inc., from Denise M. Hinton, Chief Scientist, Food & Drug Admin. (Dec. 23, 2020, https://www.fda.gov/media/144412/download) ("Each periodic safety report is required to contain descriptive information which includes: . . . A narrative summary and analysis of adverse events submitted during the reporting interval, including interval and cumulative counts by age groups, special populations (e.g., pregnant women) . . ."); FACTSHEET FOR HEALTHCARE PROVIDERS ADMINISTERING VACCINE (VACCINATION PROVIDERS) EMERGENCY USE AUTHORIZATION (EUA) OF THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19), FOOD & DRUG ADMIN. (Dec. 2020) ("There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to Moderna COVID-19 Vaccine during pregnancy. Women who are vaccinated with Moderna COVID-19 Vaccine during pregnancy are encouraged to enroll in the registry . . .").

[47] *See Schloendorff v. Soc'y. of New York Hosp.*, 211 N.Y. 125, 129 (1914); *Rivers v. Katz*, 67 N.Y.2d 485, 493 (1986).

[48] N.Y. Pub. Health Law § 2805-d (McKinney 2017).

Moreover, it is imperative that everyone who receives a vaccine has first given voluntary, informed consent.[49] The initial vaccines are distributed under an EUA, which means that the FDA released the vaccine "without all of the evidence that would fully establish its effectiveness and safety" and without reviewing – or having access to – all of the information and evidence that it typically would before approving a drug, device, or test in the normal course.[50]

Many, particularly in the Black community, remember the Tuskegee syphilis study – when, in the 1930s, the U.S. government studied the trajectory of untreated syphilis in hundreds of Black men, both concealing the nature of their research and withholding effective treatment after one had been identified – as well as surgical experimentation on enslaved people.[51] To individuals who still face stark disparities in the U.S. health care system,[52] Tuskegee feels ever-present. Black patients suffering from appendicitis, broken bones, and other serious conditions are less likely to be offered painkillers than white patients,[53] and in 2016 researchers found that half of white medical students surveyed "were willing to entertain one or more false statements about biological differences based on race, such as the notion that African Americans have less-sensitive nerve endings than whites."[54] In fact, COVID-19 researchers are using a cell line that originated from Henrietta Lacks, a Black woman whose cells were harvested without her knowledge and consent. And, although research done with so-called HeLa cells "underpin[] much of modern medicine . . . [n]one of the biotechnology or other companies that profited from her cells passed any money back to her family."[55]

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[49] It is not clear that consent can ever be truly voluntary when an individual is incarcerated, though incarcerated populations are among both the highest risk and the least likely to have access to adequate medical care. *Cf.* Camila Strassle, E. Jardas, Jorge Ochoa, Benjamin E. Berkman, Marion Danis, Annette Rid, & Holly A. Taylor, *Covid-19 Vaccine Trials and Incarcerated People – The Ethics of Inclusion*, 383 N. ENGL. J. MED. 1897 (2020).

[50] Joshua Sharfstein, MD, *What Is Emergency Use Authorization?*, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, Oct. 20, 2020, https://www.jhsph.edu/covid-19/articles/what-is-emergency-use-authorization.html.

[51] Peter Jamison, *Anti-vaccination leaders fuel [B]lack mistrust of medical establishment as covid-19 kills people of color*, WASH. PO., July 17, 2020, https://www.washingtonpost.com/dc-md-va/2020/07/17/black-anti-vaccine-coronavirus-tuskegee-syphilis/?hpid=hp_hp-banner-main_black-antivax-940am%3Ahomepage%2Fstory-ans.

[52] Khiara M. Bridges, *Implicit Bias and Racial Disparities in Health Care*, 43 ABA HUMAN RIGHTS MAGAZINE (2018).

[53] Peter Jamison, *Anti-vaccination leaders fuel [B]lack mistrust of medical establishment as covid-19 kills people of color*, WASH. PO., July 17, 2020, https://www.washingtonpost.com/dc-md-va/2020/07/17/black-anti-vaccine-coronavirus-tuskegee-syphilis/?hpid=hp_hp-banner-main_black-antivax-940am%3Ahomepage%2Fstory-ans.

[54] *Id.*; Sandhya Somashekhar, *The disturbing reason some African American patients may be undertreated for pain*, WASH. PO., Apr. 5, 2016, https://www.washingtonpost.com/news/to-your-health/wp/2016/04/04/do-blacks-feel-less-pain-than-whites-their-doctors-may-think-so/.

[55] *Henrietta Lacks: science must right a historical wrong*, NATURE, Sept. 1, 2020, https://www.nature.com/articles/d41586-020-02494-z.

Indigenous Americans, too, have survived "significant unethical research and medical care" since colonization.[56] Latinx New Yorkers remember that between the 1930s and the 1970s, approximately one-third of Puerto Rican women and girls were forcibly sterilized.[57] This history feels strikingly present as immigrants detained in ICE facilities in Georgia this year report forced hysterectomies.[58] Against this backdrop, it is no wonder that some communities are skeptical of vaccines, particularly if pushed too forcefully upon them when the vaccine is experimental and new.[59] Getting New Yorkers to take this vaccine will require planning, care, and sensitivity to these concerns.

Unfortunately, throughout the pandemic response, both the City and state have failed to prioritize cultural and linguistic competence and meaningful community engagement – to all of our detriments.[60] Given the City's high vaccine refusal rate,[61] it appears to be making the same mistakes once again. These community engagement failures are public health failures. The City must work with community members and community-based organizations to engage all New Yorkers in the vaccination effort. Just as community members have been more effective at convincing their neighbors to wear masks and adhere to social distancing,[62] community members and organizations are more likely than outsiders to know how to convince their neighbors to get vaccinated.

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[56] *See* Felicia Schanche Hodge, *No Meaningful Apology for American Indian Unethical Research Abuses*, 22 ETHICS & BEHAVIOR 431 (2012).
[57] Katherine Andrews, *The Dark History of Forced Sterilization of Latina Women*, UNIV. OF PITTSBURGH, Oct. 30, 2017, https://www.panoramas.pitt.edu/health-and-society/dark-history-forced-sterilization-latina-women.
[58] Caitlin Dickerson, Seth Freed Wessler, & Miriam Jordan, *Immigrants Say They Were Pressured Into Unneeded Surgeries*, N.Y. TIMES, Sept. 29, 2020, https://www.nytimes.com/2020/09/29/us/ice-hysterectomies-surgeries-georgia.html.
[59] *E.g.* Desi Rodriguez-Lonebear, PhD (@native4data), Twitter (Nov. 25, 2020), https://twitter.com/native4data/status/1331818437211955204. Nearly half of Black people in the U.S. say they will avoid a vaccine "even if scientists deem it safe and it is available for free," and 40% of Hispanic adults expressed skepticism about getting vaccinated while "two-thirds of white people said they would definitely or probably get vaccinated." Press Release, Kaiser Family Foundation & The Undefeated, New Nationwide Poll by the Kaiser Family Foundation and The Undefeated Reveals Distrust of the Health Care System Among Black Americans (Oct. 13, 2020) (https://www.kff.org/racial-equity-and-health-policy/press-release/new-nationwide-poll-by-the-kaiser-family-foundation-and-the-undefeated-reveals-distrust-of-the-health-care-system-among-black-americans/).
[60] *See generally* NYCLU, TESTIMONY BEFORE THE NEW YORK CITY COUNCIL COMMITTEES ON HEALTH AND HOSPITALS REGARDING OVERSIGHT OF NYC'S COVID-19 TESTING AND CONTACT TRACING PROGRAM, PART II (2020).
[61] *See* Henry Goldman & Keshia Clukey, *N.Y. Front-Line Workers to Lose Place in Line If Skip Shot*, BLOOMBERG, Jan. 7, 2021, https://www.bloomberg.com/news/articles/2021-01-07/nyc-s-de-blasio-blames-state-for-thousands-of-unused-vaccines ("More than 30% of health workers resist jabs, causing surplus.").
[62] Ashley Southall, *Police Face Backlash Over Virus Rules. Enter 'Violence Interrupters.'*, N.Y. TIMES, May 22, 2020, https://www.nytimes.com/2020/05/22/nyregion/Coronavirus-social-distancing-violence-interrupters.html.

In addition, as long as there are not enough vaccines to go around, New York City must eschew any temptation to make vaccination a pre-requisite for employment, education,[63] housing, or public accommodations. Such a requirement could worsen New York's existing racial, disability, and economic disparities.[64] In addition, some individuals may never be able to be vaccinated because of medical counterindications. These individuals must be able to continue to participate in society. As New York City adapts its policies to the changing realities of the pandemic, it must maximize adherence to the best public health practices and to equity.

Vaccine Confidentiality

In November, the federal government informed states that it was conditioning distribution of any COVID-19 vaccine to a state on that state's signing a data use agreement (DUA)[65] that committed to provide the federal government with a wealth of personal information about each vaccine recipient, including, but not limited to, name, address, date of birth, and identification number.[66] The sweeping nature of this data sharing agreement was unprecedented.

Although the federal Centers for Disease Control (CDC) run other vaccination programs and infectious disease surveillance programs, patients' personally identifiable information typically remains with state or local departments of health.[67] This is true, for example, when it comes to information collected to inform the federal government's response to the other pandemic we have faced in our lifetimes: the national HIV surveillance program.[68]

What is more, that data sharing agreement was explicit that the CDC and the federal Department of Health and Human Services (HHS) could share vaccine recipients'

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[63] COVID-19 vaccines have not yet even been tested on young people. Denise Grady, *Moderna Plans to Begin Testing Its Coronavirus Vaccine in Children*, N.Y. TIMES, Dec. 2, 2020, https://www.nytimes.com/2020/12/02/health/Covid-Moderna-vaccine-children.html.
[64] *Cf.* Esha Bhandari & ReNika Moore, *Coronavirus 'Immunity Passports' are not the Answer*, ACLU, May 18, 2020, https://www.aclu.org/news/privacy-technology/coronavirus-immunity-passports-are-not-the-answer/.
[65] Data Use and Sharing Agreement to Support the United States Government's COVID-19 Emergency Response Jurisdiction Immunization and Vaccine Administration Data Agreement (Nov. 9, 2020) (on file with the author).
[66] *See* CENTERS FOR DISEASE CONTROL AND PREVENTION, COVID-19 VACCINATION PROGRAM INTERIM PLAYBOOK FOR OPERATIONS 63 – 64 (Oc. 29, 2020).
[67] *E.g. Statistics Center*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/hiv/statistics/index.html (last visited Dec. 2, 2020) ("CDC'S National HIV Surveillance System is the primary source for monitoring HIV trends in the United States. CDC funds and assists state and local health departments to collect the information. Health departments report de-identified data to CDC so that information from around the country can be analyzed to determine who is being affected and why.").
[68] *Id.*

information with "other federal partners,"[69] which could include Immigration and Customs Enforcement (ICE), the FBI, or the Department of Homeland Security (DHS). This too was without precedent.[70] Any number of people are likely to be chilled from receiving vaccines if they believe their personal information will be shared broadly within the federal government. This is particularly true for Black, brown, and immigrant communities, who, due to a toxic cocktail of socioeconomic factors, physical environment, and inferior access to health care,[71] are disproportionately likely to suffer from COVID-19.[72] They are also disproportionately likely to be alienated from and distrustful of our health care system because of the racial biases that pervade that system.[73] This is also true of religious enclaves, such as New York City's Hasidic community, which has also been ravaged by COVID-19,[74] still harbors deep distrust of the public health system and government after 2019's bruising battle over the repeal of religious exemptions for vaccines,[75] and feels singled out for pandemic-related enforcement.[76]

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[69] Data Use and Sharing Agreement to Support the United States Government's COVID-19 Emergency Response Jurisdiction Immunization and Vaccine Administration Data Agreement (Nov. 9, 2020) (on file with the author).

[70] *E.g. National Immunization Surveys*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/vaccines/imz-managers/nis/confidentiality.html (last visited Dec. 2, 2020) ("It is against federal law for us to give your name or any other information that could identify you to anyone, including the President, Congress, National Security Agency, Department of Homeland Security, Internal Revenue Service, Immigration and Naturalization Service, or welfare agencies for any reason.")

[71] *NCHHSTP Social Determinants of Health*, CENTERS FOR DISEASE CONTROL, https://www.cdc.gov/nchhstp/socialdeterminants/index.html (last visited May 14, 2020); *see also* Ibram X. Kendi, *Stop Blaming Black People for Dying of the CoronaVirus*, ATLANTIC, Apr. 14, 2020, https://www.theatlantic.com/ideas/archive/2020/04/race-and-blame/609946/.

[72] *Fatalities*, NYS DEP'T OF HEALTH, https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n (last visited May 26, 2020); *see also The Color of Coronavirus: COVID-19 Deaths By Race And Ethnicity in the U.S.*, AMP RESEARCH LAB, May 20, 2020, https://www.apmresearchlab.org/covid/deaths-by-race; John Eligon, Audra D.S. Burch, Dionne Searcey, & Richard A. Oppel Jr., *Black Americans Face Alarming Rates of Coronavirus Infection in Some States*, N.Y. TIMES, Apr. 14, 2020, https://www.nytimes.com/2020/04/07/us/coronavirus-race.html.

[73] Khiara M. Bridges, *Implicit Bias and Racial Disparities in Health Care*, 43 ABA HUMAN RIGHTS MAGAZINE (2018).

[74] Joseph Goldstein, *N.Y.C. Warns About Rising Virus Cases in Hasidic Neighborhoods*, N.Y. TIMES, Sept. 22, 2020, https://www.nytimes.com/2020/09/22/nyregion/coronavirus-Orthodox-Jewish-neighborhoods.html ("In late April, roughly 700 members of New York City's Hasidic community were believed to have been killed by the disease, and few families have been spared . . . In some areas with significant Hasidic populations, more than 40 percent of people being tested were found to have antibodies.").

[75] *See* Bobby Allyn, *New York Ends Religious Exemptions For Required Vaccines*, NPR, June 13, 2019, https://www.npr.org/2019/06/13/732501865/new-york-advances-bill-ending-religious-exemptions-for-vaccines-amid-health-cris.

[76] Liam Stack & Joseph Goldstein, *New York Threatens Orthodox Jewish Areas With Lockdown Over Virus*, N.Y. TIMES, Sept. 25, 2020, https://www.nytimes.com/2020/09/25/nyregion/coronavirus-orthodox-jewish-communities.html.

Fortunately, in early December, as a result of advocacy from many organizations and several states, including New York, the CDC did roll back the most egregious parts of the DUA. The new DUA states explicitly in Appendix G that vaccine recipient information will not be used "for any civil or criminal prosecution or enforcement, including, but not limited to, immigration enforcement, against such individuals whose information is shared pursuant to this DUA."[77] It is also explicit that the federal government "will not seek social security numbers, driver's license numbers, or passport numbers."[78] But, the DUA itself continues to insist that only states with a state law or regulation prohibiting them from sharing identifiable information about vaccine recipients may send de-identified information to the federal government; all other states are still required to share vaccine recipients' identifiable information.[79] New York has no such law, which means that New York will still be required to share vaccine recipients' names, addresses, dates of birth, and other personal information with the federal government, unless or until we pass such a law. Moreover, the latest DUA continues to permit the federal government to unilaterally change its appendices with only notice to the states – that is, without the opportunity to agree or disagree to the changes.[80] This means that the protections in Appendix G could disappear at any time. New York must remain vigilant.

At the same time, councilmembers must be careful to avoid spreading confusion and fear about the risks of information sharing so as not to exacerbate a chilling effect. And, City Council must do everything it can to ensure that New York does not share troves of vaccine recipients' personal information with the federal government and that, where information is shared, it remains entirely within federal health agencies. This advocacy should include re-evaluating and strengthening, where necessary, the protections for the Citywide Immunization Registry, as well as pressuring state and federal lawmakers to adopt policies that protect vaccine recipients' personal information, because no one should have to worry that information shared to respond to a public health crisis will be used to criminalize or deport them or to take their children away.

The NYCLU thanks the Committees for the opportunity to provide testimony and for their consideration of this critically important issue.

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[77] Data Use and Sharing Agreement to Support the United States Government's COVID-19 Emergency Response Jurisdiction Immunization and Vaccine Administration Data Agreement 24 (Dec. 1, 2020) (https://www.cdc.gov/vaccines/covid-19/reporting/downloads/vaccine-administration-data-agreement.pdf)
[78] *Id*.
[79] *Id*. at 2.
[80] *Id.* at 9. Appendix G does permit states to refuse changes to the data elements required under the DUA, presumably because the federal government requires state cooperation to receive additional data elements information. *Id*. at 24.

NEW YORK DOCTORS COALITION

TESTIMONY FOR THE NEW YORK CITY COUNCIL COMMITTEES ON HEALTH AND HOSPITAL ON THE VACCINE ROLLOUT, JANUARY 12TH 2021

Thank you, Chairs Levine and Rivera and City Council, for the opportunity to testify. The New York Doctors Coalition represents a diverse group of physicians and health advocates located or with local chapters in the New York City area. Many of our members are actively involved in clinical care, medical education, public health and health advocacy more broadly. Since 2016, we have campaigned for a more equitable city and state response to chronic and systemic neglect of the health of low income communities of color. As health workers, we are dedicated to playing our part in ensuring effective rollout of the authorized coronavirus vaccines. As health advocates, we feel called to draw attention to several areas in which the rollout has fallen regrettably short.

I. Decrease Reliance on Medical Centers as Points of Dispensing (PODs)

While relying on large medical centers as initial points of dispensing was critical for reaching frontline healthcare workers, the lack of community-based PODs will exacerbate existing COVID-19 health inequities. Even as the state's rigid prioritization guidelines threatened to penalize providers for flouting the eligibility criteria, we have witnessed elite medical centers liberalizing the criteria to include many non-patient-facing staff with few risk factors for severe COVID-19 before frontline workers and high risk groups. Indeed, the State's restrictive and frequently revised criteria have hampered the inoculation of a larger number of people over the initial weeks of rollout despite a robust supply. Another serious issue, we believe, stems from little regulation on how elite medical centers implement vaccine prioritization in the first place. In October 2020, the NYSDOH released a prioritization matrix based on geographic prevalence of COVID-19.[1] The actual rollout has favored large health systems concentrated in affluent neighborhoods and devoted few resources to ensuring coverage of areas with high prevalence or mortality. Indeed, intra-institutional chaos has beset some of the most acclaimed institutions in the country (e.g. Montefiore, Stanford), with frontline staff often queuing behind non-clinical personnel.[2] Meanwhile, a lack of outreach to historically marginalized groups, many of whom work on the patient-facing frontline as nurses, aids, technicians and custodians, has meant lower vaccine uptake among these groups. Vaccine hesitancy among workers is even more pronounced at safety-net hospitals.

Such scenarios might have been mitigated if non-clinical community-based facilities hosted outreach events throughout the year and were introduced as PODs. We welcome the opening up of an increasing number of community-based PODs in the coming weeks. Distribution through schools, food banks, houses of worship, independent pharmacies and FQHCs increases access to low income communities and may help to address vaccine hesitancy. Mobile units capable of going door-to-door are moreover essential for reaching the high-risk demographic groups -- e.g. women with dependents -- who cannot easily leave their homes. This is particularly feasible with the Moderna and the yet-approved adenovirus vaccines,

[1] https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/NYS_COVID_Vaccination_Program_Book_10.16.20_FINAL.pdf

[2] https://www.nytimes.com/2021/01/10/health/coronavirus-hospitals-vaccinations.html

which do not require ultra-cold storage. It is also essential that communication and collaboration are facilitated between these de-centralized PODs and central decision-making bodies at city and state level, so that valuable real-time feedback from communities, and especially our most vulnerable communities, is captured to inform ongoing distribution strategy. PODs must be dispersed outside of resource-rich areas in order to reach the wider public and historically marginalized groups. This leads me to our second concern.

II. Targeted Rollout of Limited Vaccine Supplies

Currently, NYS as a whole has received only 1.1 million doses of vaccines, which is not enough to vaccinate 400,000 residents per week and reach herd immunity by summer. If the majority of these doses are distributed through large, centralized PODs, the New Yorkers who will be left behind will be those who are more vulnerable and with less access to information and fewer resources to travel. Efficient rollout should thus be carefully balanced with targeted distribution through community-based PODs. Vaccine supply must be ensured for residents and staff of congregant settings including jails and prisons, homeless shelters, isolation facilities, syringe exchanges, and assisted living facilities for those with developmental disabilities.

III. Outreach, Outreach, Outreach

Ongoing, persistent and community-based outreach is a critical component of any successful vaccination campaign. Given the high level of vaccine hesitancy, a multi-prong information campaign is crucial. Many basic facts about the vaccine and expectations about vaccination are still shrouded in mystery for the vast majority of New Yorkers. An aggressive, plain-language health education campaign is essential and will take time to reach the intended audiences. Local and ethnic radio should be enlisted in outreach. As it stands, PODs should work with community stakeholders to promote the safety and efficacy of the vaccines, again made easier if they are located in non-medical settings. Scheduling vaccines should not require internet access, but should also be handled through a telephone hotline and in-person, at the PODs. While the Moderna and Pfizer vaccines have been shown to be safe in a trial population of tens of thousands, we also know that the physiological reaction to the second dose of the mRNA vaccines can be very pronounced, requiring many to take time off from work immediately afterward. In anticipation of frequently asked questions and anxiety that may understandably develop, help and reassurance should be readily accessible through a vaccine hotline.

IV. Summary

Balancing equity and efficacy is not a zero-sum game. Ensuring equitable vaccine distribution inherently means reaching the vast majority of New Yorkers who are working class and belong to high risk categories by federal and state guidelines, be it through age, comorbidity, place of residence, or line of work. At the same time, slow distribution imperils the population of New York, especially its most marginalized, to an even greater toll of sickness and death from a wily and rapidly mutating virus. With these principles in mind, the New York Doctors Coalition has three main demands for the agencies handling vaccine rollout going forward:

1) Transition PODs away from elite medical centers to community sites and mobile units, ensuring robust communication between the community PODs and central decision making bodies.
2) Target vaccine doses to high risk groups including prisoners and group home residents
3) Increase outreach through community stakeholders

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

New York City Council Oversight Hearing –
Joint Hearing of the Committee on Health and the Committee on Hospitals:
COVID-19 Vaccine Distribution and Accessibility in NYC
January 12, 2021, 10 a.m.

Testimony of the New York State Nurses Association
Presented by:
Judy Sheridan-Gonzalez, RN, President
Pat Kane, RN, Executive Director

The New York State Nurses Association (NYSNA) represents more than 40,000 frontline registered across the state of New York. Our members have been in the forefront of the fight against COVID and we are strong advocates for universal access to care for all New Yorkers as we face the ravages of the pandemic.

NYSNA members have also been first-hand observers in the initial phases of the implementation of vaccination effort in New York City, both in administering vaccines and as priority recipients of the Phase 1 rollout of the program.

NYSNA Core Positions on COVID Vaccination
The only way that we will be able to end the current public health crisis wrought by the COVID pandemic is to quickly implement a universal vaccination program to provide enough immunity in the general population to blunt transmission.

In implementing a mass vaccination effort, we believe that the following essential principles will be decisive:

1. Any vaccination program must be premised on sound science and data, and the information must be widely disseminated to the public to allay concerns and increase confidence in the safety and efficacy of the vaccines.

2. Vaccinations, in the context of an insufficient supply of vaccine to immediately inoculate the entire population, must prioritize frontline health workers, older adults, other front line or "essential" workers, people with underlying conditions and people from low income communities and communities of color that have suffered from disproportionate infection, hospitalization and mortality rates.

3. The distribution of vaccines must not permit improper or advantaged access by people with the money or connections to "cut the line."

4. Though vaccination is critical to defeating the pandemic, it is not in itself enough. Any vaccination program must include ongoing and intensified efforts to prevent transmission in the community, in workplace settings, and in healthcare institutions. Healthcare and other workplaces must be protected from exposure and illness, even after the distribution of vaccines, through continued and effective use of ventilation, PPE, physical barriers, negative pressure room, social distancing, special accommodations for high-risk workers, and other basic public health measures to reduce the risk of infection.

5. Vaccines should be universally available, free of charge or out of pocket insurance costs, to all New Yorkers, regardless of socio-economic status, race or national origin, immigration status or ability to pay.

6. Any vaccination program must respect individual autonomy and informed consent, and maintain an individual's right to choose whether to be vaccinated. Vaccination cannot be made mandatory, either for the general public or for healthcare providers and workers.

7. Education and transparency about the benefits, risks and misconceptions of taking the vaccine is essential to making the vaccination campaign a success. The City must mount a major effort to educate the public about vaccines and their benefits, including effective communication channels to allow workers and the public to have their concerns and questions about the vaccine to be addressed.

8. Nurses and other healthcare workers, essential workers and the general public have a right to know about the risks of COVID transmission and infection in their workplaces.

NYSNA Observations and Concerns Regarding the Initial Roll-Out of Vaccinations

The initial vaccine rollout in NY City has suffered from a wide range of problems and shortcomings, many of which have been widely reported in the press. Our members have also reported concerns about the unexpectedly slow pace and the seemingly chaotic and disorganized process of its implementation.

Our initial concerns include the following:

Need for a robust and centrally-controlled public health infrastructure to administer vaccines

The coordination of the distribution of vaccines has been sorely lacking. The federal government has effectively abdicated any responsibility for implementing an effective program and has instead just distributed vaccines to the states and allowed each state to create its own distribution network.

In New York, the state has relied heavily on the private hospital networks in the first Phase to administer vaccinations to front line employees in Phase 1. The result has been very uneven and has lacked transparency. We don't know how many vaccines have been distributed and to which

hospitals. Within some of the private hospital networks there appear to be wide disparities in the administering of vaccines, and the pace of vaccination has been unacceptably slow.

The reliance on largely private sector providers to take the lead on vaccine distribution has not been effective. We expect the delays and bottlenecks in vaccination to continue, particularly as the supply of vaccines expands and wider groups of the population will have to be vaccinated.

NYSNA believes that the key to a public health campaign to conduct mass vaccinations of the entire City population must be directly overseen and centrally organized with the public health infrastructure in the leading position.

This will require giving primary responsibility to the campaign to the NYC Department of Health and Mental Hygiene and the NYC Health + Hospitals system. These entities already have wide experience working on a city wide level, providing services to underserved communities in a culturally and linguistically sensitive manner, and the infrastructure and experience to take the lead.

It should be noted that in 1947, the City of New York was able to effectively provide small pox vaccination to the entire population of the City in a matter of a few weeks. We should be using the City's public health system to recreate that dynamic and place the private sector (hospitals, other providers, pharmacies, etc.) in a supportive role.

Address vaccine hesitancy/resistance issues with a robust public information campaign

Our members report continued vaccine hesitancy among healthcare workers, our patients and in our communities. Many people have legitimate concerns and questions about the safety of the newly developed vaccines and the potential side-effects or complications.

The public information campaign around the vaccines remains insufficient and must be rapidly expanded if the pace of vaccination is to increase.

In addition, employers, health care providers and city agencies must provide forums and communication systems, including door-to-door public health teams to talk to people about the vaccines, provide information about safety concerns, listen to people's questions or doubts, and provide answers to overcome their doubts or hesitancy. This will be particularly important in immigrant, low-income and communities of color, where the levels of concern about vaccination are greatest.

Provide greater flexibility and expand the Phase 1 eligibility to a broader population

The initially approved vaccinations (Phizer and Moderna) require two doses and extreme cold storage. Once the vaccine is removed from storage to vaccinations, there is a short time period to administer the vaccine before spoilage occurs.

The current prioritization of eligible persons is too narrow and appears to be contributing to the slow pace of vaccination. A recent Executive Order issued by the Governor threatens severe fines (up to $1 million for each dose given to a person not meeting the criteria for Phase 1A vaccination). Attention must be focused on utilizing resources effectively, monitoring abuses, and addressing obstacles to the rapid inoculation of the broader population.

NYSNA fully supports measures to ensure that low priority persons be prevented from buying or using their personal connections to skip ahead of the line. There must, however, be some protocols to allow vaccines to be administered to next-level priority people in the event that vaccines will be spoiled or wasted and to speed up the pace of implementation.

Provide the funding needed to accelerate the pace of vaccination

The lack of a coordinated plan at the federal level has been made worse by the failure of a gridlocked Congress to provide states and localities with the large amounts of funding needed to implement vaccination on a rapid and mass scale.

With the imminent arrival of the Biden Administration and Democratic control of the Senate, we can expect a more focused and well-funded effort at the national level. While we wait for federal support and funding to start flowing, however, the City should provide the funding necessary to ramp up vaccinations at scale. The Council should provide emergency funding to get the vaccination effort on track and seek compensation from the federal level once the new administration and Congress are in place. We cannot afford to wait – the failures of the Trump administration have already caused immense damage and we must move quickly to make up for lost time.

Inadequate staffing for mass vaccination

The effective and rapid administration of a mass vaccination campaign cannot be accomplished on the cheap and without adequate trained and qualified staff. We need to mobilize doctors, nurses, pharmacists and other personnel who are qualified to administer vaccines, as well as support staff to assist and provide administrative, clerical and educational support.

The current reliance on private hospital systems is not sufficient to meet these urgent tasks. We need to implement a program to systematically mobilize and deploy the professional staff needed to complete this task on an emergency basis.

Current efforts to use volunteers and activate retired healthcare workers may partially assist in filling this huge gap, but such efforts have been insufficient and even haphazard. Many of our members are willing and able to provide assistance, but several have had difficulty finding out how to become involved. Many who have volunteered have reported that the process is more disorganized than they had expected.

The City should immediately deploy existing healthcare workforces in a systematic fashion for a crash effort. This must include using existing DOHMH and NYCHH workforces, as well as employing nurses and other personnel from the private sector who are currently being furloughed or laid off by hospitals due to the cancellation of non-critical services and procedures.

Need to rapidly expand the availability of properly equipped and staffed vaccination sites

The newly developed vaccines appear to be efficacious and have low rates of negative side-effects or reactions to vaccination. Despite these good initial clinical results, however, there is still a danger of severe reactions in a small percentage of recipients.

This requires that vaccination sites must not only have personnel to administer and process the patients receiving the vaccine, but also facilities and staff to monitor those who have been vaccinated and are able to respond immediately to any patients who experience serious side-effects.

The City should thus be rapidly expanding the availability of vaccination hubs or sites in our communities that are fully staffed and equipped to administer the vaccine and to monitor patients for adverse effects.

CATHOLIC COMMUNITY RELATIONS COUNCIL

80 Maiden Lane, 13th Floor, New York, New York 10038

Testimony of Joseph Rosenberg, Executive Director
Catholic Community Relations Council
New York City Council Committee on Health and Committee on Hospitals
Covid-19 Vaccine Distribution and Accessibility in New York City
January 12, 2021

Good morning Chair Levine, Chair Rivera, and members of the Committee on Health and the Committee on Hospitals. I am Joseph Rosenberg, Director of the Catholic Community Relations Council representing the Archdiocese of New York and the Diocese of Brooklyn on local legislative and policy issues. I am here today to advocate for providing human service workers, as well as the teachers, faculty, and staff of nonpublic schools to be considered as essential groups who should be given priority access to the COVID-19 vaccine.

I thank Chair Levine and Chair Rivera for holding this extremely important hearing on the distribution and accessibility of the COVID-19 vaccine. It is not hyperbole to say that this is the most important health issue confronting not just New York City but our entire country and earth in decades. This hearing could not be more timely.

Clearly, the most vulnerable New Yorkers should be prioritized to receive COVID-19 vaccinations, and City and State officials are focused on this ongoing effort. Nursing home residents and staff, and health care workers are among the groups designated by Governor Cuomo and Mayor de Blasio as currently eligible for vaccinations.

I urge that other groups be categorized as essential and provided access to the vaccinations as soon as the supply is available and being distributed. These are the human service workers of nonprofit providers, including Catholic Charities of the Archdiocese of New York, Catholic Charities of the Diocese of Brooklyn, and the faculty and staff of both public and nonpublic educational institutions including the schools of the Archdiocese of New York and the Diocese of Brooklyn.

Catholic Charities of both the Archdiocese of New York and the Diocese of Brooklyn have been at the forefront of providing food for the hungry, housing for the homeless, care for the frail elderly, and help for the needy in New York City for over 100 years. During the pandemic, this need has proven greater than ever as more New Yorkers face hunger due to job loss, more homeless are found struggling on our City's streets, and more elderly are isolated in their apartments with their only companionship being the human service workers who deliver their daily meals. The workers of Catholic Charities have been up to the unprecedented challenge created by the pandemic. They continue their mission of providing relief to New Yorkers, often putting themselves in harm's way despite following strict COVID-19 health protocols at all times. They face a high risk of exposure to the virus but their dedication to the citizens of our City remains undiminished. They cannot be forgotten and should be placed at the forefront of receiving vaccinations.

A similar situation faces the teachers and faculty of the schools of the Archdiocese of New York and the Diocese of Brooklyn. All teachers and staff, whether in public or nonpublic schools are devoted to their students, especially as the need to provide the children of our City with an education becomes more important than ever. During these times the faculty, teachers and staff of all educational facilities face health risks when conducting in-person classes. Since re-opening their schools in September, the teachers, administrators, and staff of the Archdiocese of New York and the Diocese of Brooklyn have been on the frontlines, holding the educational institutions together at personal risk to themselves and their families. It is therefore essential that as protocols are developed regarding the vaccination of public school faculty, teachers and staff, the faculty, teachers and staff of the nonpublic schools in our City be provided with the same opportunity and priority to be vaccinated.

Thank you for holding this hearing on one of the most important public health challenges that our City has ever faced.

Asian American Federation

Testimony to the New York City Council Committees on Health and Hospitals

January 12, 2021

Written Testimony

On behalf of the Asian American Federation, I want to thank Committee Chairs Rivera and Levine for giving us the chance to speak on this important topic. I'm Ravi Reddi, the Associate Director for Advocacy and Policy at the Asian American Federation. AAF represents the collective voice of more than 70 member nonprofits serving 1.3 million Asian New Yorkers.

Accessibility to, and the distribution of, the COVID-19 vaccine are issues upon which our City's economic well-being will hinge for years to come. The Asian American community, as with all communities of color, stand especially vulnerable if this opportunity isn't taken to address longstanding systemic barriers to healthcare and information access.

The COVID-19 pandemic has resulted in a 35% increase in deaths compared to the five-year average in our community and our recently released report on the devastating impact of COVID-19 on jobs our community relies on shows that our community has been hit harder by unemployment than any other in our City. Social isolation amongst our seniors combined with unprecedented strains on basic supplies continue to overwhelm our community resources, especially as the second wave is upon us.

There are 1.9 million Asians living in our city, two in three of whom are foreign-born. Over 20 ethnic groups are represented in our community and overall, 48.4% of Asians have limited English proficiency in New York City. Overall in 2019, 14% of Asians in New York City lived in poverty, compared to a statewide poverty rate of 16%. Among seniors, 23% of Asian New Yorkers lived in poverty compared to almost 19% of all seniors in the city.

Information Access

Especially in our community, the success of any mass vaccination effort will hinge on getting the right information to Asian New Yorkers the way they consume information. This means including community-based partners who have community credibility, especially with vulnerable populations like our seniors, as well as ethnic media outlets who are the primary medium of information consumption for many in our community. This means acknowledging the isolation of many of our Asian-American LEP New Yorkers and finding innovative ways to mobilize around their preferences, from ethnic media outlets, to Facebook and other social media outlets.

Language barriers present a formidable challenge, one our community-based organizations are uniquely-equipped to deal with. Amongst South Asian languages, 77% of Bengali speakers, more than 65% of Urdu speakers and half of Hindi speakers were also LEP. Even among Filipinos who have a reputation of high English proficiency, 39% of Tagalog speakers identified themselves as LEP. And for Asian American seniors living in poverty, LEP rates were 83% for Asians, compared to 48% for non-Asians. More broadly, more than 90% of Chinese and Korean speaking seniors had limited English

proficiency (LEP). An effective vaccination effort will require an unprecedented communications effort, in multiple languages, that can effectively mobilize our community with clear safety and logistical guidance. And it won't simply be enough to have information translated in multiple languages. More than at any other time, translations will need to be timely. The community education requires the outreach efforts of the Census, which had a constant informational drum beat. Community organizations, faith-based institutions, local health clinics, private doctors' offices, small business leaders, and other stakeholders need to be engaged to educate our community on the necessity of the vaccine.

Distribution

The sheer scale of any vaccine distribution effort will have to acknowledge the scale and size of our communities of color, without whose buy-in no mass vaccination effort will be successful. But vaccines are only as effective as the systems that deliver them. Throughout this pandemic, the difficulties endured by our community to get basic needs met and receive culturally-competent services must be seen as, at best, teachable moments, and at worst, mistakes we can't afford to repeat.

Nonetheless, throughout this crisis, our member and partner organizations have confirmed what all of us already knew about some of our most vulnerable and isolated populations. Asian seniors, like most limited-English proficiency and immigrant New Yorkers, will utilize services that reflect their values and ethnic identities. In so many ways, our community-based organizations are leveraging the goodwill they have earned in our communities, providing culturally-competent services and leading by example.

With the coming COVID-19 vaccination effort, we have the opportunity to create a model effort that puts community-based organizations who have done the work and developed trusting relationships in our most marginalized communities in the driver's seat alongside City agencies.

On behalf of the Asian American Federation, I want to thank you for affording me the opportunity to speak with you today. This is an unprecedented situation, but we have an unprecedented opportunity to re-imagine our City's relationship with our community.

Community Health Care Association of New York State
NYC Council Committees on Health and Hospitals
Written Testimony: COVID-19 Vaccine Distribution & Accessibility
Tuesday, January 12, 2021 @ 10:00 am

The Community Health Care Association of New York State (CHCANYS) writes this testimony on behalf of the 459 community health center (CHC) sites across New York City. We thank the NYC Council Committees on Health and Hospitals for their continued oversight of the COVID-19 vaccine distribution process across the city.

CHCs serve 1.3 million New Yorkers in the communities hardest hit by COVID-19. Over 92% of our NYC patients are low income, 85% are people of color, 14% are uninsured, and 67% are enrolled in Medicaid, CHIP, or Medicare. Due to pervasive structural inequities in the healthcare system that our patients regularly encounter, they are at highest risk for severe negative health consequences of COVID-19. They have lost community members, friends, family, and loved ones due to COVID-19. Despite historic inequities in access to care, we are optimistic that the roll-out of the COVID-19 vaccine will result in the end of this pandemic. However, the vaccine will only be a successful part of the solution if New Yorkers receive the immunization quickly and efficiently. Accordingly, it is our unequivocal mission to ensure that all patients and staff have swift access in a trusted setting. To do so, CHCs need to overcome barriers to distribution. We applaud the City Council for focusing on how to best improve distribution and accessibility of the COVID-19 vaccine.

Hurdles to Effective Vaccination Distribution & Administration

At a December City Council hearing, CHCANYS testified about the readiness of CHCs to partner with City and State government on vaccine rollout. Later that month, CHCs across the City were thrilled to begin receiving the first doses of the Moderna COVID-19 vaccine and began vaccinating according to New York State Department of Health (DOH) guidelines. These guidelines require that the vaccine be administered in phases to groups of people that have the greatest risk of exposure to COVID-19, such as health care workers. Per DOH directives, CHCs first offered the vaccine to eligible staff in cohorts, rather than all at once, for fear of excess absenteeism due to vaccine side effects. Many staff deferred vaccination until after the New Year for fear of side effects; were out of the office taking holiday vacation; or were quarantined or isolated due to exposure or infection. At the same time, CHCs committed themselves to administering vaccine for other eligible health care workers, many of whom are existing partners in caring for patients in common. In contrast, CHCs had not been permitted to begin vaccinating anyone other than healthcare workers.

The combination of the limitations on who may be vaccinated as part of Phase 1A and the way the vaccine is packaged stymied initial vaccination rates. The Moderna vaccine arrives in 10 doses per vial and once a vial is opened, providers have just 5 hours to administer all 10 doses. As such, pre-scheduling eligible internal and external staff for vaccine administration has been imperative to ensure all 10 doses can be used quickly. When an individual does not arrive for the vaccination appointment, CHCs have been forced

to scramble to find vaccine-eligible populations before the opened vial expires. This is notwithstanding the fact that eager and willing high-risk patients and non-authorized staff would be standing nearby, unable to receive the remaining doses due to the State's strict prioritization. This has slowed down the vaccination process and risks wasting limited vaccine supplies. We believe that, in instances where there is a potential of spoiling vaccines, providers should be allowed to use their professional judgement to vaccinate willing individuals to ensure that no vaccine goes unused or wasted.

For these reasons, our association has been working closely with the State to find ways to expand access. CHCANYS is pleased that the Governor announced last week that he was expanding eligible populations to phase 1B, which includes some of our patients. We believe expanding vaccine eligibility to all high-risk populations will ensure an equitable and expeditious vaccine administration and prevent wasted or discarded doses. We hope that this expansion will ameliorate many of the factors that have contributed to delays in accessing the vaccination to date, and our member CHCs are excited to start providing this service to their patients.

As was the case with COVID-19 testing and contact tracing, vaccine rollout has also experienced exponential growth, with each week becoming more sophisticated and resource demanding. This is a good sign, but only if we continue to have access to the vaccine, regardless of delays early in the process.

Improving Access and Uptake

One of the elements of CHCs that makes them so trusted in their communities is that they hire individuals who live in the communities they serve. The providers, nonclinical staff, and patients use the same grocery stores, have children who go to school together, and ride the same transit lines. In communities of color, especially the Black community, historical medical exploitation has led to vaccine distrust. As such, most CHCs have not instituted vaccine mandates for staff. Rather, our member health centers are taking the time needed to ensure that everyone who receives the vaccine makes that choice because they feel safe and empowered in doing so. It is imperative that the City work with CHCs to continue to improve education about the vaccine. Our members find that even getting staff comfortable takes time, explanation, and empathy. While we are confident that many patients and staff will soon feel secure to take the vaccine, our members continue to devote time to ensuring that New Yorkers understand the safety and efficacy of the approved vaccines. CHCs are using these communications efforts not just with employees, but also with patients who will be able to access the vaccine in the coming days, weeks and months. Our members are proud to partner with the City to implement a strong and supportive outreach and education effort, which is key to the success of the vaccination program.

Tracking Vaccinations

CHCs were initially instructed to register in the Citywide Immunization Registry (CIR) for sites in NYC and the New York State Immunization Information System (NYSIIS) for sites located outside of NYC. However, the lack of interoperability between the CIR and NYSIIS created problems for the many CHCs with locations both in- and outside of the City, forcing them to duplicate efforts and waste precious time. We urge the City to continue to find ways to collaborate with the State and streamline this reporting process.

CHCANYS and the New York City CHC network are committed to continuing to work tirelessly to ensure a successful vaccination program. We thank the Council and other City partners for their dedication to the

safety and wellbeing of New Yorkers, and for your focus on the rollout of vaccine distribution. CHCANYS and its members are proud to be the City's strongest partners and advocates to ensure that the vaccine, in conjunction with comprehensive healthcare, continue to be provided to New Yorkers that have so often been left behind by the medical field.

For follow up, please reach out to Marie Mongeon: mmongeon@chcanys.org.

We should be angered and sad by the fact that--Native Americans/indigenous peoples are 2.8 times more likely to contract the virus and 5.3 more times likely to be hospitalized; Black Americans are 4.7 more times likely to be hospitalized and 2.1 times more likely to die; and Latinx people in the U.S. are 2.8 times more likely to contract the virus and 4.6 times more likely to end up in the hospital. Asian Pacific Islander communities are also confronting high rates of COVID-19 and in many states also have been twice as likely to die from the virus. And covid-19 have posed unique challenges for people with disabilities than most of us are not aware of. The tragedies are compounded by studies showing that Black and Brown patients had to get severely sick or go to the hospital, potentially even get admitted to the hospital before they got a test and the protocols for receiving medications — like remdesivir — you have to had a documented positive COVID test in order to get access to those treatments. What also hurts is that we cannot be surprised that this is happening. The disparity is rooted in racially unjust systems have long decided who lives, who dies, who thrives and who just gets by.

Communities, especially people of color can embrace therapies and vaccination attempts, but we just can't sit in this historical context and ignore not only the Tuskegee [syphilis study] Henrietta Lacks, the US-imposed sterilization policies in Puerto Rico, the widespread institutionalization of people with disabilities, radiation experimentation on women and children from the 50's to the 70's Perry Hudson experiments on the New York City homeless in the 1950s, two decades of foster children being enrolled in HIV vaccination trials, but so many violations of sovereignty and respect that are tenets of ethical research. Medical researchers in the U.S. have taken extreme and horrible advantage of Black, Indigenous, People of Color which includes Asian and Pacific Islander and Latinx communities. If you just look up the big pharmaceutical companies that are developing the vaccines, just look at their senior leadership teams and the board of directors. It does not arouse trust for communities of color.

Vaccination is an emotional topic that divides communities and even public health and legal experts. but when the costs are a matter of life and death, sometimes we need to throw away the big stick and hold out a hand instead. This is a complicated issue, but vaccinations should not be treated differently than any other form of medical care, and they must be protected within the same framework that has been created for the public's protection. We cannot allow exceptions because it feeds the misconception that vaccinations are an option, a choice, a topic for subjective opinions. **But calls for mandatory vaccination would be a real problem because**:

- Vaccination policies that ignore social and cultural sensitivities, risk lacking public support even when they have a strong evidence base.

- People who are impoverished already had little trust in government authorities. A universal vaccine mandate in the face of widespread mistrust would raise real enforcement problems and with enforcement we have seen racist and differential treatment of black and brown communities.

- Going to mandates without transparent efforts to educate the public will cut off at the legs any efforts around vaccine safety concerns and will raise even stronger resistance.

- Cost a lot in resources, chasing up penalties often for little gain.

- Mandatory programs are marginally effective for adult populations, they risk further isolating disenfranchised parts of the community, making it even harder to eradicate potential hotspots of disease.

- Once we have an approved vaccine, and even if all goes remarkably well without a mandate, we will begin by producing and distributing doses that will not, at the beginning, have enough doses to go around for those who want them.

- We have already seen masks and social distancing politicized. Any universally applicable mandates, unless accompanied by self-enforcement mechanisms, need some buy-in and accordance to work well.

- Recognition and understanding that life's other challenges take priority in many people's lives, especially getting food at the table and maintaining a roof over the head.

- Potential challenges in courts would provide anti-vaccine groups with an additional forum in which to spread more doubt on vaccine safety.

As a public health advocate, it is critical how much public healthcare relies on winning the 'hearts and minds' of the community. We recommend the following:

Raising Public Confidence:

As we continue with vaccine trials and try to disseminate vaccines, we must have teams that look like the majority of Americans, and the affected population, advisory boards reflected of marginalized communities on those teams, community led, driven, and focused outreach, including multilingual recruitment strategies, and engagement of trusted leaders in those communities (including community-based and faith based organizations) in paid roles — they have to be paid roles, because we don't take large funding and resources and then put volunteers in charge of recruitment — they also have to be supported by grants. For too long the investment has been unequal and unfair. We must:

- Strengthen engagement with tribal, territorial, and local partners, other community-based stakeholders, and the public to communicate public health information, before and after distribution begins, around the vaccine and promotes vaccine confidence. Advocates for vaccination with similar backgrounds to the target population can help to increase trust and acceptance.

- The New York City Department of Health should build on its collaboration with frontline community-based organizations (CBOs) and institutions on the creation of short trainings and workshops for staff working at

CBOs. Training needs to be also offered to homecare workers, domestic worker/worker centers and nursing home staff. The workshop can address safety and the methods of the vaccination. We need an informed trusted broker. Trust is multi-layer, and the staff of organizations may also exhibit anxiety and misinformation, and confidence in vaccination.

- Focus on identifying and addressing misconceptions and concerns about vaccine safety and effectiveness, uniting trusted messengers and influential voices and tailoring communications to reach diverse audiences. Communicating the science and facts on sanitation, hygiene, and immunization is effective when we trust the source. The usual public service announcements on immunization simply will not cut it. We need multi-tactics usages like social media, online communications being sent to parents, circulars in supermarkets and grocery stores, informational posters in salons and barber shops, media plan to get trusted leaders and people who already been vaccinated on radio, local, and paid TV networks to speak about their experience and trust in the vaccination.

- Replicate national public health campaigns (i.e. COVID Collaborative made up of a group of leading experts in health, education, and the economy) at localize levels to create some consistent messaging but with flexibility to target the understanding and buy-in by specific communities. https://www.covidcollaborative.us/

- Increase transparency in the dissemination of vaccinations and positive + negative outcomes. We should be public and vocal about the ways the existing oversight process is conducted and monitored for the first and second doses of the vaccination. The public should have access online, responsible journalists should have access to facts and information to help the public understand, and public health advocates, health providers, and other stakeholders should have a easily searchable and readable website to access the process and progress.

- Explore a tailored mandate—one for healthcare workers or essential workers—would be better justified and more likely to be supported than a universal one.

Making Dispensing Equitable and Accessible:

- The Governor must not make further cuts to the Medicaid program and ensure equitable funding to health care facilities that play an authentic safety-net provider role. Democrats have clinched a supermajority in the State Senate, as they gained enough seats to give them veto-proof control of the Legislature. Starting in December of this year, they must capitalize on this opportunity to provide direction for the incoming year to fix the Indigent Care Pool (ICP) funding distribution to hospitals, stop any cuts to Medicaid and cuts to the 340B program-Medicaid pharmacy benefits that federally qualified health centers rely on. Ensuring safety-net facilities get their fair share from the ICP and other health equity bills is critical. We cannot have all safety-net facilities/providers be part of a robust vaccination program if they are struggling financially to just provide health care.

- Distribute vaccines immediately upon granting of Emergency Use Authorization using a transparently developed, phased allocation methodology.

- Cost of the vaccination cannot be transferred to the patient. Insurance companies must pay for it, people who are uninsured should get it for free, funding must be made available to health care providers to provide the shots, and any associated costs and surprise bills must not become a barrier.

- Prioritize early rounds of the shots in the name of fairness for these communities disproportionately affected by the disease. Race is a very critical priority but in these early planning stages, essential worker employment like health care workers, data like death and infection rates, along with housing status, age, economic stability, health care coverage and ethnic backgrounds could all play a role in who might be among the first groups to get vaccinated.

- Ensure it will be broadly and equitably accessible. Identify medically underserved areas and expand the types of providers and locations that could offer the vaccination (i.e. FQHC's, pharmacies (small and big box). Congress needs to support Senator Schumer call for at least $30 billion to ensure adequate supply of the vaccination.

- Foster and encourage places for dispensing to work with local leadership, community-based /faith-based organizations and places of worship in the planning and communication of safety of and access to vaccination (i.e. a pharmacy with a community group). This will need the city and state to provide some geographic map and information for potential partners to identify each other and link up.

- Ensure we can measure the first round through an equity assessment and evaluation to make any timely improvements and strengthen the second-round distribution of doses if required.

- Review the existing city and state vaccination plans if they have sound and effective access and communication strategies. Companies like Moderna require two shots administered four weeks apart, which could make distribution more complicated. People may need additional booster shots. supply-chain challenges and the possibility that not everyone will return to a doctor's office for the critical second shot makes it complicated. However, we have current examples of strategies efforts with the Hepatitis-B booster and HPV vaccination-in the case of Covid-19 it will be intensified.

- The state should foster and manage how hospitals, nursing homes, and other health facilities communicate and partner around addressing supply chain issues that include vials, syringes, refrigerators, patient waiting lines and clinic visits at a time when such resources are already limited. This should not be about control of their market shares- this is about people.

- Federal government should strongly encourage the companies making the vaccinations will diversify up their team and have targets for enrollment that they can live up to. Research needs to have mechanisms where the funding is dependent on your ability to recruit diverse volunteers to test the vaccination. And if you cannot recruit at the ratios that you promised to recruit, then you need a good explanation why and a corrective plan moving forward. Just because we speed up the process to create vaccinations does not mean we cannot revisit this.

- Journals accepting a paper related to COVID-19 vaccination and other related issues, need to ask for a demographic table, and they need to say a huge limitation of the study is that it was conducted in not people of color. In this pandemic, and the way it is played out in the United States, it is not acceptable to have those studies create false sense of security and inform planning and resources without a complete picture.

Accountable Monitoring:

- Monitor necessary data from the vaccination program through an information technology (IT) system capable of supporting and tracking distribution, administration, and other necessary data including safe administration of the vaccine and availability of administration supplies.

- Aggregate how the vaccine use and behavior will be across communities. We have an opportunity to correct earlier omissions of Black Latinx, people with disabilities, LGBTQ+, and other marginalized communities like Asian Pacific Islanders and Indigenous people in the breakdown of the data in testing and tracing.

- Prepare and coincide vaccination messaging with wearing masks and physically distance even after getting a COVID-19 vaccine. We cannot forget the basis for flattening the curve of the infections and deaths, especially in low-income, immigrant, and communities of color.

A COVID-19 vaccine will not work without sufficient acceptance and comprehension. Being treated equally is not about balanced representation. It is about disproportionate representation of black and brown people, because we are more affected by the disease. Getting vaccinated, is a considerate, altruistic sense of responsibility. We are doing this for the person, the infant, everyone with medical conditions yielding them completely immunosuppressed, and we are doing it for our family, friends, and neighbors. I believe in the human spirit and we can get it right. Equity in access, treatment, delivery, funding in health care and public health are fundamental values and necessities, in which the recommendations above are based on.

Written by Anthony Feliciano, Director Commission on the Public's Health System

Email: afeliciano@cphsnyc.org cell: 646-325-5317

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Organization & Individual Endorsers of the Statement

Academy of Medical & Public Health Services

APICHA Community Health Center

Brooklyn-Queens-Long Island AHEC

CAMBA, Inc.

Caribbean Women's Health Association, Inc.

Chinese Progressive Association

Coalition for Asian American Children and Families

Covid-19 Accountability Working Group

Far Rockaway/Arverne Nonprofit Coalition

Grand St. Settlement

Housing Works

JAPANESE AMERICAN ASSOCIATION, INC

National Mobilization Against SweatShops

NYITCOM

Manhattan Staten Island Area Health Education Center

Metro New York Health Care for All

Polonians Organized to Minister to Our Community, Inc.

Red Hook Community Justice Center

Nami NYC Metro

Nami NYC Metro

Neighbors to Save Rivington House

NYC DSA - Healthcare Working Group

Red Hook Community Justice Center

Roberto Clemente Center-Gotham Health

Sakhi for South Asian Women

South Bronx Community Congress

9/11 Environmental Action

Individual Supporters

Anne Bove, RN, and former President, NYSNA HHC Executive Council

Latisha Gibbs, Peer Educator

Hiroko Hatanaka, Member of the board of Japanese Am. Social Services, Inc.

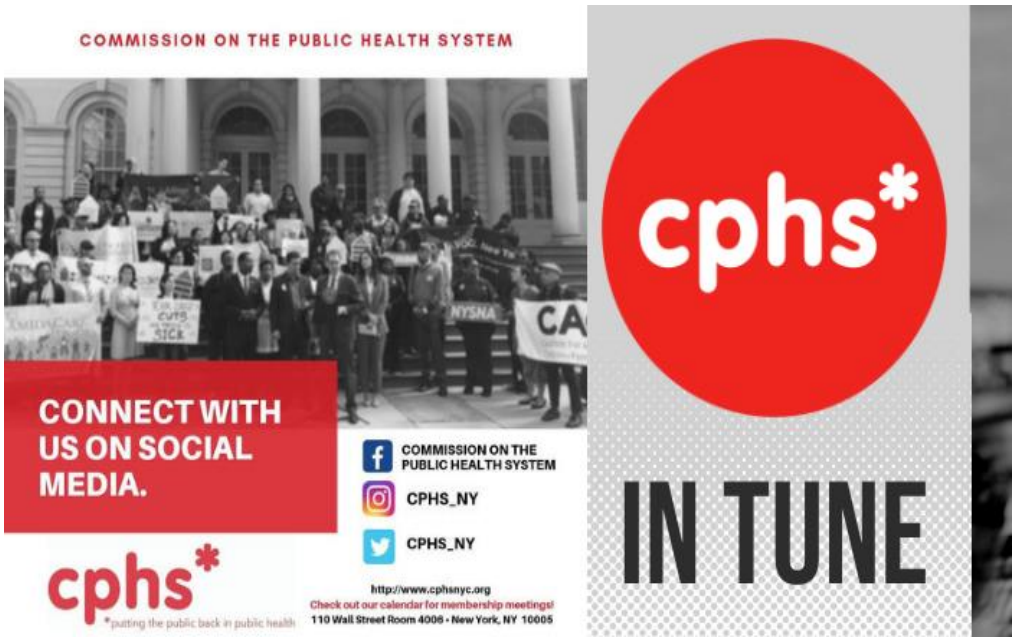
Ollivia Moscicki, Medical Student

Suki Ports- Member of the board of Japanese Am. Social Services, Inc.

Angel Roman, Puerto Rican Activist

Michelle Wrynn, Medical Student

Mon Yuck Yu, Public Health Advocate



CPHS Testimony for the Committee on Health, jointly with the Committee on Hospitals, hearing on Tuesday, January 12 at 10 AM, virtually via Zoom-Webinar titled: Oversight - COVID-19 Vaccine Distribution & Accessibility in NYC

Office: 110 Wall Street * Suite 4006 * NY * NY * 10002

Cell: 646-325-5317 Email: Afeliciano@cphsnyc.org

Good Afternoon:

My name is Anthony Feliciano, Director of the Commission on the Public's Health System. We like thank Councilwoman Rivera, Chair of the Committee on Hospitals; Councilmember Levine, Health Committee Chair; Council committee members and health policy staffers for holding this important hearing. **Please see attached CPHS statement with over 20 signers in which this testimony is based on**.

Covid-19 have posed newer challenges and exacerbated disparities for people who have suffered from the rooted racially unjust systems that have long decided who lives, who dies, who thrives and who just gets by. The roll-out is yet for me to be a true roll-out, while the last two days have improved. Maybe because the mayor's office needed to get a few things straight before this hearing. And we consider all the state issues and problems that have not been easy on the city administration. But we can do better regardless of the circumstances.

Let me tell you my own experience with my 86-year-old dad. I try to register my dad for a vaccination and face some challenges. I have just been on the NYC Vaccine hub for more than 2 hours--been bumped off twice. After going through the whole process, you must fill out the same form online each time you try a different place for an appointment. Finally got what I thought was "all the way" at one site only to be sent to the NYC Health and Hospitals portal and asked to log in with a username and

password. So, I can imagine for others. I heard others had it easy, but it should be universal. I was hoping for Gouverneur or Marta Valle School POD site but no available appointments. My dad should be able to get to a site near not to go farther. He is a strong and patient man, but this can deter even him. His access and life should not be decided by technical problems.

First finger-pointing should begin with the federal government and its lack of direction from the beginning of the pandemic. With the lack of leadership and direction regarding precautions, no one should have expected an efficient and expedient distribution of vaccines. But it does not excuse we had 10 months to be ready to distribute this vaccine as quickly as possible. It seems like the necessary preparation steps were not done and all the consideration before we tried to roll this vaccine out. We are relying too heavily on central planning and top-down approaches that are leaving out a genuine joint process for community decisions to assist. Some of this has been displayed with the state has allowed entities like Greater NY Hospitals Association and the academic medical center members (note public hospitals and other safety-net facilities are members) have too much power and direction over this. GNYHA has perpetuated the very same undermining of community needs and reform to health care that would benefit low-income, immigrant and communities of color.

I disagree with fining distribution sites if they do not move too quickly. The state moves so quickly to punish without considering they are too to blame. So, I have family who are Carpenters. They like to say, “Measure twice, cut once.” The same applies here. Count people, set appointments, stick an arm. Is it understandable more complicated but fragmented planning does not make it any better? We need to investigate the reasons for the delay, especially when we know their hesitancies with the

We created an overly complicated prioritization schemes on top of confusing communication and communication within layers of decision -making bodies. All that have come with uncomfortable tradeoffs. Health care workers and vulnerable populations, like the elderly and immuno-compromised, should clearly be given the highest priority, but hesitation among priority groups and several other issues could further delay distribution. In addition, we have too few distribution sites. Right now, most of the distribution sites are at hospitals and medical care facilities we can expand that, and it seems that the city is doing so but still slow. We need better communication among the individuals in charge of major distribution so they can see the issues coming or find solutions that are working in one place to avoid reinventing the wheel. And do this with community, faith leaders and community -based groups beyond asking for feedback.

Communities, especially people of color can embrace therapies and vaccination attempts, but we just cannot sit in this historical context and ignore many violations of sovereignty and respect that are tenets of ethical research. Medical researchers in the U.S. have taken extreme and horrible advantage of Black, Indigenous, People of Color which includes Asian and Pacific Islander and Latinx communities. If you just look up the big pharmaceutical companies that are developing the vaccines, just look at their senior leadership teams and the board of directors. It does not arouse trust for communities of color.

Vaccination is an emotional topic that divides communities and even public health and legal experts. but when the costs are a matter of life and death, sometimes we need to throw away the big stick and hold out a hand instead. This is a complicated issue, but vaccinations should not be treated differently than any other form of medical care, and they must be protected within the same framework that has

been created for the public's protection. We cannot allow exceptions because it feeds the misconception that vaccinations are an option, a choice, a topic for subjective opinions.

We must raise public confidence, dispensing vaccine equitably and accessibly, and institute accountable monitoring. These three principles mutually reinforce each other.

As we continue with vaccine trials and try to disseminate vaccines, we must have teams that look like the majority of New Yorkers, and the affected population, advisory boards reflected of marginalized communities on those teams, community led, driven, and focused outreach, including multilingual recruitment strategies, and engagement of trusted leaders in those communities (including community-based and faith based organizations) in paid roles — they have to be paid roles, because we don't take large funding and resources and then put all in just for volunteers in charge of recruitment — they also have to be supported by grants. We must:

- Strengthen engagement with tribal, territorial, and local partners, other community-based stakeholders, and the public to communicate public health information, before and after distribution begins, around the vaccine and promotes vaccine confidence. Advocates for vaccination with similar backgrounds to the target population can help to increase trust and acceptance.

- Creation of short trainings and workshops for staff working at CBOs. Training needs to be also offered to homecare workers, domestic worker/worker centers and nursing home staff. The workshop can address safety and the methods of the vaccination. We need an informed trusted broker. Trust is multi-layer, and the staff of organizations may also exhibit anxiety and misinformation, and confidence in vaccination.

- Focus on identifying and addressing misconceptions and concerns about vaccine safety and effectiveness, uniting trusted messengers and influential voices and tailoring communications to reach diverse audiences. The usual public service announcements on immunization simply will not cut it. We need multi-tactics usages like social media, online communications being sent to parents, information provided with the food distribution efforts by the city and food pantries, circulars in supermarkets and grocery stores, informational posters in salons and barber shops, media plan to get trusted leaders and people who already been vaccinated on radio, local, and paid TV networks to speak about their experience and trust in the vaccination.

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- Distribute vaccines immediately upon granting of Emergency Use Authorization using a transparently developed, phased allocation methodology.

- Identify medically underserved areas and expand the types of providers and locations that could offer the vaccination (i.e., FQHC's, pharmacies (small and big box). Federal funds that are available and have no strict requirements for how to use it-should be targeted to this effort of expanding the priority groups.

Address transportation barriers for the 24/7 vaccination sites. The MTA must return the train system back to 24 hours. We can reduce reliance of the MTA, if we ensure we have enough capacity in each neighborhood for folks to have walking distance to. However, both options must be incorporated.

- Foster and encourage places for dispensing to work with local leadership, community-based /faith-based organizations and places of worship in the planning and communication of safety of and access to vaccination (i.e., a pharmacy with a community group). This will need the city and state to provide some geographic map and information for potential partners to identify each other and link up.

- Ensure we can measure the first round through an equity assessment and evaluation to make any timely improvements and strengthen the second-round distribution of doses if required.

- Review the existing city and state vaccination plans if they have sound and effective access and communication strategies. Companies like Moderna require two shots administered four weeks apart, which could make distribution more complicated. People may need additional booster shots. supply-chain challenges and the possibility that not everyone will return to a doctor's office for the critical second shot makes it complicated. However, we have current examples of strategies efforts with the Hepatitis-B booster and HPV vaccination-in the case of Covid-19 it will be intensified.

- The state should foster and manage how hospitals, nursing homes, and other health facilities communicate and partner around addressing supply chain issues that include vials, syringes, refrigerators, patient waiting lines and clinic visits at a time when such resources are already limited. This should not be about control of their market shares- this is about people.

- Monitor necessary data from the vaccination program through an information technology (IT) system capable of supporting and tracking distribution, administration, and other necessary data including safe administration of the vaccine and availability of administration supplies.

- Aggregate how the vaccine use and behavior will be across communities. We have an opportunity to correct earlier omissions of Black Latinx, people with disabilities, LGBTQ+, and other marginalized communities like Asian Pacific Islanders and Indigenous people in the breakdown of the data in testing and tracing.

- Prepare and coincide vaccination messaging with wearing masks and physically distance even after getting a COVID-19 vaccine. We cannot forget the basis for flattening the curve of the infections and deaths, especially in low-income, immigrant, and communities of color.

A COVID-19 vaccine will not work without sufficient acceptance and comprehension. Being treated equally is not about balanced representation. It is about disproportionate representation of black and brown people, because we are more affected by the disease. Getting vaccinated, is a considerate, altruistic sense of responsibility.

Widespread vaccination is the best solution for containing the coronavirus pandemic. But ensure essential workers, youth workers, day care workers, other low-wage job workers need to be prioritized not later but now. City, State, and federal officials should focus on delivering vaccines as quickly as possible to those that want them. But let us be cautious even when we call for flexibility to expand- which we agree- but it must be grounded in the understanding of privilege, differences in experiences, and level of hesitation. Here are a few proposals that could help balance this issue and achieve that goal.

- Expand and strengthen the existing workforce to assist with vaccination sites. This requires funds but also incentives that could encourage volunteers.
- Rely upon existing vaccine distribution mechanisms to the greatest extent possible and tied them with community spaces and community groups. Millions of Americans go to CVS, Walgreens, Rite-Aid, Walmart, and many smaller pharmacies to get flu vaccines each year. These pharmacies have the infrastructure, staff, and logistical processes needed to rapidly immunize the public—they just need doses of the vaccine.

- Keep prioritization rules simple to reduce confusion over who is eligible.

- Avoid wasting doses of the vaccine. Distributors in possession of doses that are within 24 hours of expiring should be free to administer the vaccines to anyone—regardless of eligibility since a wasted, expired dose of the vaccine is worse than vaccinating an individual with less need. States should not, for example, impose criminal penalties on health care providers or vaccine recipients who ignore prioritization schemes as New York Gov. Andrew Cuomo has.

- Explore pro and cons to extend “right-to-try” laws to allow anyone to receive a vaccine approved in other countries. Right-to-try laws currently allow terminally ill patients to seek investigational treatments. Since vaccines are not readily available here, high-risk patients and others should be able to seek out vaccines approved elsewhere.

- Do not withhold vaccine supplies to ensure second dose availability to those who have already received their first shot. Preliminary research suggests that the first dose of the Pfizer/BioNTech vaccine is 82 percent effective—well above the 50 percent threshold the U.S. Food and Drug Administration (FDA) set for vaccine approvals. Also, as vaccine production ramps up, it will be possible to allocate second doses from new supplies rather than keeping existing supplies in inventory.

Who we are?

CPHS was formed out of a strong belief that decisions about health care must include public input and address the diverse needs of New York City communities.

The Commission on the Public's Health System was founded in 1991 as a challenge to the Barondess Commission, which was appointed by then-Mayor Dinkins to study the public hospital system. While most of the Barondess Commission members were health professionals from the private health sector, CPHS was formed by community groups, advocates, health workers, and unions, many of whom had worked together on earlier campaigns to save the public hospitals. CPHS organized public hearings in four of the five boroughs and forced the Baroness Commission to hold public hearings as well. The outcome of the Barondess report was shaped by these actions, and it explicitly recommended against privatization.

Today, CPHS continues to mobilize around these concerns and other public health related issues under. We also provide technical assistance, training and support for community organizations, health care advocates, patients, and anyone who is interested in learning more about public health.

CPHS continues to be a strong coalition of New York residents, community health advocates, health workers, and labor unions. While we have grown in size and influence, we remain committed to making sure that our public health system stays strong, that people have access to health services, and the public's voice on health care issues is heard.

Members of CPHS come from diverse communities, with a wide range of ideas, skills, education, and experiences. Whether you work in the health care system or simply use it, your concerns, your opinions, and your experiences need to be heard.

United Federation of Nurses and Epidemiologists

Local 436, District Council 37, AFSCME, AFL-CIO

***55* Water Street, Hospital & Health Care Professional Division**

New York, New York 10041

212-815-1436 Local436@outlook.com

"We keep New York City healthy."

January 12, 2021

Good afternoon, Speaker Corey Johnson, Chair, Councilmember Mark Levine, Chair, Councilmember Carlina Rivera and members of the Health Committee and Hospital Committee.

I am Judith Arroyo, Grievance Representative for Local 436, District Council 37. I am representing and testifying on behalf of President Sharon Braxton. We represent almost 1,000 public health epidemiologist and public health nurses who work for the City of New York.
It is our members who have been activated to be the largest group of vaccinators in the "Hubs" or Points of Distribution (P.O.D.s) where vaccines will be administered.

Our members reported to three centers on Monday, January 11, and by that evening, this union started to receive reports which were disturbing and alarming.

A member at the South Bronx Educational Campus "Hub" reported:

· people were kept waiting out in the cold
- there was no accommodation for senior citizens, some using walkers or canes, where they can wait and not stand on the long line like everyone else. both the women's and men's bathrooms onl):' had one stall for close to 1,000 people, plus staff, to use
- when our member questioned the custodial staff why the other bathrooms (with multiple stalls) were not open for use, she states the reply was that D.O.E. did not wish to provide the extra equipment & cleaning supplies nor pay the overtime to have all the bathrooms open for the 12 hours the hub would be open.
- there were only 15 public health nurses/vaccinators for almost 1,000 people;

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Similar reports came in from our members at the Hillcrest High School hub:

- long lines waiting outside
- one stall in each of the bathrooms
- this site also reported the lack of space for social distancing in the post-vaccination waiting room. Once a person is vaccinated, it is standard practice to have the person wait 15 minutes in a quiet room (with medical personnel & emergency equipment available) just in case she/he suffers any immediate negative reaction to the vaccine.

The room for this purpose at Hillcrest was too small to maintain proper social distancing. "They were seating on top of each other."

There are also reports of insufficient equipment or incorrect equipment such as wrong size syringes and needles.

This local is in the process of contacting our members assigned to the Bushwick Educational Campus to ascertain conditions there. We expect the report from there will mirror those received from the other two sites.

Our members have also reported what this local can only describe as abuse of the vaccinators.

They are required to work 12-hour shifts, five days a week, for a total of 60 hours per week. At a Labor-Management meeting, which took place on Monday, 1/11, I pointed out to the City and D.O.H.M.H. how dangerous that is. Hospitals do not have their nursing staff work more than 3 12-hour shifts in a row because of the increase danger of medication errors.
These vaccines are highly fragile and care must be taken in their handling. An exhausted, falling asleep, nurse will make a mistake under such working conditions.

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Their lunch hour has been take away and replaced with two 30 minutes breaks and the lunches that are provided arrived frozen with no place to cook them nor eat them. A half hour is insufficient time for a meal especially if the member is required to cook her/his ow·n meal and or wait on a long line to go to the bathroom.

The Department of Health and Mental Hygiene has a cadre of professionals in its Office of Emergency Management which have developed and run Points of Distribution (Hubs) assignments, successfully, in the past. Yet it does not sound as if their expertise is being used.

While we understand the urgency to vaccinate as many New Yorkers as possible as quickly as possible, it should be done with safety measures in place, with regard for the elderly, disabled, and families and it should be done with respect, humane treatment and consideration of the staff.

Thank you for your attention and I am ready to answer any questions you may have.

(Creat&d In House-labor Donated)

New York City Council

Committee on Hospitals
Committee on Health

Hearing Testimony:
"Oversight: COVID-19 Vaccine Distribution & Accessibility in NYC"

David Rich, Executive Vice President, Government Affairs, Communications, and Public Policy

GREATER NEW YORK HOSPITAL ASSOCIATION

Good afternoon, members of the New York City Council. My name is David Rich, Executive Vice President of Government Affairs, Communications, and Public Policy at the Greater New York Hospital Association (GNYHA), the trade group for every hospital in New York City—both public and not-for-profit.

Thank you for the opportunity to speak with you today about what hospitals are doing to get COVID-19 vaccines to New Yorkers as fast, safely, and equitably as possible—and how we are working closely with our member hospitals, other providers and community groups, and all levels of government to make that happen.

Our hospitals and their dedicated caregivers answered the call when COVID-19 struck—first by treating thousands of patients—a mission that continues to this day—but now also by administering vaccines. Our members are laser-focused on defeating this pandemic. New York's hospitals view their role in the vaccination effort as an affirmation of our core belief that health care is a human right.

We understand that New Yorkers continue to endure great hardships and sacrifices because of the pandemic. They expect the vaccine to get in arms fast. We completely agree and feel an enormous sense of responsibility and urgency.

GNYHA is serving as the New York State (NYS) Vaccination Program Hub Lead for the New York City (NYC) region at the request of the NYS Department of Health (NYSDOH). As the NYC Hub Lead, GNYHA's role is to facilitate the coordination, collaboration, and communications about the COVID-19 vaccine program across many entities, including our member hospitals and nursing facilities. GNYHA also has close working relationships with other key NYC-based health care providers, including continuing care facilities, ambulatory care providers, and physician practices along with the NYC Department of Health and Mental Hygiene (DOHMH), NYC Emergency Management (NYCEM), other key NYC agencies and numerous community-based organizations (CBOs). GNYHA is well-equipped to carry out this responsibility as it is consistent with our role in prior public health emergency situations, such as SARS, Ebola, and major weather-related events such as Hurricane Sandy.

Overall, the goal of the NYC Hub is to assist all the parties that are playing a critical role in the implementation of NYC's vaccination program to work together in a coordinated fashion to ensure that *everyone* in NYC has access to a COVID-19 vaccination in accordance with the prioritization plan set forth by NYSDOH as vaccine becomes available. It should be noted that many of the activities needed to successfully implement the vaccine program in this region have been developed and are being planned and implemented by DOHMH within NYS guidelines. These are described in detail in DOHMH's COVID-19 Vaccination Plan, which was prepared in October 2020 and has been approved by both the Centers for Disease Control and Prevention (CDC) and NYSDOH. Our role, then, is one of coordinating and communicating with NYSDOH and DOHMH as well as with all the other entities that will administer vaccines to New Yorkers in the coming months. GNYHA, as the Hub Lead, will provide extensive communications to ensure that all network participants have current, accurate information about vaccine program policies and procedures as they evolve; assist in troubleshooting issues that arise at both the hub and individual entity levels; and field questions and requests for information from health care administrators and practitioners, the public, and the media.

Vaccine administrators in all states must follow the priorities laid out by the governor of their state. Given the still scarcity of vaccines—according to Gov. Cuomo, the Federal government is distributing only 300,000 Pfizer and Moderna vaccines to New York State weekly, and each vaccine must be followed up by a second dose—we must prioritize who is eligible for vaccination. Currently the State has opened eligibility to those in CDC categories "1a" and "1b." Category 1a includes in its highest priority frontline health care workers, first responders in medical roles, medical examiners, long-term care facility staff and long-term care residents. Next in Category 1a are all other workers in hospitals, personnel in ambulatory care settings providing a large volume of direct patient care for COVID-19 patients such as FQHCs, urgent care centers, hospital ambulatory care centers, local health care departments, workers in ambulatory care centers where care cannot be delayed such as dialysis centers, and home health care workers. Finally, Category 1a includes all other workers in health care settings who cannot socially distance such as primary care, community health settings, behavioral health, and mental hygiene settings.

Category 1b, which became operational yesterday, includes adults over the age of 75 and non-health care essential workers such as teachers, police, firefighters, and other essential workers.

NYC and DOHMH have identified demographics that measure social vulnerability, which refers to the resilience of communities when confronted by external stresses on human health, such as natural or human-caused disasters, or disease outbreaks. Utilizing the social vulnerability measures, the following special population groups that will need to be vaccinated have been identified:

- *People who are incarcerated/detained in correctional facilities:* In fiscal year 2020, there were 23,317 admissions to NYC correctional facilities and an average daily population count of 5,841 incarcerated individuals.
- *People experiencing homelessness/living in shelters:* The NYC Department of Homeless Services (DHS) oversees services to people experiencing homelessness and people living in shelters. This population is estimated at 58,000, which includes street homeless (3,000-4,000) and persons living in single adult and family shelters. Once these populations are eligible for vaccination, NYC DHS will implement vaccination hubs throughout its system to ensure vaccination access for homeless individuals and staff.
- *People attending colleges/universities:* NYC-based colleges and universities have historically been part of DOHMH's campaigns to promote compliance with immunization requirements for this population. Additional work has been done to identify and communicate with colleges and universities as part of citywide outbreaks, including recent measles and mumps outbreaks. The larger universities have strong student health programs and offer vaccination services. There is also a large City University of New York system with approximately 275,000 students, most of whom reside off the college campuses.
- *People living and working in other congregate settings:* There currently are 214 supportive housing buildings in NYC with over 14,000 residents and 1,200 staff; 75 residential treatment programs with 4,189 residents and 1,396 staff; and 157 single-site supportive housing residents with 4,671 staffed beds and 1,000 staff. (See above for long-term care facilities and shelters. See below for residential facilities for persons with intellectual and developmental disabilities.)
- *People with disabilities:* In NYC, there are an estimated 10,150 persons with intellectual and developmental disabilities living in 2,143 residential facilities.

- *People who are under- or uninsured:*
    - The American Community Survey (ACS) 2018 Public Use Microdata Series dataset will help estimate the total NYC uninsured population by race, sex, ethnicity, poverty status, age, location, education, and other key characteristics. Given the changes in the employment dynamics because of the COVID-19 pandemic, DOHMH is working to supplement ACS data with additional sources of information.
    - NYC surveillance surveys are used to create a profile of the NYC under-insured population, including the 2017 NYC Kids survey and the 2019 DOHMH Community Health Survey. These data will help estimate the size of the population that has health insurance but went without needed care or needed prescriptions.
    - NYC will develop maps to visualize the demographic data to locate and identify areas with under- or uninsured populations.

We are and will be using these population statistics and coordinating with DOHMH, DHS, and other NYC agencies, as needed, to implement vaccination program strategies that reach these populations.

NYC's diverse population poses significant challenges to the NYC vaccination program due to language barriers, different cultural beliefs, and other issues. DOHMH is developing communication and outreach strategies tailored to the specific needs of individual population groups to help ensure that all New Yorkers are immunized. The NYC Hub—through its network of hospitals and health systems, nursing facilities, ambulatory care providers, and CBOs—will assist in the sharing of DOHMH's materials and support its community outreach efforts.

Critical to these efforts are significant activity at both the City and State level on equity and inclusion. On Dec 11, 2020, Mayor de Blasio and the Mayor's Office Taskforce on Racial Inclusion and Equity outlined the City's Vaccine Equity Plan. Under the plan, through targeted outreach and a network of trusted community messengers, NYC will ensure equitable vaccine distribution to priority groups with a particular focus on the most COVID-19-burdened neighborhoods. Through a broader outreach effort, NYC will engage New York City Housing Authority residents, community partners, and faith leaders to spread accurate, trustworthy information about the vaccine and improve the distribution process. DOHMH is also planning to host virtual conversations with residents and community leaders to share information on vaccine planning and provide opportunities for community members to raise questions and concerns. Through these conversations, community partners will be provided with information that allows them to serve as trusted messengers and hold webinars and community conversations on the City's Vaccine Plan.

The Mayor's Office Taskforce on Racial Inclusion and Equity has also established a subcommittee that is focusing on vaccine distribution equity and is engaging its robust network of over 200 community organizations to ensure effective outreach. The Taskforce's work will inform plans designed to ensure the equitable distribution of vaccine, particularly to priority populations. The Taskforce is expected to solicit feedback on an ongoing basis from hardest-hit neighborhoods throughout the distribution process. GNYHA, as the NYC Hub, will engage with the Taskforce through DOHMH's Vaccine Command Center.

GNYHA, as the NYC Hub, is also engaged with the New York State COVID-19 Vaccine Equity Task Force, which Governor Cuomo convened to help reduce barriers to vaccination and ensure equitable distribution of the vaccine. The Governor's Office and GNYHA co-hosted last week the first meeting of the NYC Health Equity Ambassadors committee of the State Task Force with Edgar Santana, who directs Downstate Regional Affairs for the Governor. The Ambassadors committee is a network of 100 NYC community leaders recruited by the State to increase consumer confidence in vaccine safety and efficacy, identify locations for vaccine administration, reduce language barriers and promote cultural responsiveness, participate in statewide public information campaigns, and partner with community and faith-based leaders in the hardest hit communities.

We applaud our partner 1199SEIU United Healthcare Workers East and President George Gresham, who are leading efforts to share educational materials with 1199SEIU members around the State. 1199SEIU members make up a large proportion of NYC's hospital and nursing home workforce. GNYHA and 1199SEIU are working together to facilitate this activity. The union has held virtual town meetings, and through our joint Healthcare Education Project has sent mailings to all 1199SEIU members encouraging vaccination. Utilizing some of the educational materials from this campaign, GNYHA has assembled the COVID-19 Community, Patient, and Health Care Worker Health Education Toolkit. It provides information on the vaccine and information targeted to the public, patients, and health care workers—a "one-stop shop" for COVID-19 health education materials from the World Health Organization and Federal, state, and local public health agencies.

As of January 10, New York hospitals had vaccinated 386,000 people statewide, including 140,000 in NYC. We are vaccinating more people each week, which we view as a sign that communication with workers, education efforts, and logistics systems are getting stronger. We expect that trend to continue. As more vaccine becomes available, we hope to increase those numbers substantially. We also are looking forward to moving to Category 1c, which would allow us to vaccinate our vulnerable patients with comorbidities.

In conclusion, GNYHA is working hand in glove with NYS and NYC governments, health care providers, unions, community groups, and others to do our part to make New York's COVID-19 vaccination program a success. The biggest obstacle right now is supply, which we hope will ramp up as more vaccines come online. We and our members look forward to the day when this pandemic is over and behind us. In the meantime, we must remain vigilant, wear masks, and social distance.

Thank you for your time and consideration.

Graham Windham Services for Children & Families
Recommendations on Vaccination Prioritization for
Front-Line Staff supporting NYC's most vulnerable kids and families.

Thank you for this opportunity to testify on this critical issue of Covid-19 Vaccine Distribution and Accessibility in NYC.

Consistent with the designation of social service front-line staff as essential and critical workers during this unprecedented time, Graham Windham Agency is recommending that vaccination priority include agency staff who have been providing uninterrupted in-person services to vulnerable New Yorkers, and Foster Parents who are providing care to children in NYC's foster care system. These services include home and community visits to foster homes and to vulnerable families in hard-hit communities who need a range of economic, emotional and concrete supports, and Community programs providing food and essential items including food and essential items including PPE.
This wide range of tasks and responsibilities has been recognized by City and State health authorities as carrying higher risks for exposure to COVID-19. Although PPE and safety protocols are strictly adhered to, staff are regularly exposed to multiple individuals each week and, especially in the case of child welfare staff, travel throughout the city, frequently on public transportation.

- Case planning staff make regular home visits in the community to promote the safety, permanency and well-being of children placed in foster care.
- Case planners also facilitate in-person visits between children and the caregivers from whom they were removed.
- Prevention services case planners make routine home visits, which are essential to supporting and stabilizing families and promoting the safety and well-being of children while preventing the need for foster care.
- Foster Parents are providing safe homes for children who have been removed from their homes, frequently with limited notice to due to emergency entries into care – and where there is minimal information about recent contacts and potential exposure at the time of placement.
- Community-based sites such as Family Enrichment and Cornerstone Centers that have pivoted to become heavily utilized food & essential items distribution hubs to the community.

In addition to mitigating the COVID-19 risks to front-line workers, early vaccination will play a critical role in alleviating exposure concerns on the part of foster parents and families in

prevention services whom have been reluctant to allow in-person home visits during this time, thus limiting staffs' ability to fully assess needs and provide support.
New York State correctly identified these front-line workers as essential, critical, first-responder supports for vulnerable families at the height of the pandemic. To deny these workers prioritization in the COVID-19 vaccine que with other essential staff is unfair and should not be permitted.

Sincerely,

Sharmeela Mediratta
Vice President for Health & Family Wellness and Chief Advocacy Officer
GRAHAM
274 West 145th Street, 2nd Floor
New York | NY 10039
C. 917-922-3378 | P. 212-368-4100 x 7129
www.graham-windham.org
Follow us **@grahamwindham**

coalition for the homeless

Testimony of

Coalition for the Homeless

on

COVID-19 Vaccine Distribution & Accessibility in NYC

submitted to

New York City Council Committees on Health and Hospitals

Giselle Routhier
Policy Director
Coalition for the Homeless

January 12, 2021

Homeless New Yorkers and COVID-19

Homeless New Yorkers, who have no homes in which to practice social distancing and protect themselves from COVID-19, face serious risks of exposure to the virus. While the Department of Homeless Services placed many residents of shelters into de-densification hotels, thousands of homeless single adults remain in congregate settings or in double-occupancy hotel rooms, and homeless families have routine contact with other households and staff in the common areas of their shelters. Ten months into the pandemic, unsheltered homeless New Yorkers who bed down in public spaces still face a critical lack of access to bathrooms, food, and clothing. Many are enduring a particularly dangerous winter with significantly reduced access to warm spaces, fewer resources to obtain essentials like warm clothing, reduced capacity at drop-in centers, and a late and inadequate availability of warming centers. A substantial percentage of homeless New Yorkers is considered to be at high risk of death or serious COVID-19 illness, particularly seniors and those with a growing list of underlying health conditions such as respiratory conditions, obesity, diabetes, heart ailments, and compromised immunity.

In recent weeks, the number of homeless New Yorkers sleeping in the DHS shelter system who are testing positive for the virus has been on the rise, mirroring broader trends in New York. The recent increase is an issue of great concern, given the toll COVID-19 has already taken on this vulnerable population: Between March and October 2020, the age-adjusted COVID-19 mortality rate for homeless New Yorkers sleeping in DHS shelters was 75 percent higher than the rate for NYC overall, with single adults and members of adult families experiencing the highest mortality rates.[1]

Vaccine Distribution and Accessibility for Homeless New Yorkers

First and foremost, homeless shelter residents, unsheltered New Yorkers, and staff who serve people who are homeless should be offered immediate access to available vaccines. We are grateful that members of priority group 1b, which includes homeless people in congregate settings and those who serve them, are now eligible to receive vaccines. Several other important steps must be taken to ensure a successful vaccination effort:

1. Eligibility and the process for accessing the vaccine must be transparent and clearly communicated. Giving homeless individuals and the staff who serve them clear, consistent, culturally competent, and accessible guidance and information is essential in order to gain and maintain the trust of New Yorkers and ensure the vaccination of a critical mass of people.
2. The process of offering and administering vaccines must always be guided by informed consent, which hinges on the success of clear and consistent information.
3. The City, State, and Federal governments should mobilize every available resource in order to distribute a sufficient quantity of the vaccine to reach all homeless individuals and families, as well as the staff who serve them.

[1] View our calculations and methodology here: https://www.coalitionforthehomeless.org/age-adjusted-mortality-rate-for-sheltered-homeless-new-yorkers/

As a city, we cannot afford to mishandle the implementation of this extraordinarily important step in controlling the COVID-19 pandemic. Lives are at stake. This is particularly important for those populations that have suffered disproportionately from COVID-19, including homeless New Yorkers. We thank the Council for the opportunity to testify today, and for your steadfast commitment to addressing homelessness.

About Coalition for the Homeless

Coalition for the Homeless: Coalition for the Homeless, founded in 1981, is a not-for-profit advocacy and direct services organization that assists more than 3,500 homeless and at-risk New Yorkers each day. The Coalition advocates for proven, cost-effective solutions to the crisis of modern homelessness, which is now in its fourth decade. The Coalition also protects the rights of homeless people through litigation involving the right to emergency shelter, the right to vote, the right to reasonable accommodations for those with disabilities, and life-saving housing and services for homeless people living with mental illness and HIV/AIDS.

The Coalition operates 11 direct-services programs that offer vital services to homeless, at-risk, and low-income New Yorkers. These programs also demonstrate effective, long-term, scalable solutions and include: Permanent housing for formerly homeless families and individuals living with HIV/AIDS; job-training for homeless and low-income women; and permanent housing for formerly homeless families and individuals. Our summer sleep-away camp and after-school program help hundreds of homeless children each year. The Coalition's mobile soup kitchen, which usually distributes about 900 nutritious hot meals each night to homeless and hungry New Yorkers on the streets of Manhattan and the Bronx, is now regularly serving more than 1,100 meals per night and distributing PPE and emergency supplies during the COVID-19 pandemic. Finally, our Crisis Services Department assists more than 1,000 homeless and at-risk households each month with eviction prevention, individual advocacy, referrals for shelter and emergency food programs, and assistance with public benefits as well as basic necessities such as diapers, formula, work uniforms, and money for medications and groceries. In response to the pandemic, we are operating a special Crisis Hotline (212-776-2177) for homeless individuals who need immediate help finding shelter or meeting other critical needs.

The Coalition was founded in concert with landmark right-to-shelter litigation filed on behalf of homeless men and women (*Callahan v. Carey* and *Eldredge v. Koch*) and remains a plaintiff in these now consolidated cases. In 1981, the City and State entered into a consent decree in *Callahan* through which they agreed: "The City defendants shall provide shelter and board to each homeless man who applies for it provided that (a) the man meets the need standard to qualify for the home relief program established in New York State; or (b) the man by reason of physical, mental or social dysfunction is in need of temporary shelter." The *Eldredge* case extended this legal requirement to homeless single women. The *Callahan* consent decree and the *Eldredge* case also guarantee basic standards for shelters for homeless men and women. Pursuant to the decree, the Coalition serves as court-appointed monitor of municipal shelters for homeless adults, and the City has also authorized the Coalition to monitor other facilities serving homeless families. In 2017, the Coalition, fellow institutional plaintiff Center for Independence of the Disabled – New York, and homeless New Yorkers with disabilities were represented by The Legal Aid Society and pro-bono counsel White & Case in the settlement of *Butler v. City of New York*, which is designed to ensure that the right to shelter includes accessible accommodations for those with disabilities, consistent with Federal, State, and local laws.

NEW YORK CITY COUNCIL COMMITTEE ON HEALTH

NEW YORK CITY COUNCIL COMMITTEE ON HOSPITALS

Oversight - COVID-19 Vaccine Distribution & Accessibility in NYC

Tuesday, January 12, 2021

Testimony by

Ronald E. Richter, Chief Executive Officer

JCCA

Good morning Chairs Levine and Rivera and members of the Health Committee and the Hospitals Committee. Thank you for calling this hearing and allowing me to testify on behalf of the children we serve in the family/child-serving and developmental disabilities systems, critical staff who work with vulnerable children and families, and foster parents who open their homes to children and young adults during the COVID-19 pandemic.

I am Ronald E. Richter, CEO of JCCA. I have been honored to serve as New York City's ACS Commissioner and as a judge in the City's Family Court.

JCCA is a child and family services agency that works with more than 17,000 children and families each year. These are New York's most disadvantaged and vulnerable children and families, served by foster and residential care, educational assistance and remediation, and care management, which provides crucial wellness services and care management to young people with behavioral health issues, to prevent child abuse and maltreatment. In addition to families already in the child welfare system, JCCA stabilizes and strengthens families who are disproportionately impacted by the pandemic by providing preventive services, which are targeted intervention and community outreach, that touch nearly 4,000 children and families each year.

Yesterday, January 11, was a groundbreaking day for the child welfare community in gaining protection against COVID-19. We received clear guidance from the NYC Administration of Children's Services (ACS), the NYS Office of Children and Family Services (OCFS) and the NYS Department of Health (DOH) that multiple categories of child welfare staff are now prioritized for vaccination against this disease. This access to vaccination will provide protection for thousands of frontline workers across New York City, in addition to reducing risk to the already vulnerable populations that child welfare staff serve.

In my testimony today, I will address the foster parent population, which is still in dire need of the protection offered by the COVID-19 vaccine. I will also address challenges in the current infrastructure, that are creating barriers to child welfare staff accessing the vaccine, despite being prioritized to receive it now, because of unclear drop-down menus. In short, they do not fit current list of options when registering on vaccination sites.

FOSTER PARENTS

Foster parents who welcome children into their homes volunteer to put themselves and their families on the front line to help young people in need. There is no greater community service. During the pandemic, they place themselves and their families at risk by caring for young people who are, in many cases, not members of their family. Given our commitment to reunify children with their families of origin, whenever possible, ongoing, in person visiting is crucial, and legally required. Vaccination of foster families facilitates safe visitation between foster children and their families.

Many foster parents are over 60 years old; based on their age alone, they are in the CDC's highest risk category. At JCCA, over 25% of our 397 foster parents are 60 years or older and therefore at increased risk of dire outcomes if they contract the virus.

We applaud the Mayor's announcement that effective yesterday, January 11, New Yorkers over the age of 75 are now eligible for vaccination. This is an important step, but it does not help the majority of foster parents who are at high risk by virtue of their age. JCCA currently has only six foster parents, 1.5% of our foster parent population, who are 75 or older. Unfortunately, the City's current efforts to help older New Yorkers do not protect the majority of our high risk foster parents, who are between the ages of 60 and 74.

The Adoptive Foster and Family Coalition of New York released a report in November that surveyed foster parents and described many struggles that foster parents face during the pandemic, including increased exposure to the virus as a result of fostering youth. The report, entitled "Fostering New York's Children During a Global Pandemic," quotes one foster parent as saying, "We have been extremely worried about [our children's health] since they have been continually bused around for court-ordered visits four times a week when the courts and

schools have remained closed."[1] While this foster parent is focused on the health and wellbeing of their foster children, the exposure clearly imperils them as well.

Our foster parents show remarkable spirit and vigilance in supporting young people in their care through the most challenging of times- a worldwide pandemic. Foster parents must be available for new placements at all times. They open their homes to children without knowing where the young people have been, including the Children's Center, city shelters, psychiatric hospitals, and other locations.

At a minimum, we must support foster parents by prioritizing these heroes for distribution of the COVID-19 vaccine, to support their work on the frontlines, opening their homes to children who need their shelter and support, as well as exposing themselves each time those children visit parents or other family members.

ACCESS TO VACCINATIONS

Other heroes are the staff who work night and day in congregate care settings, and our frontline essential staff, who visit families in their homes, local communities and interact with children and caregivers every day. The State rightfully prioritized for vaccination most people who work in congregate care facilities, such as those licensed by OASAS, OPWDD and OMH to receive the COVID-19 vaccine. We are so pleased that yesterday, January 11, the State issued guidance that extended this protection to staff of OCFS-licensed congregate care facilities as well. Residential youth counselors and their supervisors, therapeutic recreation professionals, education support staff, crisis response staff and others who play critical roles in caring for and supporting the young people in our care, work in roles that involve a high risk of exposure to COVID-19. On JCCA's congregate care campus alone, there are over 400 staff members and over 200 youth to protect. The greatest protection that we can provide at this time is the COVID-19 vaccination, and we are grateful and relieved that we can now provide it to the young people aged 16 and older (with parents' consent, where appropriate) who live on campus. We

[1] See p.10, Adoptive and Foster Family Coalition's "Fostering New York's Children During a Global Pandemic: A Report of the 2020 Foster Parent Survey," November 2020, by Madelyn Freundlich.

are equally thrilled that our staff who care for these youth will also have access to protection offered through COVID-19 vaccinations.

Our frontline essential staff, who make in-person case contacts and home visits for foster care, prevention, case management staff and others in the child welfare community are now prioritized for the COVID-19 vaccine as well. We are a true "human service." More families than ever are in crisis as a result of the pandemic with loss of jobs, insufficient food, unstable housing, and a host of stressors that JCCA caseworkers work to relieve in order to keep families safe and stable. Child welfare staff have rightfully been recognized as New York's frontline essential staff.

Although JCCA child welfare staff that work directly with clients are now prioritized for COVID vaccinations under State guidance, the infrastructure that is in place does not provide access for these essential workers. When staff log-in to any vaccination enrollment site to schedule an appointment, they will be asked to select their job category from a drop-down menu. Frontline Essential Workers are not one of the categories, and none of the current options fit for most of our staff. On behalf of the child welfare community, I ask for clarity as to which category New York City's thousands of child welfare staff should select, or to create an additional category of "Essential Frontline Workers."

In the meantime, some individuals may select what they believe to be the closest choice, such as "Public health workers with direct patient care responsibilities", although a preventive caseworker supporting families is clearly not a health worker providing direct patient care. It would be a tremendous waste of time and resources, particularly when the vaccine doses, appointments, and time from work are scarce, if that caseworker, who IS PRIORITIZED to now receive a vaccine, were to be turned away from an appointment without proof of the category they selected. Also, it is simply a deterrent for child welfare workers to schedule a vaccine, when they are unsure they will be allowed to receive it because they don't have a clear box to check. For teacher and education workers, their category is crystal clear. For Funeral workers, their category is crystal clear. It should be crystal clear for frontline

essential staff as well. The devil is in the details, but we need to clarify the process so child welfare staff can receive the vaccination for which they are prioritized.

CONCLUSION

Sadly, there have been COVID-19-related deaths among the front-line workers and foster parents in the residential and larger child welfare community. I hope that with the distribution of COVID-19 vaccines, we can reach those most at risk and protect the most vulnerable. It is a work in progress, but we ask the State to quickly remedy the confusing list of prioritized groups and add a clear category for Essential Frontline Workers, for our child welfare staff. Additionally, we ask that the prioritization include one additional, but critical population, foster parents. **Foster parents, many of whom are vulnerable based on their age, expose themselves by inviting children into their homes and supporting visits between those children and their families. Foster parents deserve and still await our protection against COVID-19 by giving them access to the vaccine. We are grateful that New York City and State have prioritized staff that care for youth in residential care and in families' homes, and the young people aged sixteen and older who find themselves in the State's residential and foster care systems for vaccination**. Thank you for taking this time to consider adding "Essential Frontline Workers" to the vaccine scheduling categories, and prioritizing another segment of New York's most vulnerable populations, our foster parents, to help them to receive life-saving COVID-19 vaccinations.

Jonathan Yehuda - Testimony - Committee on Health (Jan 12, 2021)

I am writing to express my deep disappointment with the vaccine rollout and plan in New York City. I lay out a few points for consideration below:

1. **There is a troubling lack of urgency in the rollout so far**. There have been reports of vaccines being distributed almost exclusively during weekday business hours and of a precipitous drop in distribution on weekdays outside of business hours and on weekends (https://www.nytimes.com/2021/01/04/nyregion/vaccines-rollout-coronavirus-nyc.html). This is wholly unacceptable. This is a global crisis and should be treated with the urgency of a war. Countless New Yorkers work overtime for far less important reasons and to think that people are simply clocking out when the City is in crisis is, frankly, galling. At the very least, all vaccination sites (not just those open 24 hours a day) should be open in the early morning and late evening, since most people have to work from mid-morning through mid-evening and, aside from members of the initial priority group, do not work inside hospitals.

2. **The present vaccination rates and the goals for the coming weeks/month are nothing to be proud of**. The mayor recently touted a goal of vaccinating 400,000 people each week and completing 1,000,000 vaccinations by the end of the month. This sounds like a lot until you realize that in 1947 this very city vaccinated 6,000,000 people in a matter of weeks (https://www.nytimes.com/2020/12/18/nyregion/nyc-smallpox-vaccine.html) and that Israel, with a similar population to New York City but more dispersed, is currently vaccinating its population at a rate of over 150,000 per day (https://www.washingtonpost.com/world/israel-vaccinates-the-most-people/2021/01/04/23b20882-4e73-11eb-a1f5-fdaf28cfca90_story.html). We need to do better and we shouldn't pat ourselves on the back for what is, in truth, a failure. While I applaud the current plan to open mass vaccination sites that will be open 24 hours a day, seven days a week, recent reports have noted that these initial sites, when open, will have an aggregate capacity to vaccinate 100,000 people per week, which is woefully inadequate (https://abc7ny.com/vaccinations-ny-nyc-covid-vaccine/9400547/).

3. **This is not yet a matter of lack of vaccine supply**. While I appreciate that available supply may ultimately constrain our ability to vaccinate New Yorkers in the requisite numbers, the issue at present is plainly not supply, since there are reportedly thousands of doses still in freezers and some have even been thrown out unused (https://www.nbcnewyork.com/news/coronavirus/use-the-vaccine-or-lose-it-cuomo-blasts-public-officials-for-covid-vaccination-rates/2810894/; https://www.nytimes.com/2021/01/08/nyregion/nyc-coronavirus-vaccine-delays.html). We don't need our leaders to pass the buck and blame the supply chain. We can address the supply issue separately, but for now, the main problem is distribution.

4. **Insisting on the vaccination of priority groups in order should not hold the entire process hostage**. I appreciate that priority groups are largely the purview of the state government and that New York City's leadership has been asking the state to open up new groups to get the process moving. But we need to be forceful and keep pressing this issue. News outlets have reported that around 30 percent of medical workers are refusing the vaccine, which is slowing down the process, partially because personnel are "taking their time" to reconsider or hospitals are expending energy on efforts to "persuade" personnel to take it (https://gothamist.com/news/hesitant-health-care-workers-are-slowing-down-vaccine-uptake). We simply don't have time to wait for people to make up their minds. We need to move on to the next groups quickly and efficiently.

5. **I have the following suggestions to help speed up the process, some of which will require real dialogue with the state (and putting aside of bickering between the governor and the mayor)**:

    a. **Eligible groups should open up more quickly, on a rolling basis**. New groups should open up quickly, something like every 4-5 days. People in those groups should be given the opportunity to get the vaccine during that window and if they do not, we need to move on to others, especially given that there will be members of these groups that elect not to be vaccinated (as evidenced by the fact that even some healthcare workers are reluctant). They can always come back later and get priority then. (Note that this doesn't address home-bound people, the needs of whom should be handled separately.)

    b. **Priority groups should be simplified**. The current patchwork of priority groups is too complicated. Who will enforce these rules to ensure that only members of these groups are getting vaccinated -- nurses giving the shots? How will they verify if someone is a front-line worker? If someone has a pay stub from Fairway, is that enough to prove he or she is a supermarket worker? Could he or she be a corporate employee who is not a frontline worker? Who will take the time and resources to verify these things? What if the pay stub is from a less obvious place like "Joe's Market"? Is that a bodega or an online marketplace? Who will be tasked with finding out and is that a good use of precious time? We need to simplify the process such that group membership is easily verifiable; organizing groups by age is perhaps the most obvious way to proceed because most people have IDs and can prove their ages. If someone doesn't have an ID and looks like he or she is old enough, vaccinate that person. There will always be ineligible people who slip through the cracks. We can't let the perfect be the enemy of the good. Israel has taken a more liberal age-based approach with great success so far (https://www.timesofisrael.com/what-is-behind-israels-attention-grabbing-covid-19-vaccination-spree/).

c. **Medical students and medical reserves should be recruited to help give shots around the clock**. There is already precedent for this, as medical students graduated early to help with the pandemic relief effort earlier in 2020 (https://www.ny1.com/nyc/all-boroughs/coronavirus-blog/2020/04/14/med-students-graduate-early) and there is no reason why we shouldn't be recruiting as many medical personnel or students as possible to do simple work like give shots or even assist in other ways. If possible to train non-medical personnel to assist in some way (e.g., with logistics, manning sites, etc.) that would also be something worth looking into so long as those people are also given the vaccine.

I hope this is helpful. I would be happy to speak with anyone about my thoughts and suggestions.

Testimony Before the New York City Council
Committee on Health (Joint with H+H)
January 12, 2021 10 AM

COVID-19 and Vaccines

Good morning, Chairperson Levine and Members of the Committee on Health.
This is Sara Kim for Korean Community Services, mainly serving Asian/Korean immigrants and Hispanic communities. As a program director for Public Health, I have worked with my colleagues, other community partners, and the City for our community members to overcome this Pandemic. But overall, I see a gap in the services of NYC and the COVID data for Asian Americans.

While the impact of Covid-19 on the Black and Hispanic communities is well reported, bearing a substantially higher burden of COVID-19 than Whites, the impact on Asian communities is reported as experiencing similar to the White community. But, the Associated Press and the nonprofit news organization The Marshall Project suggest that Asian Americans have been one of the racial groups hit hardest by the disease.

There are several reasons in that Asian communities are being impacted; first, many Asians living in New York, especially, work in low-wage jobs or in the food-service industry where it's not possible to work from home. Furthermore, Asian Americans are the most likely to live in multi-generational households, which leads to more chances at exposure and infection.
Secondly, the cause for underrepresentation of COVID statistics in the Asian community can be from the harassment and anti-Asian sentiment that has become much more commonplace in the public discourse. This fear of harassment is also added onto the fear of their immigration status being threatened should they enroll in public benefits.

Thirdly, changes in the public charge rule kept many Asian immigrants from seeking medical care in the midst of the fear of being denied to become legal permanent resident status.
And, the final cause that those at risk face is the lack of translators available at most public testing sites. Many Koreans who are over the age of 50 can't speak fluent English, which makes it incredibly difficult to get tested at certain testing facilities that do not offer English to Korean translators. Not only at free testing sites, Asian Americans in the city have not received precise information in their native language about testing, safety tips, housing and other critical care services.

As the NYC rolls out vaccination plan, we urge NYC DOH and H+H to work together with community-based organizations and faith-based organizations. They will be able to reach out to their communities to increase vaccination awareness and acceptance via tailored materials and ethnic local media campaign. Also, they will be accessible and convenient places for the hard-to-reach communities to be served as vaccination administration sites by having nurses and pharmacists who speak their languages.

Thank you very much for your time on listening.

Best,

Sara Kim,

Korean Community Services of Metropolitan New York, Inc.
203-05 32nd Ave. Bayside, NY 11361
325 West 38th St. Suite 1210, NY, NY 10016

KCS Main Office
Adult Daycare | Education | Immigration

203-05 32nd Avenue
Bayside, NY 11361
Tel: (718) 939-6137
Fax: (718) 886-6126

Corona Senior Center

37-06 111th Street
Corona, NY 11368
Tel: (718) 651-9220
Fax: (718) 478-6055

Flushing Senior Center

42-15 166th Street
Flushing, NY 11358
Tel: (718) 886-8203
Fax: (718) 886-8205

Public Health and Research Center | Workforce Development
325 W 38th Street, Ste. 1210
New York, NY 10018
Tel: (212) 463-9685
Fax: (212) 463-8347
2460 Lemoine Ave. #400P,
Fort Lee, NJ 07024
Tel: (201) 988-2597

Brooklyn Project

8710 5th Ave. 1FL
Bay Ridge, NY 11209
Tel: (718) 630-0001
Fax: (718) 630-0002

Mental Health Clinic

42-16 162nd Street, 2FL Flushing, NY 11358
Tel: (718) 366-9540
Fax: (718) 534-4149

New York City Council Committees on Health and Hospitals
Joint Hearing
January 12, 2021

Oversight - COVID-19 Vaccine Distribution and Accessibility in NYC

Testimony of
The Legal Aid Society
Prisoners' Rights Project

Mary Lynne Werlwas
Prisoners' Rights Project
The Legal Aid Society
199 Water Street
New York, NY 10038
212-577-3530

CHAIRMAN RIVERA, LEVINE and MEMBERS AND STAFF OF THE COMMITTEES ON HEALTH AND HOSPITALS

Thank you for this opportunity to address one of the most urgent issues of health and equity facing our City: access to COVID-19 vaccines. The Prisoners' Rights Project presents this testimony to highlight critical issues in providing COVID protection to a population that cannot attend to testify today: people incarcerated in the New York City jails.

As of today, the State of New York has specifically excluded incarcerated people from the list of people who may be vaccinated during Phase 1b of the vaccination program, which authorizes distribution of the vaccine to correctional officers, teachers, people living in homeless shelters and many more.[1] This is racism, cynically and cruelly disregarding the lives of the Black and Latinx people who comprise the incarcerated population. It is a perverse idea of "public safety" to force a group of people to sleep, breathe and eat in the same room as strangers, every day and night during a pandemic, yet deny them access to the vaccines. **We implore all New York City leadership to act with unprecedented urgency, creativity and persistence to obtain the vaccines for people held in jails and protect our City in the face of Albany's blatantly racist policy.**

More generally, we condemn as a failure any COVID management program that incentivizes New Yorkers to compete with one another for protection from COVID. While the medical ethics and equity concerns necessarily require leadership in distribution of resources like a vaccine, we are deeply concerned that the perception and reality of scarcity can mask a government failure to act with the vigor and imagination the moment requires.

While these vaccines themselves may be new, vaccination programs are not. State and local governments have had months to prepare for the arrival of a vaccine, and to create a distribution plan that maximizes public health outcomes and clearly communicates opportunities to vaccinate. Yet here we are with vaccines at the ready, but vaccine eligibility being determined in some black box in Albany, leaving millions of New Yorkers in the dark about what resources they may access to protect their health.

New York City, while subject to the State's eligibility determinations, has likewise failed to communicate expectations to the public about who may expect to be vaccinated and when. Going forward, the vaccine distribution program must have far more transparency and oversight.

Public Health Needs Point to Prioritization of Jails For Vaccination

Unless public health policy is the guide star for decisions about vaccine priority, the inequalities in our City will be deepen starkly as people with access to political machinery are protected from the virus, while politically unpopular or unpowerful people are left exposed. And what are the health officials saying? With remarkable unanimity, they emphasize the urgent need to prioritize vaccination of people living in and working in the high-density population that is the New York City jails. The American Medical Association announced two months ago:

[1] *See* https://www.governor.ny.gov/news/governor-cuomo-announces-additional-new-yorkers-individuals-75-and-older-can-begin-scheduling (accessed January 11, 2021).

> **Recognizing that detention center and correctional workers, incarcerated people, and detained immigrants are at high risk for COVID-19, …. these individuals should be prioritized in receiving access to safe, effective COVID-19 vaccines in the initial phases of distribution.**
>
> Throughout the COVID-19 pandemic, we've seen the virus spread quickly in high-density populations, particularly in correctional facilities. Because of the high risk of SARS-CoV-2 infection among people who are incarcerated, and correctional and detention center workers, the AMA is advocating for increased infection control measures, additional PPE, and priority access to vaccines to prevent the spread of COVID-19… Being incarcerated or detained should not be synonymous with being left totally vulnerable to COVID-19. These steps are vital to protect people and stop the spread of the virus.[2]

The Johns Hopkins Bloomberg School of Public Health likewise has elaborated on the well-established bioethical bases for prioritizing vaccination of incarcerated people.[3] These include not only maximization of public health outcomes, but also the needs to treat individuals equitably and fairly, and to promote legitimacy, trust and ownership in a pluralistic society. As the Johns Hopkins scientists noted, the history of inequity health care heightens the challenge of the present moment:

> [W]e are currently in the midst of a national reckoning on racial injustice, prompted by cases of police brutality and murder. The structural racism that is the root cause of police brutality is also the root cause of the disproportionate impact of the current pandemic on people of color and people living in poverty. Although structural racism was as present in the 2018 and previous influenza epidemics as it is today, the general public acknowledgment of racial injustice was not. Longstanding societal and economic inequities and structural racism in health systems have been barriers to disadvantaged populations gaining access to healthcare, contributing to their lack of trust in governments and public health authorities to meet their needs. …
>
> Ongoing social discord that continues to divide the country along political fault lines has also played a role in perceived fairness and transparency related to vaccine allocation and potential differences in vaccine acceptance and uptake across populations. Lastly, as COVID-19 vaccines will arrive after a sustained period of social

[2] American Medical Association, "AMA policy calls for more COVID-19 prevention for congregate settings," https://www.ama-assn.org/press-center/press-releases/ama-policy-calls-more-covid-19-prevention-congregate-settings (accessed January 10, 2021).

[3] Johns Hopkins Bloomberg School of Public Health, Interim Framework for COVID-19 Vaccination Allocation and Distribution in the United States, August 2020, at 2,30-31 https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2020/200819-vaccine-allocation.pdf (accessed January 11, 2021).

> and economic disruption, many of the associated burdens will fall disproportionately on already disadvantaged communities. Past thinking and strategies regarding allocation of scarce vaccines and resources have not sufficiently addressed these longstanding inequities or their consequences for vaccine acceptance and uptake among the populations who most need the vaccine. New approaches are needed, and this crisis has created an opportunity for positive change.[4]

The New York City Jails Pose a Public Health Threat

People held in the jails are particularly vulnerable during outbreaks of infectious disease not only because of the physical environment, which marries close proximity with poor ventilation, but also because of the profound constraints on self-help imposed by the coercive power of incarceration. The actions that public health authorities recommend we take to protect ourselves and each other – such as washing hands with soap frequently, seeking physical distance, and finding medical care if experiencing symptoms – are available to incarcerated people only with the overt assistance of their jailers. Nor do incarcerated people have any choice over who comes or goes from their living quarters, whether it is fellow incarcerated people or the rotating shifts of an extremely large workforce.

Compounding the problem in our City is the neglected and outdated physical condition of the jails themselves, the appalling recent record of violence by correctional staff, and the persistence of an "occupational ideology [that] runs counter to modern and professional correctional practice."[5] A jail system in which staff are "often hyper-confrontational and respond to incidents in a manner that is hasty, hurried, thoughtless, reckless, careless or in disregard of consequences"[6] is a particularly dangerous setting in which to confront a pandemic.

Despite historically low jail populations achieved earlier this year and efforts to release medically vulnerable people in the early months of the pandemic, the COVID-19 outbreak in New York City's jails led to more than 2,000 infections and at least 16 deaths among incarcerated people and jail staff since March.[7] The population of the New York City jails has now soared, reaching 4,967 individuals as of January 1, 2021.[8] Eight four percent of these individuals identify as Black and/or Hispanic.[9] As of last week, there were over 300 active COVID infections identified in the Department of Correction—a number not seen since months earlier in the pandemic.[10]

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[4] *Id.* at 2.
[5] *Eighth Report of the Nunez Independent Monitor ("Eighth Report") in Nunez v. City of New York et. al., 11-cv-5845 (LTS) (SDNY), filed October 28, 2019,* at 4. CHECK PAGE NUMBER
[6] *Id.* at 4.
[7] Board of Correction, https://www1.nyc.gov/assets/boc/downloads/pdf/covid-19/BOC-Weekly-Report-12-26-20-01-01-21.pdf.
[8] *Id.*
[9] *Id.*
[10] *Id.*

This rapid increase in jail population has been accompanied by dangerous overcrowding of housing units. It is well established that the ability to maintain physical distancing is a critical component of preventing the spread of COVID-19.[11] In jail settings, housing area density is the most important factor in whether one can remain physically distant from others. In DOC dormitory housing, beds are often 3 feet apart. As a benchmark, the New York City Board of Correction assesses whether DOC housing units are at or below 50% capacity because that density allows people in to sleep with one bed between them in "alternate bed spacing," with approximately 6 feet between them at night. The data shows that too many housing areas are overcrowded. For example, on November 2, 2020:

- In AMKC, where most dorms hold approximately 50 people, eighteen dorms were at or above 90% density. Two were at 100%.
- In VCBC, where each dorm holds 50 people, every single dorm was at 75% density or higher. Eight of the fourteen dorms were above 90%, and four were at 98%.
- In RNDC, where each modular dorm holds between 30 and 48 people, four of the eleven dorms were above 75%. One dorm was at 97%.

These dangerous physical and social conditions create an atmosphere for transmission of infectious disease unparalleled in free society. If we are to curb the spread of this virus within our city, we must stop the transmission within the jails and all who live and work there. Access to vaccines is a crucial step of this prevention regimen.

Transparency in Eligibility and Access to Vaccine

As of the day before this hearing, there is virtually no reliable public communication about whether incarcerated individuals in New York State are eligible to be vaccinated. **We strongly urge the Council and all New York City leaders to use all available means to ensure that incarcerated people are eligible in Phase 1a or 1b for vaccination.** There is no excuse at this late date for a lack of clarity on whether New York City can or will tackle the COVID crisis in the jails.

We further know of no mechanisms that shed light on how many vaccines Correctional Health Services has ordered, or will order, for incarcerated individuals, and how many vaccines have, in fact, been administered. It is essential for oversight of the protection of incarcerated people that this data be publicly reported, disaggregated by whether the vaccine was given to incarcerated people, correctional staff or health staff.

Informed Consent: who will inform, and what is "consent" in a carceral setting?

The importance of obtaining informed consent for vaccination for incarcerated individuals cannot be overstated, given the long history of medical torture in the name of experimentation on incarcerated people. As the Johns Hopkins described above notes, "[c]ommunities of color,

[11] *See* Centers for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Social Distancing, available at* https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html (last visited November 6, 2020).

particularly Black populations, may be more wary of officials responsible for vaccine-related decisions due to past medical injustices committed by authorities on Black communities."[12]

Nurses, physician assistants and other correctional health community educators need to be present in large numbers in the housing areas to provide accurate medical information to incarcerated people about the vaccine.

The delivery of accurate health information about COVID in the City jails has been a weak spot in CHS' response to the pandemic. In the absence of a robust presence of community education *in the housing areas where people live*, incarcerated individuals have been left confused, helpless and uncertain how to obtain accurate clinical advice. Countless individuals have called our office about their inability to reach CHS staff by phone, as the "hotlines" set up early in the pandemic were staffed for too few hours, by too few staff, and sometimes rang nowhere at all. Posters and written material are not sufficient to answer the questions of a justifiably wary population who have little trust in their jailers and related authorities to prioritize their health.

The Council should obtain from CHS the logistics of its patient education plan, and whether it has a sufficient complement of staffing to provide community education about the vaccine and resources for managing any local side effects; logistical support for a sustained information campaign; the hours and availability of clinicians for telehealth information; the languages in which community education can be given; and clear guidance to correctional workers who will be asked many medical questions they cannot answer.

The carceral context presents another challenge to informed consent stemming from the coercive power of jailers over the people they jail. **Stringent safeguards and oversight are needed to ensure that consent to vaccination is not coerced or obtained through leverage of carceral authority.** Incarcerated people are uniquely vulnerable to retaliation and coercion by their jailers, who regulate and oversee every aspect of their daily lives, including when or whether they may obtain medical care, whether they are provided with sufficient water, food and sanitation, and when they may remain solitary or must congregate in a line or other setting. It is imperative in a setting with such a remarkable power gradient that the consent of an individual to vaccination be thoroughly free of coercion or manipulation by threats or promises. Correctional staff should have *no* role in the vaccination program, and CHS should describe its measures for ensuring that all informed consent is, indeed, voluntary.

Conclusion

We thank the Council and its members for holding this hearing to begin to fill the void in information about public access to the COVID-19 vaccine. The need for vigorous, informed leadership could not be greater.

[12] Johns Hopkins Bloomberg School of Public Health, *supra* note 2, at 2.

Oversight-COVID-19 Vaccine Distribution & Accessibility in NYC
NYC Council Committee on Health Jointly with the Committee on Hospitals
Tuesday January 12, 2021
Testimony of Vaylateena Jones
On Behalf of the Lower East Side Power Partnership – lespowerpartnership@gmail.com

Thursday January 14, 2021

NYC Council Health Committee
Chair Marc Levine

NYC Council Hospital Committee
Chair Carlina Rivera

Dear Chairs Levine and Rivera:

The Lower East Side Power Partnership (LESPP) thanks you for the hearing on Tuesday January 12, 2021. LESPP is concerned about the process of appointment scheduling and location assignment as well as public outreach and education.

The Lower East Side is one of the hardest hit COVID 19 neighborhoods according to the Neighborhood Opportunity Network. Zip 10002 is identified as one of the zip codes on the Lower East Side by Neighborhood Opportunity Network.

Our understanding is New York City Health + Hospitals, Gotham Health, Gouverneur located in zip 10002 conducts COVID 19 testing Monday through Sunday. According to their website, "NYC Health + Hospitals/Gotham Health was formed in 2015 to address the primary care needs of families and individuals in their own neighborhoods." Our understanding is Gotham Health, Gouverneur will be providing vaccines seven days a week, from 9am to 7pm to eligible New Yorkers. Our understanding is they have in-language services for our large diverse populations, including seniors.

New York City Comptroller Scott Stringer included the following statement in an email received by LESPP on January, 2021: "Increase public outreach and education and combat misinformation, mistrust, and vaccine hesitancy. An online poll by the city's health department found that more White New Yorkers said they would get vaccinated compared to Black, Hispanic and Asian New Yorkers."

LESPP advocates for a convenient multi-language scheduling appointments process, especially for our large Senior and immigrant populations. Multiple languages should include, but not limited to, English, Spanish and Chinese. LESPP advocates for a variety of scheduling options including computer, telephone and Sign Up Centers. Sign Up Centers could have volunteers of various languages to assist Seniors with completing the necessary form as well as making the vaccination appointment.

LESPP advocates for residents of the Lower East Side to get appointment in the community or a convenient site requested by the resident.

LESPP advocates for culturally sensitive outreach which prioritizes preexisting relationship between the neighborhood and community-oriented health centers.

Betances Health Center located in zip 10002 conducts COVID 19 testing on Saturday. Their mission states, "Rooted in the Lower East Side of New York City. Betances works to enhance the health and well being of individuals and families from underserved, ethnically-rich communities by providing comprehensive, affordable health services." Our understanding is they have in-language services to address the ethnically diverse population of zip 10002.

According to NYC Health reviewed on Saturday January 9, 2021 our understanding is zip 10002 had the highest percentage of people who tested positive, below 90th Street in Manhattan, for the most recent seven days of available data.

LESPP advocates for public outreach and education by trusted neighborhood-oriented health services in zip 10002. LESPP advocates for as many trusted community-oriented Pfizer-BioNtech and Moderna vaccine sites as possible on the Lower East Side in zip 10002.

LESPP advocates that the following facts be considered for inclusion in public outreach and education on the Lower East Side.

According to *Here's how the top 3 coronavirus vaccines compare when it comes to efficacy, cost, and more* by Isabella Jibilian published by Business Insider on December 7, 2020 Pfizer-BioNtech and Moderna are mRNA-based
According to *Understanding mRNA COVID-19 Vaccines* by the Centers for Disease Control and Prevention updated Dec. 18, 2020 "mRNA vaccines **do not** use the live virus that causes COVID-19"

According to NYS Coronavirus Update dated January 7, 2021
"To date, New York has administered approximately 430,000 vaccine doses"

According to *Here's How the Coronavirus Vaccines Were Produced So Quickly* by Sara Boboltz from HUFFPOST on December 16, 2020.
"Funding is usually a big hurdle that slows down vaccine development. Not so during the coronavirus pandemic."
"The trial phases and manufacturing overlapped somewhat to save time without compromising safety"
"Scientist weren't starting from scratch. They had research to build on from past viral outbreaks."

“Plus, they had a body of research on mRNA vaccines.”

According to *Here’s how the top 3 coronavirus vaccines compare when it comes to efficacy, cost, and more* by Isabella Jibilian published by Business Insider on December 7, 2020, Pfizer-BioNtech has a 95% efficacy rate while Morena’s is 94.10%.

According to *Pfizer vs. Moderna COVID-19 Vaccines: How Do They Compare?* by Dena Bunis, AARP.
“Vaccines have different temperature requirements.”

LESPP looks forward to the Gotham Health, Gouverneur vaccination center on the Lower East Side and other culturally oriented vaccination centers that administer Pfizer BioNtech and Moderna vaccines in order to mitigate the devastating effects this pandemic has had on our many vulnerable populations which include: senior housing complexes, Naturally Occurring Retirement Communities (NORC); immigrant populations; people of color populations; and low-income residents.

First, it's a little hard for seniors and the elderly to submit testimony for a very serious issue before the Committee which requires preparing a letter, making a document and uploading it. Give me a break. Once, it's finally done you receive a stupid comment it cannot go through. I think the City Council can come up with an up-to-date format where residents can type their testimony just like filling out a form to make a complaint to 311. With that said, Sunday's **THE NEW YORK TIMES** article - January 10, 2021 titled = "Elite Medical Center, Even Workers Who Don't Qualify Are Vaccinated," by Apoorva Mandavilli, isn't really shocking because the abusive and lack of professional organization on the City and State governments allowed this to happen for the benefit of the elite.

So, what are you going to do to enforce strict adherence to State and City guidelines starting with Group 1b which begins Monday - January 11, 2021

Michael Zullo

Health Resolution

Making COVID-19 Vaccine Accessible to Communities of Color

WHEREAS, in the United States, over 1.5 million African Americans have been infected with COVID-19; and

WHEREAS, African Americans have died from COVID-19 at 1.6 times the rate of white people[1]; and

WHEREAS, at least 54,273 African American lives have been lost to COVID-19 in the United States[2]; and

WHEREAS, Black New Yorkers make up 22% of the population in New York City and account for 28% of COVID-19 deaths there, and make up 9% of the population in the rest of New York State and account for 14% of COVID-19 deaths there[3]; and

WHEREAS, disparities in the severity of COVID-19 and COVID-19-related death, as well as inequities in social determinants of health that are linked to COVID-19 risk, such as income or health care access and utilization, are well documented among certain racial and ethnic minority groups; and

WHEREAS, the federal Food and Drug Administration (FDA) has approved two vaccines to prevent COVID-19, at the recommendation of the national Advisory Committee on Immunization Practices (ACIP) and more vaccines will soon be considered for approval; and

WHEREAS, such vaccines have been developed under rigorous safety protocols, testing requirements, and monitoring through a transparent process; and

WHEREAS, allocation of the COVID-19 vaccine should promote justice by intentionally ensuring that all persons have equal opportunity to be vaccinated; and

WHEREAS, health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances; and

WHEREAS, the removal of unfair, unjust, and avoidable barriers to vaccination that disproportionately affect groups that have been economically or socially marginalized, is prioritized; and

WHEREAS, vaccine allocation strategies should aim to both reduce existing disparities and to not create new disparities; and

WHEREAS, recent nationwide surveys have found that 35% of African Americans "probably or definitely would not get a COVID-19 vaccine" due to concerns regarding possible side effects, lack of trust in the safety and efficacy of vaccines, and fear of getting COVID-19 from the vaccine[4]; and

WHEREAS, medical mistrust and reluctance to receive the COVID-19 vaccine is a direct consequence of the medical system's exploitation, abuse, and neglect of African Americans; and

WHEREAS, such vaccines that have been approved by the FDA are safe and have been deemed highly effective in preventing against COVID-19; and

WHEREAS, clinical trials of such vaccines have intentionally included the voluntary participation of black and brown individuals; and

WHEREAS, strong and clear education and communication by trusted community leaders is an important strategy for instilling confidence in the COVID-19 vaccines and the science behind them;

THEREFORE, BE IT RESOLVED that the NAACP NYS Conference will prioritize activities that seek to educate those we represent about the COVID-19 vaccines, their safety and efficacy, and their ability to return our lives and economy to normalcy; and

BE IT FURTHER RESOLVED that the allocation and availability of the COVID-19 vaccine should be carried out with a focus on the social determinants of health that make people of color more vulnerable to COVID-19 and the NAACP NYS Conference will advocate for the prioritized immunization of those who have been so disproportionately impacted; and

BE IT FURTHER RESOLVED that immunization should also be prioritized in the geographic locations where those social determinants of health are most prevalent. Individuals who live in areas of high social vulnerability should be able to get the vaccine at locations easily accessible to them such as mobile vans, community centers, places of worship, and local providers such as pharmacies and community health centers in the community; and

BE IT FINALY RESOLVED that equitable distribution of vaccines should be kept transparent by actively monitoring the demographics of those who are immunized with the COVID-19 vaccine to ensure that those who have experienced disproportionate suffering and death are receiving the vaccine.

Submitted by: Lorraine Braithwaite-Harte
Health Chairman
NAACP New York State Conference

Testimony for NYC Council Committee on Hospitals,
Jointly with the Committee on Health
January 12, 2021 Hearing

Hello, Chair Rivera and distinguished members of the City Council. I am Michelle DeMott and I am the Chief of Staff to Mitchell Netburn, President & CEO of Samaritan Daytop Village. I first want to thank you for your continued support during these challenging times. Samaritan Daytop Village (SDV) is a nationally-recognized human services organization that provides comprehensive services to more than 33,000 people each year through a network of over 60 facilities primarily located in the five boroughs of New York City. SDV depends on funding from the City Council to continue to safely provide these services for New Yorkers. We offer a rich array of programs including treatment for mental health issues and substance use disorder, transitional and supportive housing, and innovative services for veterans, homeless individuals, women, children, youth, seniors and families.

To name a few, our organization receives City Council funded: Mental Health Services for Veterans, Opioid Prevention and Treatment, and Support Our Seniors funding. We use this funding to serve thousands of vulnerable New Yorkers annually. The well-being of everyone we serve is our most important priority at this time; however, it is clear from the COVID-19 vaccination plan rollout that not all of our staff nor all of our clients are a priority.

SDV employs an estimated 1300 health and human service workers and approximately 55% of those employees work in "unlicensed congregate care settings." In laymen's terms, these are homeless shelters serving the most vulnerable New Yorkers, including those who are low-to-no income with complex medical and behavioral health needs. The staff and clients in these facilities are not included in priority:1a according to New York State guidance. Once again, during a resurgence, when ALL frontline essential workers are called to duty, the vaccine rollout does not impact all New Yorkers' equally, in fact again it disproportionately impacts communities that have already been hardest hit by COVID-19 due to structural racism, ableism, and income inequality.

Early on, we quickly adapted our services to continue reaching our clients safely amid the pandemic. To mitigate the spread of COVID-19, SDV was committed to serving our clients, and

in order to reduce exposure and transmission during this public health emergency, and to remain consistent with governmental mandates, we immediately adjusted our program operations. We purchased devices for both staff and clients incurring a huge expense, as well as provided both staff and clients with PPE. Additionally, we enhanced our cleaning and disinfecting protocols for all of our sites, not prioritized sites.

Now just imagine operating an organization of this size - where more than half of the employees provide essential City contracted mandated services - and not being able to provide them with a vaccine that can protect their lives. Our administrative staff is forced to explain why one employee is deemed more valuable than another, why one client is deemed more valuable than another.

We stand ready to help our city and our communities recover from COVID-19. We know that the long-term success of New York requires all essential human services workers to be given priority access to the vaccine and ensure that there is equity and full transparency at every step of the allocation and distribution process. With the support of the City Council, we can ensure that New Yorkers regain their health and well-being, and that our city retains its commitment to take care of those in need.

I thank you, on behalf of Samaritan Daytop Village, and we look forward to continuing to be on the front lines in partnership with you and your communities serving the most vulnerable New Yorkers.

SHELTERING ARMS

Children and Family Services

Embracing Hope *and* Building Futures *for* Generations

Testimony delivered by Josefina Perez, Assistant Vice President of Adolescent Residential Care
Prepared for the NY City Council
Committee on Hospitals jointly with the Committee on Health
January 12, 2021

Good afternoon. My name is Josefina Perez and I am the Assistant Vice President of Adolescent Residential Care at Sheltering Arms. Thank you Chairs Levine and Rivera for the opportunity to testify before you today.

Sheltering Arms is one of the City's largest providers of education, youth development, and community and family well-being programs for the Bronx, Manhattan, Brooklyn, and Queens. We serve nearly 15,000 children, youth, and families each year, and employ more than 1,200 staff from across New York City.

Several of our programs became eligible in group 1a, including our Health Clinic, Mental Health Clinics, and our residences for adults with developmental disabilities (DDS). Our HR team worked quickly to ensure that eligible staff had their required proof of employment including their category of eligibility. Staff in our Health and Mental Health Clinics have already begun to receive the vaccine and have reported a very smooth and quick process. While the process for our staff has been smooth, the rollout for residents in our DDS program has been slower. We were partnered with CVS in order to vaccinate our residents, however, CVS has not yet received the vaccine. We were informed this week that residents may receive the vaccine from their primary care physician, so we are now arranging for residents to receive their vaccine in this way.

We were very pleased to learn yesterday afternoon (1/11/21) that educators and staff in our Early Childhood Education and Afterschool programs, as well as staff in our OCFS-licensed residential and child welfare programs are now included in group 1b of the New York State eligibility list for the COVID-19 vaccine.

Our Foster Care program partners with 150 foster parents primarily in the Bronx and Manhattan, providing safe and caring homes for nearly 400 children and youth. We urge the City and State to prioritize foster parents to receive the vaccine. Due to legal mandates, foster parents must engage in various in-person interactions in order to support the safety and well-being of children and youth in care. In-person interactions have been somewhat reduced when other options are available, but there are still many cases where in-person is needed to support the needs of the child, such as home safety visits and family visits. To support the safety of children and our staff, we strongly recommend that foster parents be prioritized for the vaccine.

Thank you for this opportunity to testify and for your commitment to ensuring an efficient vaccine rollout. I'm happy to answer any questions you may have.

Josefina Perez
jperez@shelteringarmsny.org

THE LEGAL AID SOCIETY

Testimony of

The Legal Aid Society

on

Oversight: COVID-19 Vaccine Distribution & Accessibility in NYC
presented before

The New York City Council's Committees on Health and Hospitals

Rebecca Antar Novick
Director, Health Law Unit
The Legal Aid Society

January 12, 2021

The Legal Aid Society's Civil Practice welcomes the opportunity to submit this testimony to the New York City Council's Committees on Health and Hospitals.

Who We Are

The Legal Aid Society, the nation's oldest and largest not-for-profit legal services organization, is more than a law firm for clients who cannot afford to pay for counsel. It is an indispensable component of the legal, social, and economic fabric of New York City – passionately advocating for low-income individuals and families across a variety of civil, criminal, and juvenile rights matters, while also fighting for legal reform. This dedication to justice for all New Yorkers continues during the COVID-19 pandemic.

The Legal Aid Society has performed this role in City, State and federal courts since 1876. It does so by capitalizing on the diverse expertise, experience, and capabilities of more than 2,000 attorneys, social workers, paralegals, and support and administrative staff. Through a network of borough, neighborhood, and courthouse offices in 26 locations in New York City, the Society provides comprehensive legal services in all five boroughs of New York City for clients who cannot afford to pay for private counsel.

The Society's legal program operates three major practices — Civil, Criminal, and Juvenile Rights — and receives volunteer help from law firms, corporate law departments and expert consultants that is coordinated by the Society's Pro Bono program. With its annual caseload of more than 300,000 legal matters, The Legal Aid Society takes on more cases for more clients than any other legal services organization in the United States. And it brings a depth and breadth of perspective that is unmatched in the legal profession.

The Legal Aid Society's unique value is an ability to go beyond any one case to create more equitable outcomes for individuals and broader, more powerful systemic change for society as a whole. In addition to the annual caseload of 300,000 individual cases and legal matters, the Society's law reform representation for clients benefits more than 1.7 million low-income families and individuals in New York City and the landmark rulings in many of these cases have a State-wide and national impact.

The Legal Aid Society's Civil Practice provides comprehensive legal assistance on a vast array of legal matters involving housing, foreclosure and homelessness; family law and domestic violence; income and economic security assistance (such as unemployment insurance benefits, federal disability benefits, food stamps, and public assistance); health law; immigration; HIV/AIDS and chronic diseases; elder law; low-wage worker problems; tax law; consumer law; education law; and community development opportunities to help clients move out of poverty. Last year our Civil Practice worked on more than 40,000 individual case and legal matters, benefiting more than 103,000 low-income children and adults.

The Impact of COVID-19 on Our Client Communities

Nearly a year after the first COVID-19 cases were reported in New York, the virus continues to have an unprecedented impact on New York City and on the lives of millions of New Yorkers. While we are eager to be able to testify about vaccination distribution and access, we approach the topic with tremendous urgency as COVID cases continue to rise across the city and with an appreciation of the immensity of the undertaking.

The disproportionate impact of COVID-19 on our client communities is well-documented. COVID-19 has exposed the racial and social inequities that have led to vulnerable populations bearing the brunt of this crisis. Throughout the crisis, Black and Latinx New Yorkers have died of COVID-19 at twice the rate of white people and have a hospitalization rate that is four times that of white people.[1] The CDC and others have attributed those rates to lack of access to health care and exposure to the virus related to occupation, including frontline, essential, and critical infrastructure workers.

Vaccine distribution must respond to the realities of these inequities both to address current disparities and to prevent widening gaps in the future. We call on all of the leadership of New York – City Council and NYC Health + Hospitals – to mobilize in ways never seen before to get the vaccine to the crowded, working, and vulnerable parts of the City. This requires demanding from Albany unprecedented action and resources needed to fulfill the stated principle of the distribution approach based on "clinical and equitable standards that prioritize access to persons at higher risk of exposure, illness and poor outcome, regardless of unrelated factors, such as wealth or social status."[2]

To this point, we have seen a stunning lack of clarity about vaccine distribution and urge that this process proceed with total transparency. Despite the City and State having months to prepare, most New Yorkers are in the dark about who is getting the vaccine and when. It is ineffective to provide gradual, piecemeal information about the timing and order of vaccination distribution. For example, although we strongly support the inclusion of home care workers in Phase 1a of vaccine distribution, these workers and their patients also deserve information about when home care recipients can expect to be vaccinated.

Increased transparency will hold government and providers accountable and help to foster trust in the process and its outcomes. This is particularly important when historical and continued medical racism, abuse, and lack of consent have left many communities of color distrustful of the coronavirus vaccines and the health care system. A recent survey found that half of Black adults said they did not want to get the coronavirus vaccine, with safety concerns and distrust cited as the top reasons. In contrast, most white adults said they would get vaccinated and those who would not were more likely to say they did not think they needed it.[3]

We urge the Council and NYC H + H to ensure a culturally-responsive, multilingual outreach campaign, directed towards and in partnership with communities of color. A robust outreach effort is critical to reach the broadest number of people in a variety of accessible locations including in public housing, community centers, churches, and the homes of homebound individuals. It will also be necessary to overcome distrust and to combat the scarcity narrative that at times has pit vulnerable communities against each other. We urge a well-funded distribution action plan based on equity, public health, and transparency to save our communities. With these principles in mind, we highlight the issues impacting our elderly and disabled homebound clients, clients experiencing homelessness, and our immigrant and

[1] Centers for Disease Control and Prevention, COVID-19 Hospitalization and Death by Race/Ethnicity, *available at* https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (Nov. 30, 2020).
[2] New York State Department of Health, New York State's COVID-19 Vaccination Program, *available at* https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/NYS_COVID_Vaccination_Program_Book_10.16.20_FINAL.pdf
[3] Kaiser Family Foundation, KFF/The Undefeated Survey on Race and Health, available at https://www.kff.org/racial-equity-and-health-policy/report/kff-the-undefeated-survey-on-race-and-health/ (Oct. 13, 2020).

low-wage worker clients, whose unique needs demonstrate the importance of an equitable, transparent and accessible vaccine distribution. We also refer you to the testimony of our criminal defense colleagues regarding vaccine distribution for jails and prisons.

Homebound Adults

The City's vaccination plan must take into account homebound adults, including those who are elderly and New Yorkers with disabilities. Older adults who are homebound are likely to suffer from chronic health conditions that place them at significantly higher risk of death from COVID-19. While home care workers have been prioritized for receiving the vaccine, scientists do not yet know the extent to which vaccine recipients can still pass the virus to those in their care. Thus the City should prioritize homebound adults for vaccination against the virus.

We recognize that the storage requirements for the Pfizer and Moderna vaccines make transportation of the vaccine very challenging. However, the City must work with health providers to develop innovative solutions to vaccinate these vulnerable New Yorkers. This should include:

- Creating mobile or onsite vaccination clinics in buildings that are home to significant populations of homebound older and disabled adults, such as senior housing complexes;
- Encouraging providers to compile lists of their most vulnerable patients so as to identify those whom the City should prioritize for any in-home vaccination program;
- Exploring options for free transportation, such as EMS, for homebound older adults who can safely travel to locations where they can receive the vaccine;
- Conducting outreach to New Yorkers to encourage them to bring their homebound family members and friends to vaccination sites, though such outreach should emphasize the need to first consult the patient's PCP.

It is crucial that we prioritize homebound elderly individuals and New Yorkers with disabilities and that there are transparent and extensive measures taken regarding how and when home care recipients can expect to be vaccinated.

Informal and family caregivers also must understand their place in the process. We strongly support the inclusion of aides in the Consumer Directed Personal Assistance Program in the list of home care workers who are currently eligible to be vaccinated. However, we are not aware of efforts to prioritize the vaccination of the estimated hundreds of thousands of informal caregivers in New York City.[4] Although we recognize the challenge of identifying and reaching these individuals, they have many of the same vulnerabilities as paid caregivers and the City should create a system for determining how their vaccinations can be prioritized.

Seniors Living in New York City Housing Authority (NYCHA)

Seniors living in New York City Housing Authority (NYCHA) developments must be given special priority for the COVID-19 vaccine. NYCHA is home to over 62,000 seniors - its fastest-growing population. Forty percent of NYCHA households are headed by seniors, who very frequently are responsible for the care of minor children and other family members. Not only do NYCHA's seniors

[4] New York City Department of the Aging, Guide for Caregivers, https://www1.nyc.gov/site/dfta/services/guide-for-caregivers.page.

face an increased risk of death and hospitalization from COVID-19 due to age, but other factors dramatically compound this risk, including the pervasiveness of underlying health conditions and marginalization.

The majority of NYCHA seniors report having two or more diagnosed chronic health conditions, most notably diabetes and cardiovascular disease. The CDC recognizes both of these conditions as increasing the risk of severe illness from COVID-19. The prevalence of these conditions among NYCHA seniors is significantly higher than among NYC seniors generally.

Additionally, the vast majority of seniors living in NYCHA public housing are members of marginalized communities that have been hardest hit by the pandemic. Race and income have proven to be decisive factors in COVID-19 survival rates for New Yorkers. Neighborhoods with high concentrations of Black and Latinx people, as well as low-income residents, have suffered the highest death rates. Half of NYCHA's seniors have incomes below 100% of the federal poverty level, and a majority are Black and Latinx, resulting in inequities that increase vulnerability to COVID-19. The high burden of COVID-19 experienced by NYCHA's senior population can be mitigated in part by recognizing these seniors as a priority population for distribution of the COVID-19 vaccine.

Immigrants

The City's vaccination plan must take into account the particular challenges of vaccine distribution and administration in immigrant communities. It is well known that many of the New York City neighborhoods devasted by the COVID-19 crisis are those with significant populations of immigrants. It has also been well documented that many immigrants avoid medical treatment, including crucial testing and treatment for COVID-19, because of the fear of immigration consequences. Many immigrants, including but not limited to individuals who are undocumented, are understandably frightened about the potential consequences of providing their information to state or city authorities in order to receive the vaccine.

It is also true that fear of immigration consequences might keep undocumented immigrants away from government run vaccination centers. We should aim to get the vaccine to undocumented New Yorkers by making it available at schools, fairs and houses of worships in the communities in which they reside. The vaccination outreach and distribution campaign must include clear, definitive, and consistent messaging regarding the protection of personal information of vaccine recipients, and the fact that this personal information will not be shared with the federal government. Not only must New York City ensure that all City-created materials and outreach are clear on this message, but the City must advocate with the State to ensure consistent messaging across counties and other localities. The messaging must be culturally competent and comply with Local Law 30.[5]

The online "New York State COVID-19 Vaccine Form," which according to the State Department of Health website, individuals are instructed to fill out before receiving their vaccine, provides the vague and general statement, "The information you provide will be protected pursuant to the New York State Personal Privacy Protection Act and any other applicable state or federal law."[6] Much more is needed. The statement must specifically address the fact that information will not be shared with the federal

[5] https://www1.nyc.gov/assets/immigrants/downloads/pdf/Local_Law_30.pdf.
[6] https://forms.ny.gov/s3/vaccine.

government and that there is no risk of immigration consequences from receiving a vaccine, nor is there a risk of losing, nor a risk to using, other benefits to which individuals and families are entitled should they get vaccinated. It also must be available in multiple languages and there must be telephonic interpretation available.

As noted above, a culturally competent, multilingual outreach campaign is crucial to equitable vaccine distribution, particularly in immigrant communities. The development of the outreach campaign itself must be transparent and publicized, including transparency and publicity in the process of partnering with community leaders and organizations led by and serving the immigrant community.

Low-Wage Workers

A large number of clients in Civil Practice's Employment Law Unit are undocumented workers who perform important work in frontline jobs that are necessary for all of us to survive. These individuals play a critical role in maintaining the health and safety of New Yorkers: they are cleaners, janitors, home health aides, restaurant and delivery workers. According to an April 2020 report by the Center for Migration Studies of New York, "70 percent of the undocumented labor force in NYS consists of essential workers." A failure to seriously consider how such workers can be reached and vaccinated quickly poses an enormous health risk to the entire population. Achieving "herd immunity" based on a vaccination program will be impossible to achieve without efforts to reach and participation of undocumented workers.

Risks to the general population aside, we must focus on undocumented workers because they work in the industries most prone to exploitation such as food processing, food preparation, delivery, transportation, and construction. Large numbers of undocumented individuals work "off the books" in these areas and are often denied the legally mandated minimum and overtime wages. This leads to high levels of poverty despite working long hours. In turn this means that such workers frequently reside in crowded apartments where it is difficult to isolate or quarantine. Further, they often are not eligible for food stamps and other supports and cannot necessarily afford to stay home after an exposure to a COVID-infected person. Certainly, the type of work they do – cleaning, acting as paid caretakers, serving, cooking and delivering – means they are not able to work from home during the pandemic.

Homeless Individuals

Homeless New Yorkers, who cannot isolate at home, face compounding risks of exposure to the coronavirus and of experiencing severe symptoms of COVID-19. While many of those in shelters have been placed in de-densification hotels, thousands of homeless single adults remain in congregate settings or in double-occupancy hotel rooms, and homeless families have routine contact with other households and staff in the common areas of their shelters. Ten months into the pandemic, homeless New Yorkers on the streets still face a critical lack of access to bathrooms, food, and clothing. Many are enduring a particularly dangerous winter with significantly reduced access to warm public spaces, reduced capacity at drop-in centers, and a late and inadequate rollout of warming centers. A substantial percentage of homeless New Yorkers are considered to be at high risk for experiencing serious symptoms of COVID-19, including seniors and those with underlying health conditions such as respiratory conditions, obesity, diabetes, heart ailments, and compromised immunity.

In recent weeks, the number of positive cases among homeless New Yorkers in the DHS shelter system has been on the rise, mirroring broader trends in New York. This recent increase is an issue of concern given the toll COVID-19 has already taken on this vulnerable population: Between March and October 2020, the age-adjusted COVID-19 mortality rate for homeless New Yorkers in DHS shelters was 75 percent higher than the rate for NYC overall, with single adults and members of adult families experiencing the highest mortality rates.

First and foremost, homeless shelter residents, unsheltered New Yorkers, and staff who serve people experiencing homelessness should be offered immediate access to available vaccines. We are grateful that priority group 1B, which includes homeless people in congregate settings and those who serve them, is now eligible to receive vaccines. Several other important steps must be taken to ensure any vaccination effort is successful:

1. The vaccine rollout must be carried out with transparency and clear communication. Giving homeless individuals and the staff who serve them clear, consistent, culturally competent, and accessible guidance and information is paramount to gaining and maintaining trust and ultimately achieving success in vaccinating a critical mass of people.
2. The process of offering and administering vaccines must always be guided by informed consent, which hinges on the success of clear and consistent information.
3. The City, State, and Federal governments should mobilize to distribute a sufficient quantity of the vaccine to cover all homeless individuals and families who want it, as well as the staff who serve them.

Conclusion

There is no excuse at this point in the pandemic for confusion or lack of transparency with regard to vaccine distribution. New York City's immediate priority must be cooperating with the State and other localities to create a clear and efficient vaccine distribution process that recognizes, prioritizes, and reaches the most vulnerable New Yorkers. Thank you for the opportunity to submit this testimony.

TESTIMONY: UJA-FEDERATION OF NEW YORK

New York City Council Committee on Health
New York City Council Committee on Hospitals
Oversight: Covid-19 Vaccine Distribution and Accessibility in NYC

Submitted by:
Ariel Savransky
UJA-Federation of New York

January 12, 2021

Thank you to Chairperson Rivera, Chairperson Levine and members of the Council Committees on Health and Hospitals for the opportunity to submit testimony on NYC's Covid-19 vaccine. My name is Ariel Savransky and I am an advocacy and policy advisor at UJA-Federation of New York.

Established more than 100 years ago, UJA-Federation of New York is one of the nation's largest local philanthropies. Central to UJA's mission is to care for those in need. UJA identifies and meet the needs of New Yorkers of all backgrounds and Jews everywhere. UJA connects people to their communities and respond to crises in New York, Israel and around the world, and supports nearly 100 nonprofit organizations serving those that are most vulnerable and in need of programs and services.

Thank you to the city for bringing together the Test and Trace (T2) Corps to fight COVID-19 so that NYC can safely reopen, and for inviting UJA to be a participating member of the T2 Community Advisory Board (CAB). UJA appreciates the city's commitment to ensuring the vaccine is distributed widely and equitably as well as to including the CAB in these discussions. UJA submits the following recommendations to ensure that all New Yorkers are receiving the appropriate resources in anticipation of vaccine eligibility, as well as throughout the vaccination distribution process:

Vaccine education:

1. **UJA recommends that DOHMH educate Community Based Organizations (CBOs), Faith Based Organizations (FBOs) and significant gatekeepers and messengers around vaccine safety and efficacy, and then work with them to develop a standardized message that can then be adapted linguistically and culturally to reach diverse communities. This should include a frank discussion of the history of vaccines and experimental treatments in the US that have created mistrust of the public health system and its experts as well as language regarding insurance, language interpretation and the confidentiality law.**
    a. Vaccination uptake will likely be low among communities of color and other marginalized and/or insular communities because of widespread distrust and misinformation about vaccines in general and more specifically the COVID-19 vaccine, particularly in light of the rapid development and political atmosphere surrounding these vaccines. CBOs and faith leaders have in-depth knowledge of the communities in which they work and are trusted leaders—an asset that must be used to understand community engagement. . CBOs and faith partners in these communities are familiar with existing cultural and religious nuances. In developing overall outreach and education strategies, UJA urges the Council and the Administration to tap into the knowledge base of these CBOs and faith leaders in both developing messaging as well as deciding how to disseminate information to different communities. This will result in greater likelihood that community members trust that the vaccine is safe and effective and will therefore result in increased vaccine uptake.

b. Furthermore, it is imperative that the City include language regarding insurance, language interpretation rights and the confidentiality law in any messaging efforts being developed. With the integration of vaccine education into the existing Test and Trace contracts, many of the organizations that are currently engaged in test and trace efforts will be communicating vaccine messaging concurrently. In order to ensure complete trust in these messengers, individuals should be made aware that their personal information will be kept confidential and that it will not be misused or shared inappropriately.

2. **Ensure that all vaccine education materials are translated into appropriate languages.**
    a. All New York City agencies are required to create a Language Access Implementation Plan to ensure access to services for limited English proficient individuals. Local Law 30 of 2017 strengthened language access services for individuals by expanding the list of designated citywide languages to 10. UJA urges the Council and the Administration to ensure that all outreach materials are translated into, at minimum, these 10 languages. Additionally, UJA urges the Council and Administration to go further and communicate directly with those in hard-to-count neighborhoods to expand existing translation. CBOs and faith partners can be resources in these efforts, ensuring that all messaging is translated into the appropriate language for their communities.
3. **Ensure that community-based organizations and faith partners are involved in educational engagement and strategy conversations in real-time as vaccination efforts begin to analyze where in the city vaccination efforts need to be concentrated.**
    a. UJA urges the Council and the Administration to think creatively about ways to open communication between the City and faith and CBO partners to help direct resources to the communities that are seeing especially low vaccination rates in real time. Engaging these entities will serve to strengthen the relationship between the city and community partners and will ensure that the messaging to each community is both appropriate and coming from a trusted source. Furthermore, this engagement will help to dispel misinformation that may be coming into specific communities by providing these leaders with the facts which can then be communicated to their communities. This will be especially relevant as vaccinations become widely available.
4. **Ensure the City and State are communicating unified messaging regarding the 7-day Covid test positivity rates**
    a. As the City and State make decisions regarding closures of various sectors of the economy and public life, it is essential that a unified message is communicated. Because State health officials have decided to report positivity based on all tests reported to the state on the previous day and the City has chosen to base their calculations on the day the test is being performed, conflicting numbers are being communicated to the public. Because the positivity numbers are still being referenced to determine policy that has and will effect the lives of city residents, UJA urges the City and State to work together to use the same set of metrics when making these decisions.

Vaccine distribution:

1. **Ensure Human Services workers are prioritized for vaccine distribution**
    a. The human services workforce has been on the frontlines since March putting their lives at risk to ensure others are safe. As COVID-19 vaccines are allocated and distributed, UJA urges New York City to prioritize human services workers, facilitate equitable access to the vaccine, and develop a transparent process that determines where the sector stands in the distribution queue.

    There are over 125,000 human services workers in New York employed by the nonprofit sector. These individuals are at high risk of exposure and have been disproportionately affected by the pandemic, yet they continue to serve their communities. Many human services programs are funded through government contracts and provide legally mandated services, meaning that these programs are required to keep their doors open regardless of high COVID-19 exposure risks to staff. This is an issue of equity as New York City's human services workforce is 82% women and 80% people of color.
2. **Develop a clear, equitable and transparent system in which essential workers understand where they land in the distribution of the vaccine.**
    a. UJA urges leaders in New York City and New York State to work together to create a clear plan for distribution and a system for people to check their place in the queue. It is essential for the City and State to communicate unified messaging regarding eligibility and timeline to increase vaccine uptake, as well as communicating a detailed timeline that includes the estimated date by which the city anticipates reaching each vaccination phase.
3. **Ensure vaccine information and appointment scheduling is available to older adults who are isolated, lack cell phone or internet access, and are not connected to a CBO.**
    a. As vaccination appointments open up for New Yorkers age 75 or older, it is imperative that New York City have a plan to reach older adults, who are not within the Department for the Aging service system, do not have a cell phone to receive text alerts or internet access to schedule an appointment, and are otherwise isolated. Other means of communication and education are necessary to ensure older New Yorkers receive the information they need to get a vaccine.
4. **UJA recommends that vaccines be made available in trusted community settings, such as Article 31 clinics and community-based health centers, to increase vaccination uptake as well as strengthen community-clinical partnerships. Additionally, UJA urges the Administration and the Council to ensure that there is an equitable distribution throughout the city of vaccinations, including through the private pharmacy system, and to ensure that CBOs are connected to these spaces so that they can refer clients to these vaccination sites.**
    a. Community clinics not only have staff on site qualified to administer the COVID-19 vaccine but are trusted pillars of their communities and understand how to engage with community members. Furthermore, these clinics are already

providing services to the individuals in their catchment areas and can have success integrating vaccinations with other services they may be providing.

Furthermore, community clinics can also serve as partners in directing clients to private pharmacies in their catchment areas that may be providing the vaccine. Ensuring that CBOs are aware of the availability of the vaccine at pharmacies in their area, as well as ensuring that the vaccine availability is equitably spread out throughout the city, will result in increased vaccine uptake.

Thank you for the opportunity to testify. UJA looks forward to working closely with the Council and the Administration to ensure widespread vaccine acceptance and uptake. Please contact Ariel Savransky at savranskya@ujafedny.org or 212-836-1360 with any questions.

University Settlement testimony
Hearing on COVID-19 Vaccine Distribution & Accessibility in NYC

As the Advocacy Director for University Settlement, I am submitting the following testimony for the Hearing on COVID-19 Vaccine Distribution & Accessibility in NYC.

For 134 years, University Settlement has been one of New York City's most dynamic social justice institutions. Our programs, which extend across Manhattan and Brooklyn, include eviction prevention and benefits assistance, quality early childhood, afterschool and youth development programs, extensive mental health services for adults, families, and children, adult literacy and arts enrichment programs, support for the aging, and community center resources.

Throughout the pandemic, nonprofits like University Settlement have been integral to ensuring our communities stay safe and supported. We've mobilized to help our neighbors with essential needs like accessing food and medication. Within weeks, we reinvented our sites for food distribution in the spring and Learning Labs in the fall. We rapidly shifted our valued in-person programming into virtual and worked to get all participants the technology they need.

Now, as we see an end to this trying time and the city begins distributing vaccines, we ask the city to take the following three points into consideration:

First, since the state expanded access to the vaccine to more older adults, our staff has been working hard to get our eligible older adults vaccinated. In our efforts these past few days, we have encountered several obstacles that we believe the city and state can work to fix so that older adults, and other eligible New Yorkers, can more easily access the vaccine.

Because the primary way to register for vaccination is online, older New Yorkers with less internet fluency have struggled. Many older New Yorkers do not have internet access or the technology to even access the online registration. Additionally, the online registration requires an email address, which, again, many older adults do not have.

Even when older New Yorkers can access the online registration, the process of registering is unnecessarily cumbersome. In order to determine whether a location actually has appointments available, the patient needs to first fill out online forms. As right now, the need for vaccines far outstrips the availability, patients often discover that, after spending time filing out the forms, there are no available appointments at their selected location, and the patient is forced to cancel out of their appointment. When the patient attempts to register at another location, the filled-out personal information is lost, and the patient—or their aide—must fill out the form once more. Additionally, networks or site locations (for example, NY Health + Hospitals versus Affiliated Physicians) have different registration websites, making it more confusing.

These added steps are due to a lack of a centralized registration system, and this experience would leave most people frustrated; for older adults, who may not be as comfortable with navigating online, these steps leave them defeated or confused. And for those people or programs, like ours, that seek to help older adults, these additional barriers make it almost impossible in practice to help. Our staff have already spent hours on the phone or walking through multiple online registrations with our participants, only to find out there are no appointments left.

And importantly, though the website to locate vaccination sites is translatable into different languages through Google translate, it seems that the actual registration page for a vaccine appointment – at least for New York Health + Hospitals and Affiliated Physicians - is not. If there is a way to translate these pages, it is not intuitive, and it would be difficult for those who are less technologically fluent to figure out how.

These vaccination websites should make it clear whether there are appointments available at all *before* patients even start filling out registration information. If there are no appointments or vaccines available at a particular location, that location's registration page clearly indicate that they have no available appointments. And in a multilingual city like NYC, the websites should be in multiple languages.

We know that there is the technological capacity to streamline registrations and more clearly communicate to users the availability of appointments in advance. We worry that the time-consuming, often inaccessible, and confusing nature of the current system will deter older adults from getting vaccinated, and our older adults are one of the groups that most need the protection of vaccination.

Second, we believe that that the city and Health + Hospitals should be sending vaccines to directly to senior centers and human services community-based organizations like ours. We have the physical space to accommodate safe, socially-distant vaccine distribution. We also have the essential personnel and connections to hospitals necessary to be a successful vaccination site. Community-based organizations like University Settlement have the trust of the community and deep connections with our neighbors, who already know and rely on us as community centers and resource sites.

Third, as the city and state roll out the vaccine schedule, we hope that the city continues to remember the essential role that non-profits like University Settlement plays in the daily lives of so many New Yorkers. We believe our staff should be prioritized when decided the vaccination schedule.

Our services are interwoven into the daily lives of New Yorkers, and even after the pandemic ends, non-profits will continue to be essential in helping NYC return to pre-pandemic activity and appropriately addressing how the pandemic has widened the gulf of inequality in this city.

Every week, our staff provides emergency food assistance, distributing food to hundreds of our neighbors. Every day, we provide mental health services to children, adults, and families, early childhood education, afterschool programming, and housing and eviction prevention counseling.

Providing human services workers access to the vaccine is itself an equity issue. New York City's human services workforce is 82% women and 80% people of color. Through the past nine months, many of our essential, frontline staff have been providing in-person services, working to support working NYC families even as they, too, have had to balance their work with caring for their own families.

Fourth, throughout the vaccination process and after we emerge from this immediate health crisis, the city will need non-profit community-based organizations to be ready and strong enough to offer continued essential services and public health education, to manage outreach to communities, and to help rebuild. For this to happen, the City needs to keep its promise on full funding for the real cost of indirect expenses in all human service contracts.

Finally, we ask the City Council Members and all our elected officials to continue advocating the federal government for more vaccines on behalf of New Yorkers.

Thank you for the opportunity to provide testimony regarding this issue.

Veronica Wong
Advocacy Director
University Settlement
awong@universitysettlement.org

Testimony before City Council Committee on Health and Committee on Hospitals
Remote Hearing
January 12, 2021 | 10:00am

Good morning Chair Levine, Chair Rivera, and members of the Committees. My name is Nicole McVinua and I am the Director of Policy at Urban Pathways. Thank you for the opportunity to testify at today's oversight hearing on COVID-19 vaccine distribution and accessibility in New York City.

Urban Pathways is a nonprofit homeless services and supportive housing provider. We assist single adults through a combination of street outreach, drop-in center services, safe havens, extended-stay residences, and permanent supportive housing. Last year Urban Pathways served over 3,900 New Yorkers in need. Our client population is at high risk for COVID-19. 79% of our clients have a disabling condition, and many live with chronic health challenges, including hypertension and diabetes.

Over the past 10 months, our programs have remained fully operational thanks to the dedicated frontline staff that have continued to work on-site throughout the course of this pandemic. **Our staff have put their own health at risk to ensure the safety of our clients and residents.** And like Urban Pathways, human service providers across the City have come to the aid of those most in need to provide food, childcare, and other critical in-person services. There are over 125,000 human services workers in New York employed by the nonprofit sector who are at high risk of exposure as they continue to serve communities disproportionately impacted by COVID-19. Despite this, **not all human services workers providing in-person services have been made eligible for the COVID-19 vaccine in Phases 1A and 1B.**

Prioritization of the vaccine is also an issue of equity. In New York City 82% of the human services workforce are women and 80% are People of Color. Many not only serve communities disproportionately impacted by COVID-19, but are also members of these communities themselves. The disparities are stark: A September 2020 study[1] published in the *Journal of Racial and Ethnic Health Disparities* shows that in New York City, Black people were nearly twice as likely as White people to require hospitalization.

[1] Renelus, B. D., Khoury, N. C., Chandrasekaran, K., Bekele, E., Briggs, W. M., Ivanov, A., Mohanty, S. R., & Jamorabo, D. S. (2020). Racial Disparities in COVID-19 Hospitalization and In-hospital Mortality at the Height of the New York City Pandemic. *Journal of racial and ethnic health disparities*, 1–7. Advance online publication. https://doi.org/10.1007/s40615-020-00872-x

The guidance surrounding eligibility for the vaccine has been everchanging and inconsistent. For example, licensed supportive housing programs were made eligible in Phase 1A, but unlicensed supportive housing programs were just added to Phase 1B last night, while the set-up and risk level of exposure working and living in these programs is essentially the same. **A lack of clarity around who is included in current guidance continues to cause confusion.**

- While "individuals living and working in homeless shelters where sleeping, bathing or eating accommodations must be shared with individuals and families who are not part of your household" are included in Phase 1B, there has been a lack of clarification as to whether this includes staff of Drop-in Centers and Street Outreach teams, who are at a very high risk of exposure interacting with clients who are experiencing street homelessness.
- While the single adult shelter system is included in the current guidance, there is a lack of clarity around those residing in hotels. Of particular concern are those with shared rooms.
- Tier II shelters do not seem to be included in current guidance since they do not have shared quarters among different families, but these are still congregate living facilities with high-risk populations due to high rates of pre-existing conditions[2].
- Individuals experiencing street homelessness do not appear to be included in current guidance, but face high risk of exposure with a lack of PPE and other basic needs, and have higher rates of pre-existing conditions[2] that increase their risk of contracting COVID-19.

The City and State are relying on nonprofits to encourage communities in which they are integrated and seen as trusted messengers to help overcome vaccine hesitancy. Confusion and inconsistencies only make an already difficult task more overwhelming.

We urge City and State leaders to work together to create a clear and equitable plan for distribution of the vaccine. This includes prioritizing all essential human service workers and high-risk populations in Phase 1B.

Thank you very much for the opportunity to testify today.

For questions or further information, please contact:
Nicole McVinua, Director of Policy
nmcvinua@urbanpathways.org
212-736-7385, Ext:233

[2] National Healthcare for the Homeless. February 2019. *Homelessness & Health: What's the Connection?* https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf

YAI Seeing beyond disability.

yai.org

220 East 42nd Street
New York, NY 10017
Tel. 212.273.6100
Fax 212.268.1083

Good Morning, and thank you to Health Committee Chair Mark Levine and Hospitals Committee Chair Carlina Rivera for today's hearing and allowing us to testify. I'm testifying today on behalf of YAI, one of the largest nonprofit agencies in New York State, which provides critical services for more than 20,000 people with autism, Down syndrome, cerebral palsy, and other intellectual and developmental disabilities, or IDD, and their families. I'm also testifying as a representative of Premier HealthCare, a YAI affiliate which offers primary care and specialty outpatient services. While Premier HealthCare has expertise in services for children and adults with disabilities, we provide care to everyone and have performed more than 4,200 COVID tests for New York since the start of the pandemic. Premier 6HealthCare provides 8,000 to 9,000 medical visits per month. Doctors and nurses at our five New York City locations are outstanding medical professionals who have been pressed into service despite the risks to their own health, to help New York conquer coronavirus and limit its spread.

We are extremely grateful for support from the city Department of Health & Mental Hygiene, especially from Dr. Bindy Crouch and Jennie Sutcliffe, which has allowed us to progress toward our goal to vaccinate all Premier HealthCare providers and YAI residents and staff in congregate care settings by January 18th. We are also eager to partner with New York City in vaccinating more than 8,000 people, including staff, in congregate care settings run by our peers, including QSAC, Rising Ground, CFS, and Job Path, over these next few months. To vaccinate New York and protect this vulnerable section of the population, we need support. If the City could provide vaccine-specific funding Premier HealthCare could rapidly accelerate vaccinations and prevent thousands of infections.

While we have the expertise and facilities to succeed, we are not able to optimize either without assistance. As you would expect, vaccinating adults with intellectual and developmental disabilities simply takes more time.

- People who cannot wear a mask must be placed in an isolation room, requiring additional space and supervision
- People with behavioral challenges normally require additional staff for support
- People with sensory motor challenges need additional support and time for the incorporation of desensitization techniques
- We need additional time to explain the vaccine FAQs to be sure people understand and to answer any questions
- We require consent from legal guardians which takes time and can result in rescheduled or missed appointments

Given these characteristics, administering the vaccine requires at least two staff members - one to provide the vaccine and one to collect required paperwork, review screenings, and document vaccination. Under ideal conditions, two staff members can administer **10 vaccines an hour.** Managing this process for this population requires more trained staff. We could increase the speed at which we administer vaccines if we received additional funding to increase staffing levels. Currently, we administer an average of 40 vaccinations per day, with Saturdays hitting an average of 80-100. With support, we could double this rate, getting protection to twice as many people.

In addition, we cannot yet reach Premier HealthCare patients not in congregate settings, who share the same disproportionate vulnerability, which is why it is so important we conclude these vaccinations as quickly as possible so we can move on to other New Yorkers in need.

We could use your help in making this happen. City funding for vaccine providers like Premier HealthCare could help us vaccinate vulnerable New Yorkers in half the time, and make sure we're doing it safely. This funding cannot wait for a State budget in April or City budget in July - the need is great and the need is now. The pandemic has been hard on us, and ensuring federal, state, and city funding reach non-profit providers will help us continue this valuable work. Given our experiences, our expertise, and the public health imperative, I implore you to support our efforts with additional vaccination funds.

Thank you again for allowing us to testify, and for all the work you are doing in this difficult time.

AMERICA SCORES New York

Where Poets Play

January 8, 2021

Dear New York City Council Members,

I am writing to share my strong desire for all youth workers in NYC to be eligible for the COVID-19 vaccination alongside the distribution to teachers.

As the Executive Director of America SCORES New York, an after-school and summer program offering free soccer, poetry and civic engagement programming for free to NYC public school students, I feel strongly that my coaches and other front-line staff should be able to receive the vaccine.

We have operated our program both in person and online throughout the pandemic, and at the request of our public school partners, expect to continue this blended format throughout the rest of this year. We are a critical part of the school community for 25 public schools across the city, and I know many other nonprofits and youth serving programs are in a similar position.

If teachers are vaccinated soon, our staff should be right alongside them, to keep themselves, their students and families safe and healthy.

Thank you very much for your consideration.

Sincerely

Shannon Schneeman
646-660-0404
sschneeman@americascores.org