Testimony

of

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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 Vaccines

December 4, 2020
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 plan for distribution of COVID-19 vaccine to New Yorkers. I am joined today by my Health Department colleague, Dr. Jane Zucker, Assistant Commissioner for the Bureau of Immunization, Dr. Andrew Wallach, Ambulatory Care Chief Medical Officer at NYC Health + Hospitals and Chief Medical Officer of NYC Test and Trace Corps, and Dr. Lee D. Fiebert, Senior Assistant Vice President Business Operations at NYC Health + Hospitals.

Local health departments play a critical role in vaccinating the public against communicable diseases, and the New York City Health Department has long held expertise in vaccination efforts. In 1947, we led the first citywide vaccination campaign – the effort to eradicate smallpox – and established the foundational infrastructure needed for mass vaccination that still exists today. Over the years, our agency has adapted our vaccination efforts for everything from seasonal influenza to the routine immunization of children and adults against diseases such as hepatitis A and B, measles, mumps, rubella, HPV and chicken pox to emerging threats like H1N1 and now COVID-19. The Department's expert immunization team works year-round to increase New Yorkers' access to vaccination services, with a focus on equity and reducing disparities. It is an everyday miracle that New Yorkers regularly receive vaccinations and are protected against disease and public health threats that, some time ago, were simply not preventable.

It is with this foundational expertise that the Health Department has approached the unprecedented vaccination planning effort for both seasonal influenza and COVID-19 this year. We began planning for both this spring. Knowing that the COVID-19 virus would still be spreading during influenza season, it was more critical than ever to increase our seasonal influenza vaccination numbers. To achieve these historic vaccination rates, the Health Department launched a citywide campaign to encourage New Yorkers to get their flu shot and has worked with partners to expand vaccine activities across the city. As our media campaign says, this year's flu vaccine could be the most important one you ever get. And New Yorkers have answered our call. To date, we have seen a remarkable increase in flu vaccination coverage among New Yorkers – from July through the end of November, there was a 35% increase in the number of adults who received the vaccine compared to the same period last year, and a 7% increase for children. We are working with NYC Health + Hospitals, community health centers, community-based organizations, urgent care centers, and are offering flu vaccine at several COVID-19 testing sites. The Health Department also launched a new program this year to deploy teams of community vaccinators throughout the city to meet New Yorkers where they are – including at popup vaccination events, pharmacies, and houses of worship. This work will continue throughout the coming months as we reach peak influenza season – it's never too late to get your flu shot.

Simultaneously, the Health Department has been hyper-focused on preparing for a COVID-19 vaccine, and we have been working with our State and Federal partners to prepare for phased and equitable distribution. Once available widely, vaccines can be one of our most critical tools in preventing the spread of COVID-19. Preliminary information from the vaccine manufacturers suggests that at least two vaccines will likely be available in the United States soon, both will require two doses, and preliminary studies have indicated that they are safe. I will be up front – these are new vaccines for a new disease, and there is still a lot that we do not know – such as when there will be authorization by the Food and Drug Administration, how long protection lasts, and how often people will need to get vaccinated – but we remain optimistic that a vaccine may be authorized and become available as soon as mid-December.

After a vaccine is authorized, it will be distributed in phases to groups of people based on their risk of COVID-19 exposure and severity of illness if exposed. While these phase designations are still being determined by federal and state governments, the first category of people to receive the vaccine will likely be high-risk health care workers as well as staff and residents of long-term care facilities such as nursing homes. High-risk health care workers include those who are taking care of COVID-19 patients, such as emergency department and intensive care unit clinicians, or non-clinical staff working in areas of a facility where there are COVID-19 patients. Distributing to these individuals first will help reduce the burden of transmission and mortality and will ensure the protection of our critical health care workforce as they continue to treat patients infected with the virus. We expect initial allocation of vaccine to be made available as early as December 15th, and to be distributed initially to hospitals throughout the City who have capacity for ultracold storage, which is required for the Pfizer vaccine. High risk hospital staff will receive vaccines from this initial distribution. The Health Department is prepared to stand up and operate temporary sites exclusively for vaccination of emergency medical services (EMS) personnel, who will also be included in the first few weeks of vaccination. Additionally, the Centers for Disease Control is operating a program in partnership with pharmacies to bring vaccination to long-term care facilities throughout the country. Through this program, providers from CVS and Walgreens will bring vaccine and needed supplies to long-term care facilities in order to vaccinate both residents and staff. We are working with New York State to align on a start date for this program, which also depends on vaccine allocation for New York City.

The vaccine will likely next be available to essential workers who interact with the public and are not able to physically distance, followed by people at high risk of complications from COVID-19 because of their age or underlying medical conditions. Once there are enough vaccine doses available for widespread distribution, doses will be made available to all New Yorkers, though this will likely not be until mid-2021 depending on supply and availability. The Health Department has been working closely with healthcare providers in New York City to prepare for a forthcoming vaccine distribution. This has included sharing information on what we know about vaccine trials, timelines and anticipated logistics for a campaign. We

are also enrolling healthcare providers in the Citywide Immunization Registry, which allows the Health Department to track doses and vaccinations across healthcare providers within the City. We are additionally prepared to launch sites across the City in coordination with our emergency response partner agencies to offer vaccinations, ensuring access and availability citywide.

The COVID-19 vaccination effort will be the largest in the City's history. As we receive more information from the federal government, the Health Department continues to plan for vaccine distribution, building on the Department's existing infrastructure; and incorporating lessons learned from H1N1, last year's measles outbreak, and annual flu vaccination programs. The staff working on this effort bring a range of expertise to the team, including vaccine distribution, allocation and accountability, health care provider and public communications, community partner engagement, congregate setting support, health care system support, and field operations. We are also coordinating across the Administration, working closely with our sister agencies and the Mayor's Office to leverage all of the city's resources. As is the case across our work, our COVID-19 vaccination planning is rooted in evidence and equity and informed by individuals and advocates from the many communities we serve.

Behind the scenes, we have been working steadily over the past several months to enhance, innovate, and reinforce the robust infrastructure for vaccine distribution in New York City in order to ensure that it is ready to safely serve all New Yorkers. This includes working with health care providers and pharmacies to enroll them in the Citywide Immunization Registry, making sure they have completed the federally required CDC Provider Agreement, and providing technical assistance for storage and handling capacity across hospitals. We will deploy the vaccine through these channels, so it is vital that providers and other partners have both the resources and information they need and have a trusted relationship with the Health Department. In addition to gathering vital information needed to prepare logistics for distribution, we recently conducted a successful end-to-end delivery test in partnership with the CDC and BronxCare. We are also actively assessing New Yorkers' willingness to receive a COVID-19 vaccine, reasons for wanting or not wanting to be vaccinated, and preferred places for vaccination. These insights inform our distribution planning with providers and facilities and will help shape our outreach and messaging related to the vaccine.

It is more important now than ever that government be transparent, equitable, and ensure reach of information and resources to all communities. We have learned this lesson through decades of public health experience, but the past 10 months has further transformed how government must communicate with the public. To put it plainly, we need New Yorkers to trust us. Trust is an essential ingredient of turning a vaccine into a vaccination – and this begins with ensuring we are worthy of the public's trust. In some communities – specifically the Black community – this trust will be hard won due to decades of systemic racism. It will be challenging and we will need the support of community partners in order to be successful.

Listening to community input and welcoming collaboration will be central to our understanding of where New Yorkers believe vaccination should occur, whom New Yorkers trust to share vaccine information, and how vaccines should be distributed. We plan to leverage our existing mechanisms for community collaboration, such as our Health Opinion Polls, Community Advisory Boards, and New York Academy of Medicine public deliberation, and are establishing additional partnerships with community-based leaders and organizations in neighborhoods that experience greater barriers to vaccination. Within our agency, we have developed a Vaccine Equity Plan, focused on addressing equitable access, uptake and outcomes, to guide our work in the coming months.

Furthermore, the Health Department is committed to reaching New Yorkers in multiple languages and in ways that will most effectively deliver a trustworthy and relevant message about the safety and value of this vaccine. We recently launched our COVID-19 vaccine webpage, which we will keep updated with the latest information about vaccine approvals and distribution. This will include transparent and credible communication about the phased distribution of vaccines, where and when vaccinations will be available to New Yorkers, and which New Yorkers will be eligible to receive vaccinations during each phase. And in the coming weeks and months, we will launch citywide media campaigns across multiple platforms to deliver these messages. We will adjust our communication strategies based on feedback from our partners and the public and as new information becomes available.

New Yorkers have become more familiar with key public health terms this year – percent positivity, epidemiological curves, incidence rates – so I will take this moment to explain yet another core public health concept: the difference between individual and population impact with regard to vaccine. When vaccination begins for these priority groups of people, it will have an *individual benefit*, meaning the vaccine will reduce the risk of those individuals becoming infected if exposed. Only in later months of broader distribution – if sufficient numbers of people get vaccinated – will we likely begin to see the *population-level benefits* of the vaccine, such as significant reductions in community transmission and protection of those who cannot get vaccinated due to a medical condition. While the vaccine is a light at the end of the tunnel, it will be important for New Yorkers to continue to follow prevention strategies to stop the spread of COVID-19 even once a vaccine becomes available and even after they have been vaccinated.

I implore all New Yorkers to remain vigilant and continue using the prevention tools that we all have on hand – staying home if sick or exposed to someone with COVID-19, practicing hand hygiene, wearing a face covering, and keeping physical distance from others. These simple strategies – in combination with testing and contact tracing – enable us to control transmission of COVID-19 in our communities, flatten the curve, and protect ourselves and our loved ones.

I want to thank Chairs Rivera and Levine for holding this hearing today and for being committed partners in the effort to stop the spread of COVID-19. I am happy to answer any questions.

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

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Community Health Care Association of New York State
NYC Council Committees on Health and Hospitals
Written Testimony: Vaccines and Future COVID-19 Treatments
Friday, December 4th @ 10:00 am

On behalf of our members' network of 459 community health center (CHC) sites across New York City, the Community Health Care Association of New York State (CHCANYS) thanks the NYC Council Committees on Health and Hospitals for its attention to critical issues surrounding the response to the novel coronavirus (COVID-19) pandemic and, most importantly, the concern for ensuring an equitable and safe vaccine distribution process.

Health centers have built community trust over generations; they employ individuals that live in the community and are governed by a Board of Directors composed of a majority of community members and patients. Our CHCs serve 1.3 million New Yorkers annually, many of whom, without our services, would not benefit from primary and preventive care. Community health centers are pillars in the community, committed to serving everyone who seeks health services regardless of insurance status, immigration status, or ability to pay. The communities we serve have long been adversely impacted by systemic racism and generational poverty, leading to long term health disparities that have only been exacerbated by COVID-19. In NYC, 85% of CHC patients are people of color, 92% are low income, 9% are elderly, 5% are homeless and 14% are uninsured. As a COVID-19 vaccine becomes available, it is imperative that government partner with healthcare service providers to establish sound policies that will help these communities avail themselves of the necessary preventive care.

A Kaiser Family Foundation report released in early November confirmed what we have long suspected about racial disparities and vaccination rates: in New York State, flu vaccination rates remain relatively low at about 53%, just barely over the US average of 52%, and the vaccination rates for Black and Hispanic New Yorkers are even lower at 45% and 50%, respectively.[1] Given this backdrop, a rational and coherent COVID vaccine policy is sorely needed. As such, we laud the Council's efforts to ensure that vaccine distribution is executed through an anti-racist and intersectional lens. Similarly, we applaud the Department of Health and Mental Hygiene (DOHMH) for stressing in its vaccination plan that was submitted to the Centers for Disease Control and Prevention the importance of equitable vaccine distribution for communities most at risk for severe health complications due to COVID-19, and are thankful that DOHMH recognized the role of federally qualified health centers in its distribution plan. Our network of health centers can be quickly deployed to provide wide access to the COVID-19 vaccine and help educate communities of color on the vaccine's safety and efficacy, thereby increasing vaccination rates in hard to reach communities.

[1] https://www.kff.org/coronavirus-covid-19/issue-brief/state-variation-in-seasonal-flu-vaccination-implications-for-a-covid-19-vaccine/?utm_campaign=KFF-2020-Coronavirus&utm_medium=email&_hsmi=98810273&_hsenc=p2ANqtz--veMffXIJN-EoaOFNuOSn-nwH3MCMxCPmCRN6evwN0oF1Ydlq4t18OuPBQ7eUvn7cXdBI7RYXisgRdJSaPh6yr6D2dww&utm_content=98810273&utm_source=hs_email

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CHCANYS
Community Health Care Association of New York State

Recently, CHCANYS surveyed its members on anticipated vaccine acceptability amongst its patients and staff. Health centers reported that the newness of COVID-19 vaccines, coupled with an "information vacuum" where patients and providers alike do not feel informed about vaccination creation and distribution plans, is exacerbating vaccine hesitancy. We therefore urge the City to collaborate with New York's CHCs in any government sponsored education and outreach efforts to help confirm for our healthcare consumers – particularly the historically underserved communities of color – that the medical community that they trust and rely on not only endorses the vaccine but is available to assist with access.

CHCs stand ready to partner with City and State officials on COVID-19 vaccine rollout. For the program to be successful, the City must ensure continued access to personal protective equipment (PPE) for all patient-facing staff, including surgical masks, protective eyewear, and nitrile gloves. According to a recent CHCANYS survey, 85% of CHCs do not have access to ultra-cold storage required for some COVID-19 vaccines. Distributing those vaccines to CHC patients will require close coordination between CHCs and DOHMH. We welcome the opportunity to participate in any pre-distribution planning sessions conducted by the Council and/or DOHMH to appropriately vet and address these, and other, important logistical issues, in advance of the availability of the vaccine.

Thank you for your time today. For any questions or follow up, please reach out to Marie Mongeon, Director of Policy with CHCANYS: mmongeon@chcanys.org.

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TESTIMONY: UJA-FEDERATION OF NEW YORK

New York City Council Committee on Health
New York City Council Committee on Hospitals
Oversight: Covid-19 Vaccine

Submitted by:
Ariel Savransky
UJA-Federation of New York

December 4, 2020

Thank you to Chairperson Rivera and 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 once approved and for including the CAB in these discussions. UJA submits the following recommendations to ensure that all communities are receiving the appropriate resources in anticipation of vaccine approval, as well as throughout the vaccination distribution process:

1. **UJA recommends that DOHMH educate CBOs, FBOs and significant gatekeepers and messengers around vaccine safety and efficacy and then work with them to develop a standardized message set 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.**
    a. Vaccination uptake will 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 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 to be used in understanding how to engage with community members. CBOs and faith partners in these communities are familiar with existing 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.
2. **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.

3. **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 their 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.
4. **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 that 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 and the medical community more clearly understands the safety and efficacy of the vaccine.

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.

hispanicfederation

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Testimony re: Oversight - COVID-19 Vaccines
Submitted to
NYC Council, Committees on Health and Hospitals

Submitted by
Frankie Miranda
President & CEO
Hispanic Federation

December 4, 2020

Good Day. My name is Frankie Miranda and I am the President and CEO of the Hispanic Federation. I would like to thank Chairwoman Rivera, Chairman Levine, and all committee members for bringing us together today to discuss the integral role that the distribution of vaccines has in the war against the virus SARS-CoV-2. As is colloquially accepted, when discussing this issue further I will be using the term COVID-19 to refer to both the disease and virus.

For over two centuries, vaccines have been used to help us curb the devastating impact of diseases. We have seen the success of vaccines in protecting us from serious illness and complications resulting from diseases. Not only are vaccines important for sound public health and safety, but they also help lift the financial burden that pandemics and epidemics have in our society.

The federal government intends to distribute the COVID-19 vaccine similarly to the influenza vaccine, through providers and mainstream pharmacies. However, racial disparities exist with current and ongoing flu vaccination distribution efforts, where only 37% of Hispanics and 39% of blacks are vaccinated compared to 49% of whites. These rates reflect the higher uninsured rates among Hispanic and Black communities, which result in lack of access to consistent health care and/or health care providers.

People of color face significant barriers to accessing health care, including their proximity to health care services, previous negative experiences with health care (including discrimination, income, and insurance), and immigration status. Inequalities in accessing healthcare has existed for decades before this current pandemic and are one of many factors why COVID-19 has had an enormous disproportionate impact on communities of color.

We have seen our communities ravaged by this health crisis and must ensure that equitable distribution of this vaccine is of paramount importance. Anyone seeking a COVID-19 vaccination should be able to get vaccinated, regardless of ability to pay, access to health care, or lack of health insurance.

Two major components of an effective distribution plan are working in partnership with trusted institutions rooted in community and ensuring that anyone can get vaccinated, regardless of cost or immigration status.

The current New York City distribution proposal mentions that the Vaccine Task Force will be dedicated to community partner engagement. If we are to effectively address this unprecedented crisis in New York City's Latino neighborhoods, we must make sure that Latino community-based organizations are working hand in hand with any institution or agency leading this effort. Our nonprofits are deeply embedded in our neighborhoods, providing frontline health and human services to millions of Latino New Yorkers. Our community has historically counted on community-based organizations for information and resources. For the vaccine distribution to be effective, Hispanic Federation believes that working with community-based organizations, faith-based institutions, and community partners at large must be intentional and a definitive goal of the Vaccine Task Force.

Additionally, communities must be engaged in the COVID-19 vaccine distribution process to provide education and address vaccine hesitancy in communities of color. According to a recent Gallup poll (conducted before Pfizer/BioNTech and Moderna made promising announcements about the likely effectiveness of their coronavirus vaccines), 58% of Americans stated that they would get the vaccine if available. Yet, the World Heath Organization has stated that 70% of the population needs immunity to achieve herd immunity.

Mistrust within communities of color regarding vaccines administered by the government are rooted in history, where people of color have been used without authorization as guinea pigs for vaccinations and medical experimentation, including sterilization. While these concerns are legitimate, we must work to dispel many myths that can lead to vulnerable community members refusing to get vaccinated. Communication and education campaigns must include collaboration with and leadership by trusted health care providers and community partners. It is imperative that private and public agencies are included to develop culturally and linguistically competent strategies to build trust and increase acceptance and demand for vaccinations. As such, agencies should target investments in community-based organizations, not only as partners in public education but also to ensure regular, transparent responses to concerns around the distribution and safety of the vaccine.

CBOs have the unique ability to build essential bridges for community. Hispanic Federation's network of 150+ Latino community-based organizations, over 60 of which are located in New York City, are front-line service providers for our neighborhoods and communities. The work they are doing today – and are committed to doing over the coming months – will be essential for us to get through this public health crisis.

CBOs can also be essential to ensure that individuals receive the 2-dose vaccine requirement. Unfortunately, federal distribution plans may be asking Governors to sign agreements that would provide sensitive information to federal agencies. While we understand there is a need to require information in order to ensure follow up with a second dose, we must also be vigilant about what kind of information and how much can be available to the federal government as this can be used against many of our undocumented community members and can hinder willingness to get vaccinated among these vulnerable populations.

Hispanic Federation has experience with successfully distributing funds to vulnerable community members, including distribution of funds to undocumented immigrants directly affected by the 9/11 attacks, undocumented immigrants that were victims of the flight 587 crash, and undocumented community members rebuilding after Hurricane Sandy. As a trusted source within the Latino and immigrant community, we were able to successfully seek out those that needed help and effectively implement the program while collecting personal identification information that did not put anyone at risk of deportation.

Through community involvement, prioritizing dissemination of information through culturally and linguistically competent mediums, and ensuring that the vaccine is available to anyone, regardless of cost or immigration status, we will be successful in stopping the spread of COVID-19 and save lives. Thank you for your time. Hispanic Federation is here to serve and is happy to work with the New York City Council to protect all New Yorkers.

Dear members of the City Council,

My name is Jesse Soll, I am a media communications professional, and I am testifying regarding the need for aggressive and creative communications campaign planning to encourage COVID vaccinations on the scale required for the effort to be a success.

First of all, thank you for your time and hard work guiding the city through the pandemic.

I want to further emphasize the need to start planning communications campaigns around the vaccine now. While I understand distribution is an enormous challenge, it is extremely important to have a creative, customized and aggressive communications plan to encourage vaccinations and fight disinformation, and it doesn't sound like there is much in place at this time.

It's my understanding that adoption of the COVID tracker app is only around 5% of the population, and only 900 people have tested positive and entered their code in the app total, a fraction of DAILY positive cases. I believe around 30% of 18-49 year olds get flu shots. The resources and logistics involved in the city's efforts are incredible, but when it comes to communicating these efforts in a way that drives a critical mass of participation, it seems clear there is more that can be done to consider new approaches.

As commissioner Chokshi mentioned, trust in public officials is unfortunately a massive problem at this time, and I feel it's important to work more with local media, with a more diverse strategy, to encourage vaccination in a way that is creative and comes from voices that reach a wider range of New Yorkers. For example, Chicago Public Health just worked with important members of the local music scene to reach millennials, in particular millennials of color, in targeted neighborhoods aligned with those personalities to encourage flu vaccinations.

I think it is very telling that CM Rosenthal testified that an NPR program was more informative and clear in why a vaccine is safe than her own dealings as a council member. Most get out the vote/voter registration campaigns rely on media partners and the involvement of cultural figures. For better or worse, many people rely on and trust these sources more than public officials or scientists. To increase vaccinations to the coverage that is needed to end the pandemic, we need a plan that drives substantially better results than the tracker app or flu shot efforts. We need to find a network of Fresh Airs and varying content plans that, together, engage as many citizens as possible.

Thank you for the opportunity to testify and I would love to continue this conversation and share some ideas if anyone is interested. I have spoken with employees for firms that represent various city departments as well as census employees who think they would be great to incorporate into your vaccine communication plans, but it is understandably difficult to start a conversation with the decision makers as a non pre-existing contact at this time.

Full disclosure - I work for DoNYC, and while my ideas would be great fits for us, they could absolutely be executed with other partners, so I hope I can share them with someone in more detail whether or not we can play a role in these plans.

Sincerely,

Jesse Soll
646-320-5295
yalejsoll@gmail.com / jesse@donyc.com

Make the Road New York
Committee on Health and Committee on Hospitals Vaccine Testimony
December 4, 2020

My name is Becca Telzak, Director of Health Programs at Make the Road New York. I want to thank the Committee on Health and the Committee on Hospitals and for the council members for the opportunity to comment today.

The communities that we serve are among the hardest hit by the crisis. Our largest base is in central Queens, the epicenter of the epicenter, where Elmhurst hospital has been in the national spotlight heroically trying even with diminishing resources to save some of the most impacted community members.

In May, MRNY released a report entitled *Excluded in the Epicenter* which details the devastating impact that Covid-19 has had on working class, immigrant, and black and brown New Yorkers. Our healthcare findings show a stark reality for our people: Overall, survey respondents are getting sick at substantially higher rates than average New Yorkers, with more than 58 percent reporting they or a family member was sick since March 1, and 60 percent of those confirmed or believed to be COVID-19. The death count, too, has been frightening. A full one in six respondents (16%) has lost a family member to COVID-19. This tragic tally is consistent with the experience across MRNY's broader membership. To date, 86 MRNY members, clients, and students have passed away due to COVID-19.

While the city moves forward with developing a vaccination plan, we want to ensure the following: (1) The vaccine needs to be accessible to everyone (especially low income and immigrant communities), (2) Ensure clear privacy protections are in place so that individual data is not shared with other federal agencies, including law enforcement agencies and ICE (3) The city should partner with trusted community based organizations to conduct outreach and education about the vaccine. We need a responsible public health approach and we must undergo these efforts with impacted community members at the forefront of any solutions we implement as a city.

<u>Accessibility of vaccines:</u>

In order to get through this crisis, it is essential that vaccines are accessible to everyone at no cost. Vaccines must be available during evenings and weekends to accommodate those who are working essential jobs during the day and cannot get vaccinated during normal business hours. Distribution must be available in all five boroughs, especially in the neighborhoods that have been hardest hit by COVID-19. All forms and documents should be translated and accessible in multiple languages. The vaccine distribution plan already disadvantages low income communities, many of which were hardest hit by the pandemic, by prioritizing private pharmacies, hospitals, and clinics for distribution. It is essential that everyone have access to the vaccine, and that everyone feels safe doing so. Therefore,

there should be a more inclusive distribution plan that includes the public hospital system, health clinics, community schools and other community settings all of which are places where low income communities go for healthcare and services. Additionally, the definition of who gets the vaccine in the initial rounds should be expanded to include all essential workers such as delivery workers.

Privacy and Data sharing:

The data sharing agreement that the federal government has asked states to sign, permits HHS to share personally identifiable information about vaccine recipients with any other federal agency, which could include law enforcement agencies and ICE. This is horrific, and will cause many people in the communities most affected by the virus, including black, brown, and immigrant communities from getting vaccinated. Many individuals will not participate in the public health response- whether that's contact tracing or receiving a vaccination- if they believe that their personal information they share for those efforts will be used to criminalize or deport them.

There should be clear privacy protections in place to ensure that information is not getting shared with agencies other than healthcare agencies, and is not used for any other purpose. It is also important that individuals are informed of their rights and are provided with clear information on the data protections that will hopefully be in place.

Partnership with community based organizations in education efforts:

The city should partner with trusted community-based organizations to do outreach to high risk communities to ensure they are aware of the vaccination options available to them, and how to access them. Community based organizations should be provided resources to educate community members on the importance of getting vaccines and help answer any questions or concerns. Immigrant communities in particular who lack health insurance are often concerned that getting vaccinated could be considered a public charge and are fearful that it may impact their ability to get a green card, and are also concerned that they will be left with debilitating medical debt. Trusted community organizations based in immigrant communities, can play an essential role in mitigating these fears and making sure that immigrant communities have access to accurate information and resources.

Thank you again to the Committee on Health and the Committee on Hospitals for the opportunity to comment today.

Bill Introduction Number 1766-2019

Leading by Example: A Plan to Expand Meatless Mondays to Municipal Agencies

Food at the Root of New Yorkers' Health Outcomes

Healthcare expenditures stemming from diet-related conditions in the United States (US) are projected to reach more than $1.72 trillion (9.3% of US GDP) in 2020, with New York State ranking *second* in dollars spent in this realm among all 50 states.[1,2] More worrying is the uptrending prevalence of these diet-related conditions in the US population – specifically obesity and its associated complications, such as osteoarthritis, heart disease, cancer, stroke, and diabetes mellitus.[6] For example, almost 1 in every 2 US adults are either identified as prediabetic or formally diagnosed with diabetes, compared to the population rate of less than 1 case per 100 people identified 50 years ago.[6] This trend portends further increases of healthcare costs if preventive measures are not introduced effectively and expeditiously.

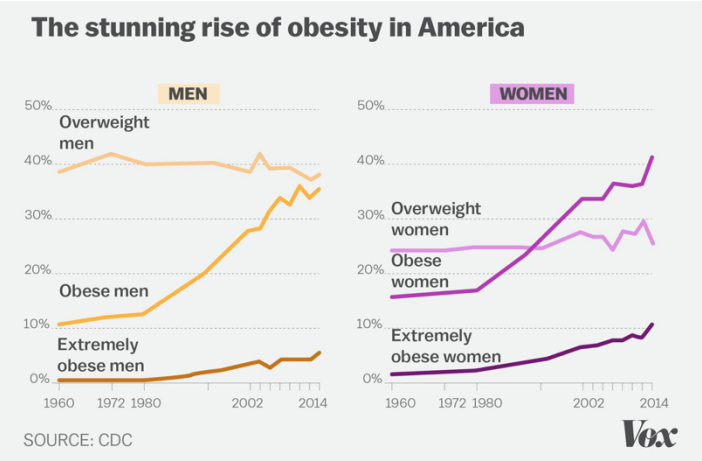

Figure 1: Uptrending Obesity Prevalence in US [5]

Food Can Fuel Primary Prevention of Chronic, Diet-Related Conditions

One dietary modification that has been studied extensively is the replacement of animal-derived protein for plant-based protein sources.

- Processed red meat has been classified as a carcinogen by the WHO.[7]
- As such, animal protein replacement strategies have been shown to improve all-cause mortality, with reduced risks of developing type 2 diabetes and cardiovascular disorders.[8,9]
- COVID-19 has more severe clinical consequences in patients with obesity-related comorbidities,[10] which has correspondingly affected Latinx and African American communities, as these populations are disproportionally afflicted by obesity at higher rates than the general population.[11,12]

Thus, it is more pertinent now than ever to target and prevent the development of diet-related conditions in order to protect & create a more equitable society for NYC's constituents.

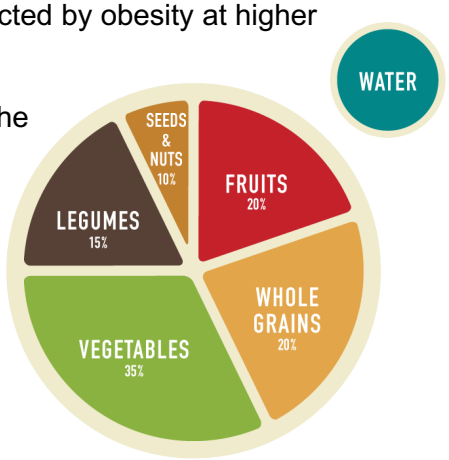

Figure 2: Recommended Breakdown of Foods in a Plant-Based Diet [4]

Food for Thought: Where Are We, and Where to Go from Here?

The "Green Monday" initiative, evolved from the previous Meatless Monday program successfully implemented in all NYC public schools (Res 0379-2018), would codify interventions aimed at addressing the root causes of the aforementioned issues. Briefly:

- The City's Department of Health and Mental Hygiene (DOHMH) would develop a voluntary program coordinating city-wide agencies in the effort to exclusively deliver plant-based food services every Monday.

- The decision by city agencies to participate in this program would qualify them for recognition certificates with the intent to incentivize the replacement of animal-derived protein with plant-based alternatives.
- Furthermore, this bill places the onus of public nutrition education on the City Commissioners of DOHMH and Environmental Protection (i.e. by effectively broadcasting literature findings with regards to health risks of the chronic integration of animal protein in diet).
- This Green Monday Initiative has been successfully adopted in several large US cities, including Berkeley, CA. [3]

Policy Impact

By combining efforts targeting nutrition knowledge and practice, the City will play an active role in encouraging lifestyle changes by introducing simple meal substitutions that can be brought home from the workplace and incrementally implemented in everyday life. Even *partially* eliminating animal-derived protein from one's diet for plant-based protein alternatives has been shown to decrease cardiovascular risk by *11-12%,*[8] reduce the risk of developing type 2 diabetes by *21%*,[3] and has been associated with reduced rates of hypertension, certain cancers, and obesity in general.[13] Therefore, because the benefits of adopting more plant-based foods within one's diet are not "all-or-nothing," any pragmatic steps we can take toward this goal will create a healthier, more cost-efficient, and (most importantly) more equitable society for NYC constituents moving forward.

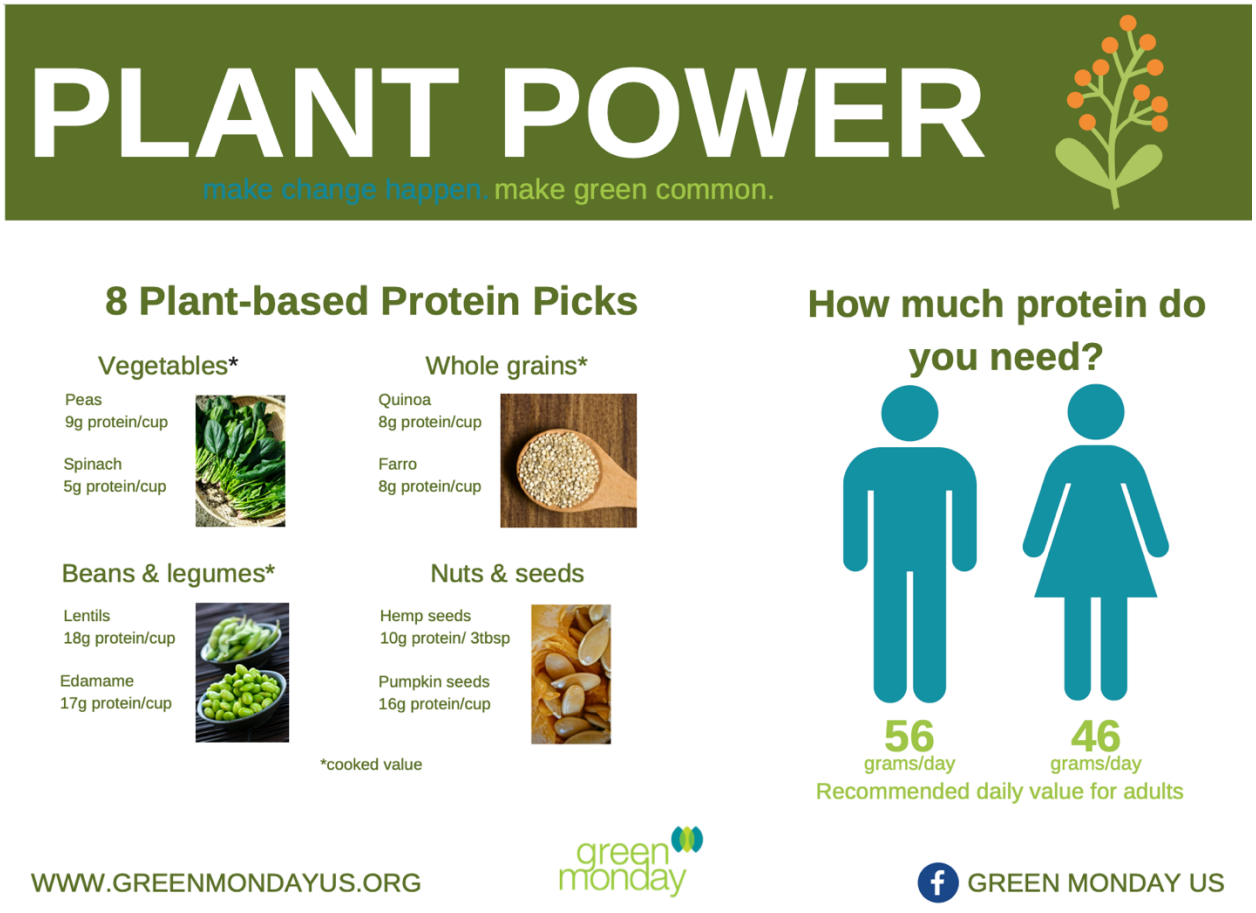

Figure 3: Plant-Based Protein Sources & Daily Intake Recommendations [3]

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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**

December 4, 2020

The New York Civil Liberties Union (NYCLU) is grateful for the opportunity to submit the following testimony regarding oversight of the COVID-19 vaccine. 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 on emerging from the coronavirus pandemic on the development and distribution of an effective vaccine.[1] And, with COVID-19 vaccine companies concluding phase 3 studies on two vaccines, reporting over 90% effectiveness at stemming coronavirus symptoms in adults,[2] and submitting applications for emergency use authorization to the FDA,[3] many New Yorkers are beginning to hope that we will soon put the pandemic behind us. Still, 24% of New Yorkers statewide say they are unlikely to take a

[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] The vaccine candidates were not tested for their efficacy at preventing transmission of COVID-19. *Vaccine may not stop virus transmission, says Moderna chief scientist*, THE STRAITS TIMES, Nov. 27, 2020, https://www.straitstimes.com/world/vaccine-may-not-stop-virus-transmission-says-moderna-chief-scientist.

[3] Press Release, Pfizer, Pfizer and BioNTech Conclude Phase 3 Study of COVID-19 Vaccine Candidate, Meeting All Primary Efficacy Endpoints (Nov. 18, 2020) (https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-conclude-phase-3-study-covid-19-vaccine); Press Release, Moderna, Moderna Announces Primary Efficacy Analysis in Phase 3 COVE Study for Its COVID-19 Vaccine Candidate and Filing Today with U.S. FDA for Emergency Use Authorization (Nov. 30, 2020) (https://investors.modernatx.com/news-releases/news-release-details/moderna-announces-primary-efficacy-analysis-phase-3-cove-study).

coronavirus vaccine.[4] And even for those who seek to be vaccinated, many challenges remain. The City Council must do everything in its power to ensure not only that all New Yorkers who want to be vaccinated can get the COVID-19 vaccine, but also that all New Yorkers both are and feel safe doing so. This testimony will articulate three challenges the City Council must keep front of mind: vaccine confidentiality, vaccine distribution mechanisms, and equitable, culturally competent vaccine distribution.

Vaccine Confidentiality

The federal government is conditioning distribution of any COVID-19 vaccine to a state on that state's signing a data sharing agreement[5] that commits 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.[6] The sweeping nature of this data sharing agreement is 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.[7] 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.[8]

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

[4] Jimmy Vielkind, *Nearly a Quarter of New Yorkers Say They Won't Take Covid-19 Vaccine*, WALL STREET J., Nov. 24, 2020, https://www.wsj.com/articles/nearly-a-quarter-of-new-yorkers-say-they-wont-take-covid-19-vaccine-11606213801. Even health care workers are hesitant to be vaccinated. Pien Huang, *Some Health Care Workers are Wary of Getting COVID-19 Vaccines*, NPR, Dec. 1, 2020, https://www.npr.org/sections/health-shots/2020/12/01/940158684/some-health-care-workers-are-wary-of-getting-covid-19-vaccines. This wariness persists even though widespread vaccination will be critical to stem the pandemic. Josh Michaud & Jen Kates, *The Dangers of Vaccine Disillusionment*, FOREIGN AFFAIRS, Dec. 2, 2020, https://www.foreignaffairs.com/articles/united-states/2020-12-02/dangers-vaccine-disillusionment.

[5] 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).

[6] *See* CENTERS FOR DISEASE CONTROL AND PREVENTION, COVID-19 VACCINATION PROGRAM INTERIM PLAYBOOK FOR OPERATIONS 63 – 64 (Oc. 29, 2020).

[7] *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.").

[8] *Id*.

with "other federal partners,"[9] which could include Immigration and Customs Enforcement (ICE), the FBI, or the Department of Homeland Security (DHS). This too is without precedent.[10] 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,[11] are disproportionately likely to suffer from COVID-19.[12] 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.[13] This is also true of religious enclaves, such as New York City's Hasidic community, which has also been ravaged by COVID-19,[14] still harbors deep distrust of the public health system and government after last year's bruising battle over the repeal of religious exemptions for vaccines,[15] and feels singled out for pandemic-related enforcement.[16]

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[9] 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).

[10] *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.")

[11] *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/.

[12] *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.

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

[14] 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.").

[15] *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.

[16] 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.

Councilmembers must be careful to avoid spreading confusion and fear about the risks of information sharing so as not to exacerbate a chilling effect. At the same time, 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 with the 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 information shared to respond to a public health crisis should not be used to criminalize or deport people.

Vaccine Distribution Mechanisms

The federal government has also 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.[17] Unfortunately, the traditional private health infrastructure does not serve all communities equally. In fact – and, unsurprisingly, 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[18] – this network is woefully inadequate in the neighborhoods hardest hit by COVID-19. For example, Manhattan has nearly *four times* as many traditional vaccination sites as the Bronx – despite comparable borough populations.[19] Particularly galling, there is only *one* lonely vaccination site in East Elmhurst, Queens[20] – which is home to more than 23,000 people.[21]

The paucity of traditional vaccination sites in the lower income communities that have been devastated by the pandemic is likely to be exacerbated by the extremely cold storage required for the two leading vaccine candidates. Pfizer's vaccine must be stored at -70 degrees Celsius and will go bad if not injected within five days of thawing.[22] Moderna's vaccine must be stored at -20 degrees Celsius, although it remains stable for 30 days at 2 – 8 degrees Celsius.[23] Extreme cold storage and transport procedures ("cold chains") are

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[17] 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).
[18] *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.
[19] *Flu Vaccine*, NYC, https://a816-healthpsi.nyc.gov/NYCHealthMap/ (last visited Dec. 2, 2020).
[20] *Id*.
[21] U.S. Census Bureau, Census 2010, Table PL-P5 NTA: Total Population Per Acre New York City Neighborhood Tabulation Areas.
[22] *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.
[23] 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).

expensive, and to ensure that the early vaccine candidates are not solely options for the rich, appropriate cold chains will need to be established throughout the City.[24]

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. 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.

Equitable, Culturally Competent Vaccine Distribution

Questions of vaccine distribution are likely to arise imminently. Earlier this week, Governor Cuomo announced that New York's first vaccine delivery, expected on December 15, will include enough doses for 170,000 New Yorkers statewide.[25] New York will have the unenviable task of deciding who to prioritize for vaccination, among many groups and individuals with compelling needs: health care workers; those working at and those living in congregate settings, including the elderly and the disabled, as well as those working at and those detained in prisons and jails; essential workers of all stripes, including teachers and other school staff, grocery store and pharmacy workers, and bus drivers and subway conductors, among others; those with pre-existing medical conditions; those whose racial, ethnic, and socioeconomic circumstances heighten their vulnerability; and the list goes on.[26]

It is imperative that New York prioritize those with the most need and that, within the prioritized groups, vaccines be distributed on an equitable basis. The City must also develop a mechanism for distributing vaccines to those for whom traditional identification documents

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[24] *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.

[25] Press Release, Gov. Andrew Cuomo, Governor Cuomo Announces State to Receive Initial Delivery of COVID-19 Vaccine Doses for 170,000 New Yorkers (Dec. 2, 2020) (https://www.governor.ny.gov/news/governor-cuomo-announces-state-receive-initial-delivery-covid-19-vaccine-doses-170000-new).

[26] The CDC's Advisory Committee on Immunization Practices has recommended that health care workers and adults living in long-term care facilities receive the first vaccines, although this recommendation is not binding on the states, and the initial batch of vaccines will be insufficient to fully vaccinate these two populations. *See* Jon Cohen, *CDC advisory panel takes first shot at prioritizing who gets the first shots of COVID-19 vaccines*, SCIENCE, Dec. 1, 2020, https://www.sciencemag.org/news/2020/12/cdc-advisory-panel-takes-first-shot-prioritizing-who-gets-first-shots-covid-19-vaccines.

present a problem, including undocumented individuals.[27] 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.[28]

Moreover, it is imperative that everyone who receives a vaccine has first given voluntary, informed consent.[29] The initial vaccines will be distributed under the FDA's Emergency Use Authorization (EUA), which means that the FDA will release 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.[30]

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.[31] To individuals who still face stark disparities in the U.S. health care system,[32] 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,[33] and in 2016

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[27] Despite IDNYC and Green Light, ID requirements continue to present unique challenges for undocumented people.

[28] *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.").

[29] 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).

[30] 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.

[31] 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.

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

[33] 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.

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."[34] 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."[35]

Indigenous Americans, too, have survived "significant unethical research and medical care" since colonization.[36] Latinx New Yorkers remember that between the 1930s and the 1970s, approximately one-third of Puerto Rican women and girls were forcibly sterilized.[37] This history feels strikingly present as immigrants detained in ICE facilities in Georgia this year report forced hysterectomies.[38] 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.[39] 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.[40] The City must do better this time. It 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

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[34] *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/.
[35] *Henrietta Lacks: science must right a historical wrong*, NATURE, Sept. 1, 2020, https://www.nature.com/articles/d41586-020-02494-z.
[36] *See* Felicia Schanche Hodge, *No Meaningful Apology for American Indian Unethical Research Abuses*, 22 ETHICS & BEHAVIOR 431 (2012).
[37] 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.
[38] 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.
[39] *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/).
[40] *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).

wear masks and adhere to social distancing,[41] community members and organizations are more likely than outsiders to know how to convince their neighbors to get vaccinated.

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,[42] housing, or public accommodations. Such a requirement could worsen New York's existing racial, disability, and economic disparities.[43] 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.

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

[41] 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.
[42] 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.
[43] *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/.

New York City Council
Committee on Health
Oversight – Vaccines and Future COVID-19 Treatments
Friday, December 4, 2020

Peter Taback
Chief Engagement and External Affairs Officer, YAI

Thank you to the Council's Committee on Health and to Chair Mark Levine, whose understanding of the health of New Yorkers before, during, and we anticipate, after this pandemic, gives us confidence in our city's ability to meet an unprecedented challenge, and to the Committee on Hospitals and Chair Carlina Rivera, a long-time advocate for New Yorkers with intellectual and developmental disabilities and good friend to YAI.

Our time today is brief. But the difficult story of the coronavirus and our community – New Yorkers with I/DD – dates to the pandemic's earliest days. We are here to request that the Council recognize the special vulnerability of people with intellectual and developmental disabilities (I/DD), affirm the urgency of priority access to a COVID vaccine, and demonstrate that outpatient clinics such as Premier HealthCare, especially those that specialize in treating people with I/DD, and their staff, must be on the front-lines of vaccine distribution. Now that the Centers for Disease Control has published guidelines that prioritize residents of long-term care facilities, we are here to urge the Council to make certain its planning includes residents of the city's supported housing for people with I/DD, and the exceptional direct support workers who make those houses into homes.

The unvarnished truth is painful: the last several months have revealed enormous gaps in the availability of resources to support New Yorkers with intellectual and developmental disabilities. More than four decades after de-institutionalization, New Yorkers with I/DD remain marginalized and unable to access adequate care. Now that a vaccine may be just hours away, we must not exacerbate this disparity.

YAI is one of the largest nonprofit agencies in New York State, providing comprehensive support for children and adults. YAI is also the institutional home of Premier HealthCare, a primary care and specialty outpatient clinic. YAI and its affiliates operate programs across New York City, and in Long Island, Westchester and Rockland Counties, Northern New Jersey, and California. Our 4,000 employees deliver housing, medical, dental, and mental health care, education, job training, community integration, and social programs to more than 20,000 people with autism, Down syndrome, cerebral palsy, and other intellectual and developmental disabilities, and their families.

Despite the prevalence of underlying health conditions within the I/DD population, people with I/DD have flown under the radar since the start of this pandemic. From mid-March to the end of April, COVID cases ballooned with a disproportionate

mortality rate at their heels. One national study, published on November 10 in the *New York Times*, showed a mortality rate almost six times that of all patients with COVID-19. November data from New York State's Office for People with Developmental Disabilities is even more distressing: of 3,906 confirmed positive COVID cases among people with disabilities, almost 80 percent lived in certified residential programs like those operated by YAI. The mortality rate was greater than 12 percent.

The challenges of senior housing during this pandemic are well understood. Far less visible, but more troubling, have been stories from supported residences for people with I/DD, known to most as group homes. At YAI, which operates more than 80 residences, this can be illustrated simply: after antibody testing became widely available, we learned that more than 50 percent of the residents of YAI homes were found to be antibody-positive.

Many factors explain this outsized vulnerability. Simple preventative measures like social distancing, masks, and handwashing pose serious challenges for people with I/DD. Many have underlying health conditions that exacerbate their susceptibility, which worsen as they get older. At Premier HealthCare, 80 percent of patients with I/DD have one or more chronic conditions that place them at high risk of severe illness from COVID. People with Down syndrome who reach the age of 40 average more than five chronic health conditions, including hypertension, diabetes, and obesity.

Hope Levy
Executive Director, Premier HealthCare

Premier HealthCare, an Article 28 clinic under New York State health law, offers primary care and specialty outpatient services. While Premier has expertise in services for children and adults with disabilities, it provides care to everyone and has performed more than 3,800 COVID tests for New York since the start of the pandemic. Premier 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.

Clinical and direct support staff working in this field mirror these vulnerabilities because many people with I/DD require hands-on support throughout the day. In March and April, our colleagues beat the odds of supply shortages and confusion to diagnose and treat, reduce transmissions, and protect people in their care. Staff are Premier and YAI's greatest asset. They were determined to help throughout this nightmare, entering places of known infection, risking their health and the health of their families to keep people safe or ease the journey to peace. Although YAI learned quickly how to contain infection and limit its spread, we did ultimately lose 20

people to whom we provide long-term support as well as three members of our direct support staff.

The current surge in transmission and illness has, predictably, hit our community hard…again. From May to October Premier HealthCare patients had a positivity rate of just 1%. During the month of November, that rate tripled. Last week, Premier tested eight people in two residential homes; all tested positive as did three Direct Support Professionals.

As the city and state prepare for the massive undertaking of a COVID vaccine, Premier HealthCare and other specialty outpatient clinics should be mobilized in the first phase of vaccine roll-out. Only specialty clinics can effectively administer the vaccine to the I/DD population, relying on knowledge of behavioral challenges and months of familiarity with all elements of COVID care.

To date, Premier has performed more than 3,800 rapid and PCR COVID tests. Premier has all of the necessary equipment, including medically suitable cold storage, to receive vaccines and retain them at the correct temperature. What's more, Premier can provide vaccines at its five locations, including several in underserved areas of the city, and at group homes across the metropolitan area. Outpatient clinics are far safer venues for vaccination than hospitals, which are prioritized in the current plan. With infections increasing in the months ahead, the burden to treat people in hospitals is already overwhelming their capacity.

Margaret Puddington
Parent Advocate

I am the mother of a person with developmental disabilities. I am also an active parent advocate at the local and the state levels.

I would like to put a face on the data you just heard from Peter.

This is my son Mark. He is 40 years old with a sunny, warm, and irresistible personality. He makes friends wherever he goes despite his challenges: he cannot speak but communicates via sign language and has the most expressive face I have ever seen. He can't open a jar or cut his food or shave himself. He has emotional intelligence but limited cognitive abilities. To remain safe, he needs staff with him every waking moment.

And now he has tested positive for the coronavirus, along with all of his housemates in his group home in Washington Heights. One of the staff has also tested positive. Miraculously, all the housemates are asymptomatic so they can stay put at home and do not need hospitalization.

My greatest fear, aside from a fatal infection, has been that if Mark got very sick and needed hospitalization, he would be totally alone without staff, without me or his dad. That would be like sending your two-year-old to a hospital alone. Mark would never recover from such a terrifying experience.

As you heard from Peter, people with developmental disabilities who contract COVID are dying at 3 times the rate of the general population because many with DD have co-morbidities and live in congregate care residential facilities. People living in such facilities have a higher risk of contracting the virus because they interact daily with staff who assist them with intimate tasks, such as bathing and tooth brushing, which cannot be performed at a 6-foot distance. Many people with DD cannot tolerate masks, cannot comprehend the need to keep a distance or to refrain from shaking hands or hugging. Staff come in shifts, so you have a large number of staff people in and out every day. And these people come by subway or bus, and they have their own families who may or may not have risky professions. If a staff person working in a residence gets COVID, it's a sure bet that others will catch it. Just like people in nursing homes.

Now compare the risk level of people with DD with that of seniors like myself. I am 78 and have a heart condition. That makes me high risk. But I physically interact with no one except my husband. We go nowhere. No eating in restaurants, no visits with granddaughter, no visits with friends, no holiday gatherings. For the most part, we can control our risk. Mark cannot.

People with DD like Mark should be top priority for vaccines, right after front-line health care workers. Their risk is tremendous, as is the risk of staff who work with them. In some respects, people with DD have a higher risk than people in nursing homes because of the difficulty people with DD have in following safety protocols. For vaccine dissemination, I urge you to prioritize people with DD and their staff in the same tier with long-term care residents.

I also urge you to ensure that people with DD can access vaccines through specialized Article 28 clinics, such as Premier HealthCare. We can't take Mark to a hospital for the vaccine. He is so fearful that he would fight off that needle. Last year, when he needed blood drawn, it required four separate visits to Quest, plus the support of both his favorite staff person and me. A hospital setting does not have time to wait for Mark to acquiesce to the procedure. The Article 28 clinic he uses knows how to defuse the experience for people with DD who are fearful and may even become combative. Article 28s must be a viable option for people with DD. Thank you for the opportunity to share my very strong feelings with you today.

Hope, Peter, and I applaud New York City's efforts to prepare for a vaccine and to understand the need to prioritize the most vulnerable populations. We urge that the I/DD population, I/DD specialty outpatient clinics, and the clinical and direct support staff who have sacrificed so much for this community be included as priorities in New York City from the earliest hours of vaccine availability.

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Testimony on COVID-19 Vaccine Oversight
December 4, 2020

Good Morning. My name is Mon Yuck Yu, Executive Vice President & Chief of Staff at the Academy of Medical & Public Health Services (AMPHS). I would first like to thank the New York City Council Committee on Health and Hospitals for considering our testimony.

AMPHS is a not-for-profit healthcare organization in Sunset Park that provides free health services integrated with individualized health education and social services to the immigrant populations of New York City. Our mission is to deinstitutionalize healthcare and make it a basic human right for all New Yorkers.

We are here today to call for a vaccine strategy that is culturally responsive and elevates community organizations as critical players in vaccine delivery. We anticipate that vaccine hesitancy will be a major challenge in Sunset Park, and many other communities of color. Many in our community have a deep seated mistrust of institutionalized healthcare settings and have long been underrepresented in clinical trials. Medical researchers in the U.S. have taken terrible advantage of Black, Indigenous, and People of Color, including Asian and Pacific Islander and Latinx communities.

This is a complicated and divisive issue because vaccination should not be an option, but it is a matter of life and death. However, calls for mandatory vaccination will create resistance. We have seen mask-wearing and social distancing guidelines politicized, whereas overenforcement has led to the mistreatment of brown and black individuals.

One thing we know for certain is that the COVID-19 pandemic has proven the need for transparency to inspire the public's trust. Culturally competent messaging to immigrant communities about the importance of vaccination, where to vaccinate and the current status of vaccination efforts are all essential to this effort. Every culture and community has different reasons for vaccine hesitancy. We have already heard from people we work with who are afraid to receive the vaccine because they are distrustful of the effectiveness of vaccine research; they don't want their children to get a vaccine even if available. They are afraid that just going out to get the vaccine will get them sick. As a personal anecdote, my grandmother is going blind now, because our family had been hesitant to take her to receive critical health services from her ophthalmologist during COVID-19. We need to determine a safe and secure way to get vaccines of homebound individuals. We must also remember that in 2019, the measles outbreak in South Brooklyn was met with resistance from many

people in the Hasidic community, requiring on-the-ground and culturally-competent outreach. Misinformation is also rampant across social networking platforms like WeChat. New York City must invest resources in tailoring messages, based on learning from each community rather than targeting "communities of color" as just one block in its vaccine delivery strategy.

In order to effectively reach all New Yorkers, nonprofits and community organizations like AMPHS, which have already been involved in Test & Trace Advisory efforts, should be prioritized as essential partners in vaccine distribution and education. These must be funded efforts, supported with up-to-date information from the health agency. The people we work with have historically been underserved by healthcare institutions that are foundational to the federal government's vaccine distribution strategy. While flu vaccines are offered for free through Health + Hospitals, there were no sites local to Sunset Park and neighboring hospitals to administer the vaccination. Over this season, we had to contact and partner with the multiple pharmacies to offer over 400 vaccinations in open spaces, and there is even higher demand now. We need local institutions that actively offer the vaccine for free to uninsured community members in order to fully reach the unmet need. Without trusted messengers to champion the vaccine, we fear that the most needy in our communities will go unprotected.

We recommend that the vaccine be offered through phased, equitable distribution strategy, first targeting the most at-risk communities, including essential workers like delivery workers, people with elevated health risks, and people over age 65, and subsequently prioritize vaccination sites in communities that have experienced the highest COVID-19 rates. All cost-sharing mechanisms should be eliminated; insurance companies must cover all vaccine costs, whereas free vaccinations should be offered to those who are uninsured. Companies like Moderna require two shots administered four weeks apart, which could make distribution more complicated. Culturally-competent messaging must be in place to communicate with and educate communities to ensure maximal compliance.

With COVID cases rising across the country, this is not the time to ignore this vulnerable population, but to support them. Here at AMPHS, we never ask about documentation, insurance or ability to pay because we believe that healthcare should not be based on a name, an ID number, or a status. Healthcare is not a privilege but a basic human right; we strongly urge the Mayor and City Council to consider supporting a community based and culturally sensitive vaccine delivery strategy in solidarity with our immigrant neighbors and to promote a city that is committed to equal opportunity, social justice and health equity.

Thank you for this opportunity to testify.

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 1950's to the 1970'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.

Council Members Rivera, Ayala, and Levine and fellow Council Members,

I am a Manhattan resident and medical care provider for people detained in New York City jails through Correctional Health Services of New York City Health + Hospitals and I write to you in my personal capacity. I cannot attend or watch the Council meeting on the Covid19 vaccine as I will be seeing my patients on Rikers Island at that time.

There are currently almost five thousand men and women who are 'in longterm care' of New York City in its jails. These people who are incarcerated have the same human right to health as those who are not detained but have a much higher risk of contracting SarsCoV2 infection and many of them have a higher risk of developing severe disease or dying from it.

I am considering declining my vaccination until my patients get theirs. Please consider a plan to include these five thousand individuals who are incarcerated for vaccination at the same time as the health care providers who care for them. **They should stand, like their caregivers, first on line.**

Thank you for your consideration.

Dr Jamie Uhrig