



## **NEW YORK CITY POD**

**ANNOUNCER:** This podcast is presented by the Centers for Disease Control and Prevention. CDC – safer, healthier people.

**MODERATOR:** On the topic of pan flu exercises, our next panelist, Marisa Raphael of the New York City Department of Health and Mental Hygiene, will give us a glimpse into how these exercises are used at the local level.

**MARISA RAPHAEL:** Thanks, Dan. The Five POD, or Point of Dispensing, operation was a 1-day, mass vaccination exercise using seasonal influenza vaccine. Our overall goal was to provide vaccinations in under-vaccinated communities. We used this Operation to test New York City's mass prophylaxis plan, but we were also testing the POD operational efficiency and capacity. The POD operation also met CDC's requirement of running a mass vaccination clinic before March 1, 2007.

To give you a little bit of background of how we got to the Five POD, I'll review New York City's previous experience running PODs.

In mid-October 2004, there was a dramatic increase in city residents seeking seasonal flu vaccination immunization clinics due to media reports of a possible national shortage of influenza vaccine. In response, New York City's Department of Health and Mental Hygiene partially activated its Incident Command System in order to increase patient services through the use of POD clinics. We also conducted two full-scale exercises involving PODs. The first was in June 2005, where we operated 4 PODs simultaneously, and the second was a flu POD in November 2005, where we operated one POD and provided approximately 3,500 flu vaccinations in one day.

During the November 2006 Five POD exercise, we had three major operation objectives that were based on the lessons learned during the 2005 POD Operation. The first objective was related to Customer Service, the second objective was related to data collection, and the final objective was related to POD site leadership structure.

To implement the POD operation required a 6 month planning effort with other Bureaus. The Bureau of Emergency Management took the lead in planning for this operation. Planning started in June 2006 and we established a biweekly meeting schedule. Each bureau with a significant role was asked to designate someone to attend the meetings. We maintained a tracking grid of all actions that needed to occur, including timeframe and responsible entities. Each Bureau had a planning role that was critical to the success of the Operation. The initial meeting discussions revolved around neighborhood and site selection. The Commissioner of Health and Bureau of Immunization strongly advocated for locating PODs in underserved neighborhoods. We analyzed citywide vaccination coverage data, as well as city maps to select locations that were in underserved neighborhoods, meaning that the neighborhoods had low coverage rates but were accessible via transportation hubs. We worked with the New York City Office of Emergency Management to select existing POD locations

maintained in the citywide database. Locations were selected for each neighborhood and site visits were jointly conducted by DOHMH and OEM to make final decisions.

PODs were located in each of New York City's 5 boroughs, and were open to the public between 8 am and 6pm. We used 2 shifts to staff the Operation. More than 1,000 DOHMH staff participated in the Operation, and approximately 200 Medical Reserve Corps volunteers participated, as well. While participation was not mandatory for DOHMH staff, they were paid overtime.

Leadership, including POD Team Leaders and other lead positions from our Incident Command System, were pre-identified and invited to attend an in-depth training the day before the POD to prepare them to perform their roles as leaders, as well as how to train the general POD staff on the day of the operation. General staff were given a very abbreviated Just in Time (JIT) training the day of the operation, which covered staff organization and physical POD layout.

This slide shows the general layout of the POD. Flu POD layout is slightly different than other PODs because they require that certain paperwork be filled out and patients need to wait 15 minutes post-vaccination to ensure no adverse reactions occurred.

Here are a few photos of the POD operation to give you a better understanding of our set up. While we didn't meet our vaccination targets of 25,000, we did reach 5,000 people in underserved neighborhoods who may not have otherwise been vaccinated. To date, 5,000 is the highest number of vaccinations we have achieved in one day. This is also our first time running 5 PODs involving seasonal flu shots and real life patients simultaneously. We also had success in achieving our customer service objective.

Analysis of our patient respondent information indicates that patients were satisfied with the service they received. They felt the experience met their expectations, and found that our staff to were professional and courteous. This POD included many staff in the Operation who had never participated in an emergency operation previously.

It was an excellent opportunity for us to provide training (either the day before the Operation or during the Just in Time training). Staff respondents indicated that they had a good or full understanding of their POD responsibilities, and were confident in their abilities to perform their responsibilities based on the training and events of the day.

Similarly, feedback received from our MRC volunteers indicated a very positive experience for most. This was an excellent opportunity to incorporate our MRC volunteers into a real operation and have them work alongside our DOHMH staff, as they would during a real event. They performed exceptionally well and even stepped into leadership roles when necessary, relying on training they had received pre-event as part of our regular training program.

As mentioned previously, an overall goal of the operation was to increase rates of vaccination in underserved communities. The NYC DOHMH's GIS department geo-

coded the basic address data from the encounter forms collected on the day of the operation and produced the map you see here. Since the POD locations were specifically chosen to fulfill this goal, this map provides graphic evidence of the achievement of that goal. We are working now to produce maps of past operations where one larger, higher-volume POD was conducted for comparison of patients' willingness to travel to receive free vaccinations, which will be extremely useful to future POD planning.

In the future, we hope to refine our data-gathering process to include determination of which POD the patients attended – this map merely shows that the patient attended one of the PODs that day, but does not specify the actual site visited.

This Operation allowed us to test our system to further refine and develop our mass prophylaxis plan. As with many aspects of planning, this is a continual process and each new exercise presents new challenges and issues that need to be addressed to enhance planning.

We also used this exercise as an opportunity to implement some necessary changes identified in the November 2005 POD Operation, including the implementation of a formalized real-time data collection process to inform decision-making at the POD. These data will help us to refine our POD capacity and planning for future exercises and real-events. We also established a personnel station for staff sign-in and sign-out. During the November 2005 POD, it became clear that a dedicated personnel station was needed to better control staffing coverage and track time for reimbursement purposes, which is very important. This addition proved beneficial to staffing operations.

### **(Training)**

In terms of training, while we received overall high marks on the training (both day before and Just in Time), many comments heard at hotwashes and debriefings were that more pre-training would have made staff feel better prepared to handle the challenges of their respective positions. Leadership staff also indicated that Just in Time (JIT) training could be improved to better prepare non-leadership staff. As a result, the DOHMH is rolling out a new training initiative this year to provide basic POD training to all DOHMH staff that could be expected to work in a POD.

### **(Command and Control)**

In regards to command and control, staff comments and surveys indicated that many POD leadership staff felt there was a lack of clarity about how the decision-making process worked. There were certain leadership functions that were left unfilled, including Public Information Officers to handle the media. In some PODs, the Safety Officer's function was unclear, and some staff were not aware of the Safety Officer's existence.

The POD Team Leader is in charge of the entire POD operation. Some POD Team Leaders felt they needed more staffing support to do their job, such as a dedicated Deputy POD Team Leader.

### **(Community Outreach)**

In terms of community outreach, we were disappointed by the relatively low turnout; we were prepared to provide 25,000 flu shots, but only provided 5,000. Only 25% of respondents heard about the POD through the media. Staff and customers indicated that there was inadequate publicity for this POD operation. On the day of the operation, we, in fact, redeployed staff to promote the POD throughout the neighborhood. For future POD exercises, we need to conduct more aggressive outreach with media, community-based organizations, faith-based organizations, as well as to tap into existing relationships that DOHMH already has to reach our vaccination goals.

### **(Special Pops)**

In regards to special populations, we did our best to ensure that all sites were accessible for all potential patients who would come to our POD by pre-surveying them and planning the layout in advance of the operation. However, as we ended up registering an excessive number of staff, we tried to set up as many stations as possible in the POD space, which caused us to have more narrow aisles than we would have liked, and perhaps not enough room for families, which we saw a lot of.

In New York City, we can usually find a staff member or other patient who can assist with translation, as the PODs draw patients from the same neighborhoods. However, this may not always be possible. To help us with our ability to provide adequate translation services, we entered into a contract with a telephone translation service called Language Line, which was available to us for this operation, although it was not ultimately utilized. In addition, our Employee Data Bank and Medical Reserve Corps databases each contain language skill information for our staff and volunteers, respectively. Paired with census data, these data were a valuable resource that can provide us with information to assist us with staff assignments, where such assignments are possible.

A number of issues were identified as part of the ongoing After Action Review process. Many will require collaboration from entities within and outside of DOHMH. Working with these internal and external partners will further enhance our efforts to be better prepared to respond to an incident requiring mass-prophylaxis, and will enhance general preparedness, as well. We will test many of the recommendations from our AAR during our next large-scale Flu POD planned for next fall. We will begin our planning efforts this Spring, and will use the Homeland Security Exercise and Evaluation Program guidelines to direct our efforts.

The POD Operation was very important in testing our mass prophylaxis plan, and also has helped to enhance our pandemic influenza planning efforts. This Operation gave our staff and volunteers the opportunity to practice working under the ICS, which is broadly applicable to many incidents, including a response to pandemic influenza. It allowed us to mobilize large numbers of staff, volunteers, and resources to stand-up 5 simultaneous large-scale flu vaccination clinics throughout the five boroughs. Prior to the Operation, New York City had never run 5 PODs simultaneously. The POD

Operation allowed us to receive and evaluate honest feedback from our customers and staff. This feedback has helped us to revise plans as needed to improve POD operations in future exercises and real events. And finally, the outreach in preparation for the operation allowed us to better engage external partners, such as community and faith-based organizations, thus building and enhancing relationships that are a critical part of our planning efforts, particularly for pandemic influenza preparedness.

MODERATOR: Thank you Marisa. What a rich learning opportunity this exercise provided for you. Two questions now related to the POD layout and flow:

- First, you mentioned the need for these “waiting rooms” for individuals. Now, could this, or, did it cause backlogs with your POD flow?
- And what about if you’d had the 25,000 show up, would that have presented problems?

MARISA RAPHAEL: The waiting area was staged in a separate area after participants passed through the dispensing station. This area was not past capacity during the operation, and we believe we would have had the capacity to accommodate 25,000 participants.

With an expected flow of up to 500 patients per hour, we would need to be able to provide seating for up to 125 patients in the waiting area.

MODERATOR: Interesting. My second question deals with special populations. NYC, of course, is such a diverse population, with many people speaking different languages. Did you have signage in your PODS in languages other than English?

MARISA RAPHAEL: Yes, we ensured that we had a lot of signs in the top 10 languages for New York City’s population. However, we didn’t create an instruction guide to accompany the signs, which made it very difficult for Logistics staff, unaware of all of the signs they were supposed to place, to actually place the signs properly in the POD site. We are now developing a guide that could be used with our standard signs.

MODERATOR: And you learn through those exercises, don’t you?

MARISA RAPHAEL: Yes

MODERATOR: An example of unexpected results – even though you’d planned for those languages.

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