Vaccine Roll-Out 2021 (VRO-2021)

Suggestions

Introduction:

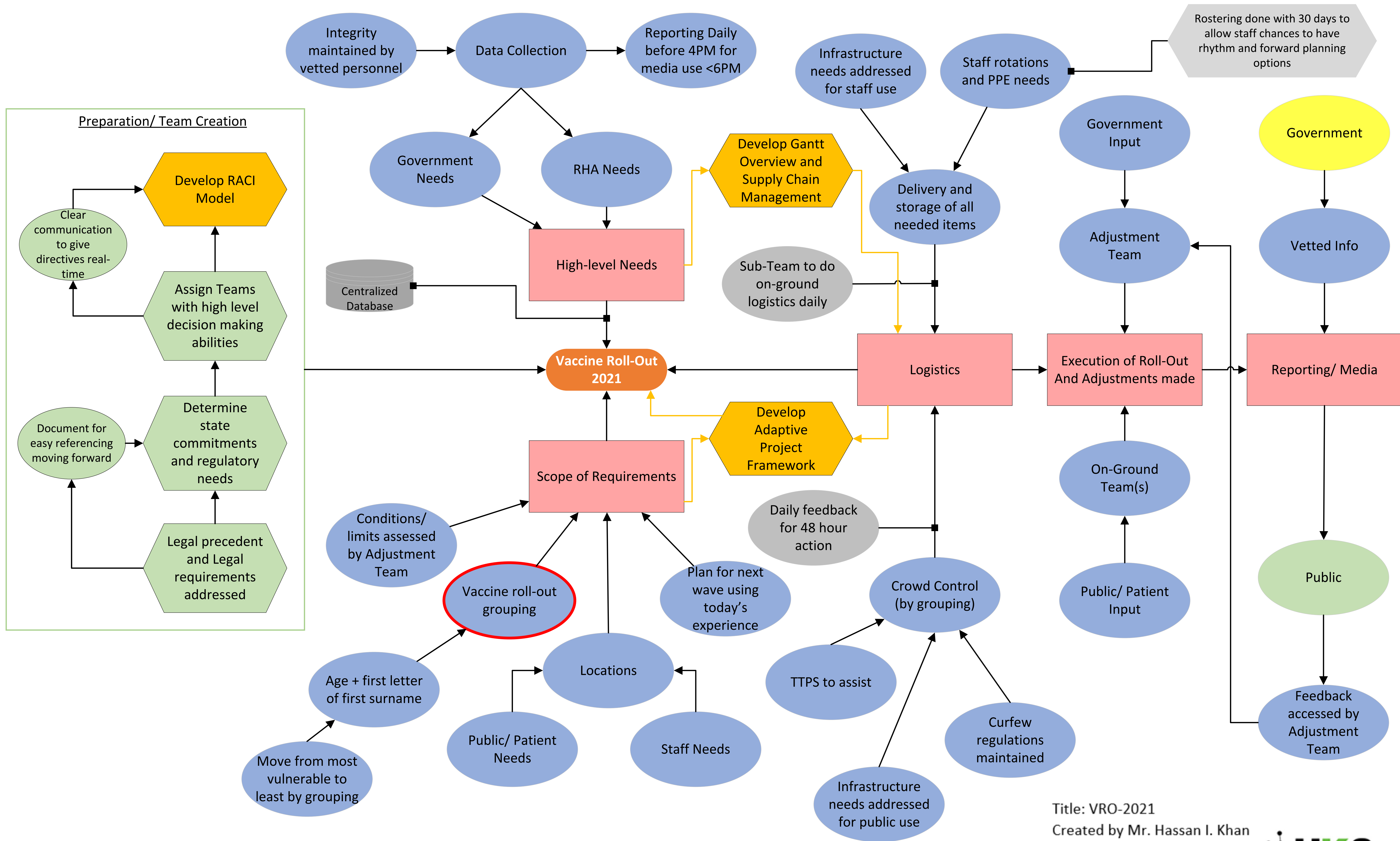
This document outlines several suggestions from my outside point-of-view of the internal decision-making being done to date for the vaccination roll-out plan.

Expressed are some ideas to streamline the communication between RHAs and their supplemental entities, which has been illustrated in two flow charts, and other criteria examples for phased groupings of the populace for vaccination. My background is not medical, but the vaccination roll-out requires a multi-layered approach using several types of project and logistical planning methodologies.

I have suggested models such as RACI, Gantt, Waterfall, Supply Chain Management (SCM) and Adaptive Project Framework (APF) to name a few, for assisting the planning and execution by the main decision makers in how to adjust real time for the roll-out and subsequent follow up with reporting and management of the pandemic with-in The Republic of Trinidad and Tobago.

There is a need for a centralized hub to coordinate all efforts with Ministerial effect, however, the RHAs and other local entities are not always in synch and my suggestions are provided to help to reduce the ad-hoc nature seen.

VRO-2021 FLOW



Title: VRO-2021
Created by Mr. Hassan I. Khan
Date: 11/ June/ 2021
Mobile: +1 (868) 772-8976
Email: hkhan@hksltd.net

HKS

This brief serves to supplement the VRO-2021 FLOW above:

Based on limited information it is my understanding that the vaccine roll-out has been faced with miss-communication issues at critical junctions, limited use of resources already activated on the ground (state entities), Human Resource Management and Crowd Management inefficiencies.

I hope there is some guidance that can be found from the suggestions I have presented in this document. It would be best to speak to a team directly involved with the roll-out to offer services in providing a better solution to all parties concerned if that is deemed necessary.

There are numerous other processes/ protocols that must be followed, and this is my viewpoint outside of the internal decision making currently being done.

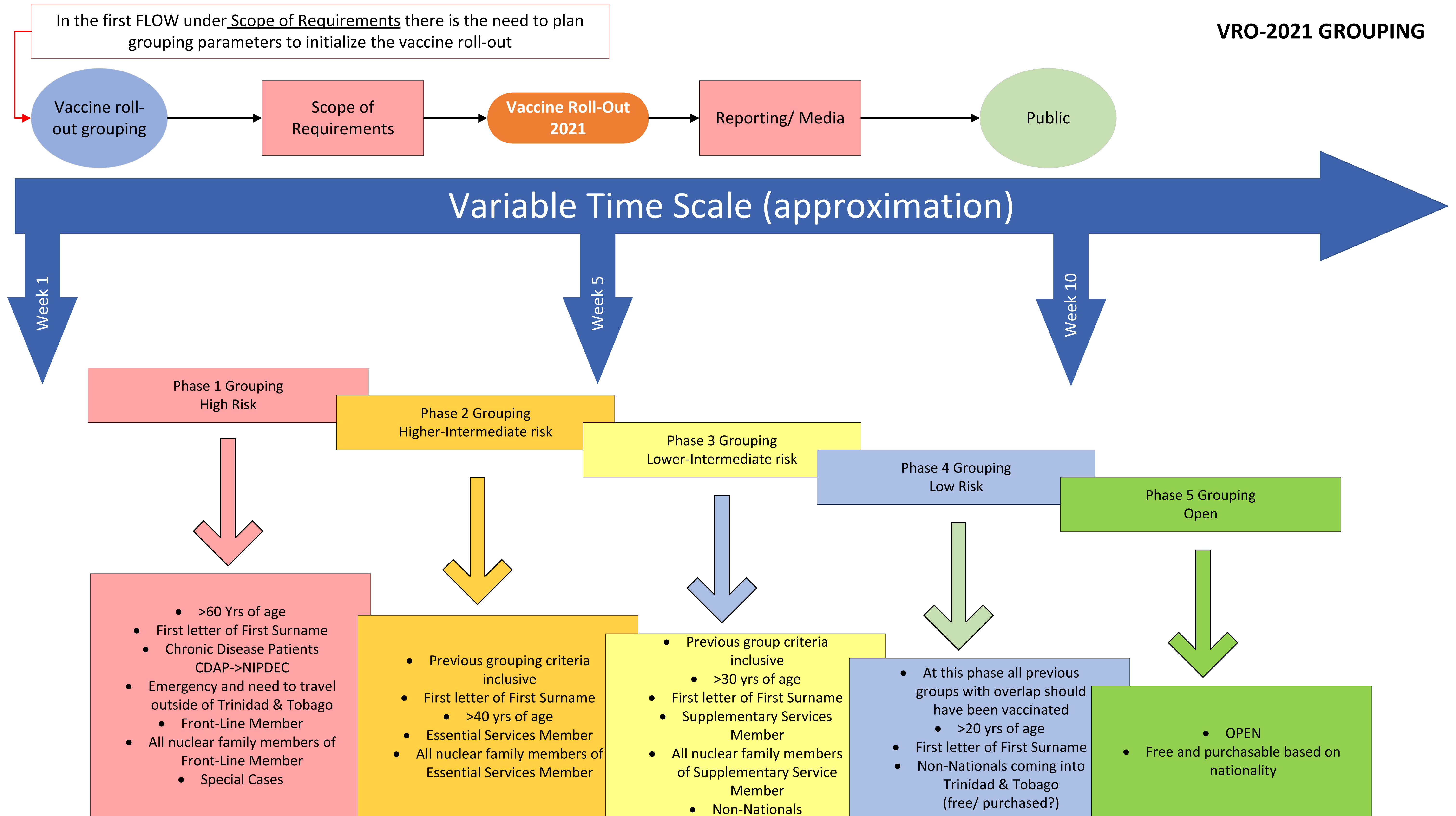
At this point the best way to make drastic changes with authority and direction in the shortest time frame possible is to provide input at the ministerial level and work down to the external-public level.

Key Points:

- Scope of Requirements and RACI models are absolutely needed at this point to streamline all communication and have RHAs and Ministry of Health work hand-in-hand on a real-time basis for the sole purpose of vaccine roll-out. The valuable data collected, and subsequent reporting will help all future efforts during the pandemic management process.
- Phasing roll-out and controlling specific groups for vaccination will of course lower the burden seen to-date by all parties. However, there are calls from the public requesting that third-party entities such as pharmacies and private clinics be allowed to administer the vaccine. This will not be a good direction at this stage as the methodology in capturing quality data and reporting back to RHAs must be maintained. There are several steps in providing a vaccine with quality control and safety being part of the process and using un-trained or un-supervised persons to administer the vaccine will be a critical break in the entire process.
    - Space requirements and comfort levels for the public and staff doing the vaccine are paramount in a controlled roll-out.
    - There also needs to be a place for persons to wait as a registered nurse observes for any allergic reactions, with facilities to treat such an outcome if it arises.
    - Infrastructure for all the above will cost too much to install and maintain and using already built state owned infrastructure will be the best solution.
- Repurpose state entities for drive-through vaccinations and use current locations for walk-ins. Lowering the daily load per location will have several positive effects, patient morale, trust between all parties and throughput in vaccinations. Having the public utilize different locations via different modes of transport will also allow current staff to spread the workload to maintain their own PPE requirements.

Key Points *(Continued)*:

- PPE should be cycled as required by international standards (4 hours approx.) and hot and cold zones designated. This is to ensure safety.
    - Separating critical components mitigates exposure if there is a break in the system.
    - PAHO and WHO directives should be applied where necessary, and reporting on their execution to stakeholders for adjustment as needed.
- Staff requirements need to be reviewed as “burn-out” has affected many to date. Following some of the recommendations above will lower the shock impact seen on staff and give them the needed ease to rest and recover for the next working day.
- Using specific surnames for certain days is useful, but the number of persons in Trinidad and Tobago per first letter of their surname is varied and there should be caps and over-laps assessed daily and adjusted for the following working week.
- Data capture to maintain clear knowledge of who is vaccinated and when their next dose is needed, with all relevant documentation, is vital and offers reassurance to the public of their (government) efforts in combination of staff efforts during the roll-out.
- Grouping is per phase as the current practices globally are to vaccinate the most vulnerable and move on to lesser vulnerable in phased groupings of the populace.
    - An example of this is illustrated on the next page.
- From a security point of view the information gathered can be also used later by the TTPS, Immigration and other state agencies for census reporting and other Operational Security needs.



Grouping criteria should be determined by medical professionals using modern methodologies. The criteria listed above is based on my none medical background coupled with my professional experience in crowd management and operational security practices. I do not have access to current ages of the population nor any other census data when forming these groups. Please note that at some point there will need to be hard cut offs by grouping to ensure there is a sense of “urgency” given to the populace.

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Conclusion:

Resources: Currently there are areas that can have better communication applied and movement of staff (doctors and nurses) lowering the mental and physical strain experienced.

RHAs (HR departments) are moving in what appears from my outside point-of-view in an ad-hoc manner and this lowers efficiency for every party connected. Using a central hub or base with a high-level team making decisions will help in the final solution and roll-out of all resources available, vaccine and other wise.

RHA communication to external persons: There are many persons in Trinidad and Tobago with multiply names as part of their surname, and to solve this there should be a clear protocol expressed via the media detailing the first letter of the first surname (where applicable) is to be used from their state issued ID or Driver's Permit, and Passports may be used. This will eliminate confusion from the public in knowing which day(s) to visit a location for vaccination. As the more vulnerable groups become vaccinated, the other groups should follow the same order; Age + first letter of first surname. This can be clearly communicated via the media easing tensions by the public and over crowding of those not grouped for that specific date or location.

If there are limits on the number of vaccines available per day and/or per location, then the cross communication from RHAs (clinics) to persons seeking the vaccine need be further expanded to accommodate accurate information and scheduling for all parties connected. This will lower dis-trust and increase positive optics of the service being provided.

Following up and using the hotline and WhatsApp should be manned by a single hub for easier collection and reporting of data, but also to present the public who contact them with faster and more accurate information.

Fake news and its impact: Many social media users are bombarded daily with varying degrees of miss-information and fake news. Using a standardized output model, seen already by TTPS and MoH, will lower chances of fraudulent information being shared. There is no realistic way to stop fake news all together but having a centralized page for all disseminated information from MoH helps the public know where to go and when to access critical updates from trusted sources within the MoH. Maybe apply a specific water mark which helps because taking screen shots of previous material and trying to apply a watermark will make it harder, but not impossible.

Recommendations: From an external point of view many departments and professionals are doing their best to coordinate and manage resources, and it appears that a high-level committee of seasoned operational and project consultants can help to better roll-out the needed phases and processes to satisfy government and public needs. Maybe establish a central hub to coordinate all efforts, loop in CDAP under NIPDEC to provide chronic disease persons information for faster scheduling, and maybe create a committee whose single task is vaccine management and then post-vaccination management. CDAP uses Cellma to record patient information, maybe that can be employed in some form to help bring all the various data point sunder one solution.