Conference Call Convened at 12:00 p.m. Eastern Daylight Time

✓ **Present:**

✓ Jonathan Ballard, MD, MPH, MPhil – NH Department of Health and Human Services, Chief Medical Officer (accompanied by Fallon Reed at NH DOS HSEM)

✓ Kathy A. Bizarro-Thunberg, MBA, FACHE – Executive Vice President / Federal Relations, New Hampshire Hospital Association (in office alone)

Charles P. Burney, MD – Resident, General Surgery and Leadership Preventive Medicine

✓ Michael Calderwood, MD – Infectious Disease and International Health, Dartmouth Hitchcock Medical Center (in office alone)

✓ Polly Campion, MS, RN – Former New Hampshire House of Representatives (in home office alone)

✓ Patricia E. Clancy, MD – Pleasant St. Family Medicine, Chair, Concord Hospital Ethics Committee (in office alone)

Carl Cooley, MD – Developmental Pediatrician

✓ Adam Crepeau – Policy Director, Office of Governor Chris Sununu (in State House office alone)

✓ James Culhane – President and CEO, Home Care Hospice & Palliative Care Alliance (in office alone)

✓ Kevin P. Desrosiers, MD, MPH – Chief Medical Officer, Elliot Hospital and Elliot Medical Group Acute Care Services, Vice President of Medical Affairs, Physician - Critical Care and Preventive Medicine (in office alone)

✓ Jeff Dickenson – Advocacy Director, Granite State Independent Living (in office alone)

✓ Paul Drager, JD – MedEthics Consulting (home office alone)

✓ Anne Edwards, Esq. – Associate Attorney General, NH Department of Justice (in office alone)

✓ John E. Friberg, Jr. Esq. – Chief Legal Officer, Manchester and Nashua SolutionHealth (in office alone)

- ✓ Marc D. Hiller, MPH, DrPH – Associate Professor, Department of Health Management and Policy, College of Health and Human Services, University of New Hampshire (home office alone)

- ✓ Lucy C. Hodder, JD – Director, Health Law and Policy, Professor of Law, University of New Hampshire, Franklin Pierce School of Law, Institute for Health Policy and Practice (home office alone)

- ✓ Joseph Hoebeke, Chief, Hollis Police Department (in office alone)

- ✓ Sally Kraft, MD, MPH, VP of Population Health at Dartmouth-Hitchcock (in office alone)

Richard Levitan, MD – Emergency Medicine, Littleton Regional Hospital

- ✓ John McAllister, President, Professional Fire Fighters of NH (in office alone)

- ✓ Kenneth Norton LICSW – Executive Director, National Alliance of Mental Illness, New Hampshire Chapter (in office alone)

Debra Pendergast – New Hampshire Department of Safety, Director of the Division of Fire Standards and Training and Emergency Medical Services

- ✓ James G. Potter – Executive Vice President/CEO, New Hampshire Medical Society (in office alone)

- ✓ Susan A. Reeves, EdD, RN, CENP – Chief Nurse Executive, Dartmouth-Hitchcock Health Executive Vice President, Research & Education, Dartmouth-Hitchcock, Clinical Professor, Department of Community and Family Medicine (in office alone)

Kate Riddell, MD – Anesthesiologist, Southern New Hampshire Medical Center

Rae Ritter, MSN, APRN-CRNA – President, New Hampshire Association of Nurse Anesthetists

- ✓ Justin Romello – New Hampshire Department of Safety, Bureau Chief, Division of Fire Standards and Training and EMS (in office alone)

- ✓ Luanne Rogers, RN – Administrator, St. Theresa's Rehabilitation and Nursing Center (in office alone)

- ✓ David Ross, Administrator – Hillsborough County Nursing Home (in office alone)

- ✓ Sedden R. Savage, MD, MS – Addiction Medicine and Pain Medicine Clinician, Advisor to Dartmouth Hitchcock Substance Use and Mental Health Initiative (in office alone)

Sen. Tom Sherman – New Hampshire Senate

- ✓ Michael Sitar, Jr. Chief, Tilton Northfield Fire and EMS (in office alone)
- ✓ Steve Surgeoner, MD – Anesthesiologist, Dartmouth Hitchcock Medical Center (in office alone)
- ✓ Elizabeth Talbot, MD – New Hampshire Department of Health and Human Services, Deputy State Epidemiologist, Dartmouth Hitchcock Medical Center, Infectious Disease Clinician (in office alone))
- ✓ Robert Theriault, Jr., BSPharm, MB, RPh – Director of Pharmacy Services, Wentworth-Douglass Hospital (in office alone)
- ✓ Joan C. Widmer, MS, MSBA, RN, CEN – member, New Hampshire Nurses Association (home office alone)
- ✓ Tom Wold, DO – Chief Medical Officer, Portsmouth Regional Hospital (in office alone)

NH state agencies participating on the call:

- ✓ Carole Totzkay, MS, CHES® - NH Department of Health and Human Services, SDMAC Facilitator
- ✓ Fallon Reed – Planning Chief, NH Homeland Security and Emergency Management

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Ballard: Meeting opened with reading of the State-required public access meeting statement and SDMAC member roll call. Previous meeting notes were not reviewed. Since the last meeting, DHHS released guidelines for Phase 1a, subject to initial draft guidelines. They have rolled out both Pfizer and Moderna vaccines to frontline healthcare workers, first responders and older adults living in residential care settings. As of Wednesday, 12-30-20: 64,775 doses allocated to NH and 46,000 received. There have been 21,176 doses administered as of 12-30-20, and more since then. There are 13 fixed sites set up across the state, managed by the NH National Guard and Regional Public Health Networks. The State continues to work with hospitals. Walgreens and CVS are administering vaccine to skilled nursing facilities and assisted living facilities (12-21-20 kickoff) as part of the federal Pharmacy Partnership Program (PPP) from the CDC.

The National Academy of Sciences, Engineering & Medicine framework was used to initially guide NH's vaccine allocation strategy. SDMAC included long-term care in Phase 1a (departure from NASEM), but then CDC Advisory Committee on Immunization Practices recommended to include this population in Phase 1a after the State had already decided to include this population in phase 1a. NH also included first responders in Phase 1a (another departure from NASEM) with the recognition this population delivers care to and serves the most vulnerable persons who if they contract COVID-19 would be at significant risk of poor outcomes and death. Recent update to Advisory Committee on Immunization Practices has also now included first responders in phase 1b, moving this group up in the tiers similar to New Hampshire's decision. It seems that the national agencies were following New Hampshire's lead.

Primary purpose of this meeting is to discuss the continued phased vaccine allocation approach in New Hampshire. The ACIP has now had an additional meeting designating frontline essential workers as receiving vaccine in phase 1B, which is a departure from New Hampshire's plan to protect the most vulnerable and save the most lives by vaccinating the most at risk of poor outcomes and dying, which from the epidemiology is older persons and persons with two or more specific health conditions. Therefore, we are holding today's Emergency Meeting of the SDMAC/Vaccine Advisory Committee to discuss this issue.

Talbot: Slide presentation on current vaccine allocation phases. Over the past eight months, 25 people at DHHS have been working diligently on the COVID-19 vaccine program at DHHS. She expressed appreciation to SDMAC for convening when needed.

SDMAC Update Presentation:

- Founded on decades of planning.
- Driven by dedicated, multi-disciplinary COVID-19 Vaccine Allocation Strategy Branch.
- Reviewed by senior leadership.
- Supported by the SDMAC.

Guiding Procedural Principles

- Fairness
- Transparency
- Evidence-based

Guiding Ethical Principles

- Maximum benefit, saving the most lives
- Mitigation of health inequities, protecting the most vulnerable

NH Allocation Framework:

- Goal: reduce severe morbidity and mortality and negative societal impact due to transmission.
- 4-phase allocation strategy.

Strategy Provided Table available at https://www.nh.gov/covid19/resources-guidance/vaccination-planning.htm

Actively navigating Phase 1b decisions now:

- People of all ages with comorbid and underlying conditions that put them at significantly higher risk.
- Other older adults.

Phase 1a

- Healthcare workers
    - Most risk: Front line clinical staff who provide direct patient care and support staff with risk of exposure to bodily fluids or aerosols
    - Moderate Risk: staff who have indirect or limited patient contact.
- Older adults in LTCF, SNF and ALF settings
- First responders

ACIP on 12-20-20 issued guideline for Phase1b: Frontline essential workers (firefighters, police officers, corrections offices, teachers and school staff, agricultural works, postal workers, manufacturing workers, grocery store workers public transit workers and some educational sector workers) and persons aged 75 and older. Major concern with ACIP recommendation is that it may include up to 80% of the total population and does not prioritize those most at risk of dying if they were to contract COVID-19.

Phase 1c: persons aged 65-75 and persons with high-risk conditions (16-64 years) and frontline essential workers not previously vaccinated.

NH is moving toward Phase 1a, 1b, 2a, 2b and 3 nomenclature for vaccine roll out plan

    - Morbidity & Mortality (M&M) prioritized over risk of acquiring infections
- Negative societal impact
    - Potential exemption of school and daycare staff
    - Considering prioritizing this population in phase 2a as soon as those who are most vulnerable to dying if they contact COVID-19 are vaccinated

DHHS is working on a dashboard for vaccine distribution success.

Clancy: What phase includes homeless population? **Talbot:** NH Phase 1b includes individuals with health conditions, older persons, and Regional Public Health Networks will have flexibility to achieve health equity to vaccinate individuals living in shelters. But this is different than ACIP

recommendations. We want to choose populations to move through at manageable rate and size. These decisions are not finalized yet.

Calderwood: Complexities of operationalizing rollout will be challenging regardless of which populations are included. What is opinion of modeling the impact of "bending the curve" if focus on frontline workers? M&M may be greater for some of the other groups than the frontline essential workers. **Talbot:** We do not have NH modeling on impact if focus on frontline essential workers, but ACIP did do national modeling on this and that was why they made their recommendations, however the ACIP plan does not prioritize those most vulnerable of poor outcomes as the current State plan.

Bizarro-Thunberg: Perhaps we should consider some further segmenting within each of the recommended phases, as we did with phase 1a. **Talbot:** Yes, segmenting in phase 1a was relatively easy, but very helpful for distribution of the vaccine. For instance, the issue of co-morbidities would require relying on community partners. Age is an easier way for allocation.

Potter: When will be engaging in Phase 1b and issuing guidance? **Ballard:** We expect to have Phase 1a done by the end of January. **Talbot:** 1a included about 110K individuals. Persons with medical vulnerability-170K, person 75+ age-100K, congregate living adults-15K. Vaccine hesitancy will likely increase as we move through phases. NH proposed phasing is more manageable from a time perspective.

Clancy: Will the mobile units be used for reaching out to homeless settings?

Talbot: We will have mobile strike teams that will facilitate vaccine distribution through the Regional Public Health Networks.

Clancy: Will later phase be through state sites or through community pharmacies? **Talbot:** NH will have multiple venues, the 13 regional sites, mobile teams and there are providers that are applying as well.

Wold: Provided CISA definition of frontline essential workers. **Talbot:** familiar with these guidelines and have done some deeper dives to these definitions within NH workforce.

Clancy: Co-morbidities to be defined by PCP. What sort of documentation will be required?

Talbot: NH will rely on health homes and have a way of helping those without health homes. The state will develop a way to operationalize this.

Hiller: How will the public be made aware they are eligible? **Talbot:** Multi-media outreach is currently being planned. The NH Medical Society is also working on this.

Potter: Overview of NH COVID Vaccine Alliance: evolving from efforts of #maskupNH. Weekly call on Tuesdays (noon to 1:00pm) getting brief updates on allocation process and addressing questions from stakeholders. Feedback from stakeholders (200 on last call) has helped with transparency of process. As NH moves into later phases, stakeholders will shift. Then their communication plan is to more toward public outreach. Working with DHHS to form mission and goals; looking to promote public buy-in for vaccines, to promote understanding of the vaccine roll out plan and to counter disinformation on the vaccines.

Wold: Is there a plan to vaccine moderate risk healthcare workers sooner than currently planned in areas of high infection rates? **Talbot:** infection rates are relatively consistent across the state so have not looked at regional distribution variances.

Hodder: We had good reasons for supporting our prior allocation scheme rather than adopting the ACIP frontline essential worker plan. How impactful is this proposed shift given where we are in the rollout? **Talbot:** there is some overlap in the populations so it's hard to know where we are exactly. The big decision is regarding frontline essential workers vs. medically vulnerable older adults and persons with health conditions. Vaccinating the former could drive down the R_o.

Hodder: We would need some high evidence to challenge our initial prioritizing. **Talbot:** NH DHHS as had lots of requests to prioritize some groups over others.

Talbot: A key challenge is between getting the vaccine out as fast and efficiently as possible vs. getting it out in the most equitable manner possible.

Calderwood: We need to be driven by the science as much as possible. Models depend on whether cases rising, flat or falling. We can reduce the number of infections or the number of people dying. If averting death is the most important outcome, then how do we allocate for this? He suspects 75+ is driving the death rates. **Talbot:** in NH 90% of death is in 70+ age group, but also significantly influenced by co-morbidities.

Bizarro-Thunberg: Having most, moderate and less risk has really helped in distribution during Phase 1a. It seems this could help with segregating frontline essential workers. **Talbot:** Yes, need for NH DHHS to provide guidance is important, but we need to move quickly here.

Sitar: Most of those being transported by EMS are elderly. There will be a point when the vaccine will become available in greater quantity than we can manage to administer it.

Dickinson: Would like to see NH framework stay as it is with prioritizing older persons and persons with health conditions who are more at risk rather than adopting the frontline essential workers prioritization.

Kraft: Do we have estimates on the number of available vaccines on a weekly basis? **Talbot:** Operation Warp Speed is working to give same amount each week, currently around 14K doses per week. Very fluid as more vaccine companies get approved.

Wold: Are the ACIP recommendations being impacted based on where the virus spread is currently at, e.g. currently in a third wave? Is there a need to shift our priorities to mitigate current spread? **Talbot:** Yes, this is an important point. She wishes we had the modeling to support recommended change.

Public Questions from Chat Box:

from Lucy Hodder to all panelists: 12:43 PM
Thank you so much for this excellent overview - Is there a recommendation from the work group?

from steve surgenor to all panelists: 12:44 PM
Is a key factor to consider ensuring that we as a State maintain momentum as stewards of this resource ... as part of the plan

from Lucy Hodder to all panelists: 12:46 PM
Can you show the slide of our priority groups as we discuss?

from Polly Campion to all panelists: 12:46 PM
thank you for pulling apart the differences b/t ACIP and NH recs. Would you please remind us of the #s in each of our priority phases 1a, 1b and 1c?

from Michael Calderwood to all panelists: 12:47 PM
I want to discuss population versus individual in terms of vaccine impact

from Michael Calderwood to all panelists: 12:55 PM
Those with comorbidities means those with defined comorbidities, thus access to healthcare. I worry about the inequity.

from Marc Hiller to all panelists: 1:00 PM
How do members of the public learn that they are eligible for a vaccine (particularly in 1B and 2A & B)... do they have to rely on their PCP to contact them ... or will many who are eligible for vaccination simply not know that they are eligible

from Lucy Hodder to all panelists: 1:07 PM
I have a question - and mostly just need some clarity around what our options are realistically

from Michael Calderwood to all panelists: 1:08 PM
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19/evidence-table-phase-1b-1c.html

Ballard: That is what we are asking today.

from Michael Calderwood to all panelists: 1:19 PM
Worth a review: https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-10/COVID-Biggerstaff.pdf

from Polly Campion to all panelists: 1:23 PM
Would there be benefit in continuing with the current prioritization plan, but initiating subsequent phases (essential workers) before earlier phases are completed? I would worry about putting off vaccinating medically vulnerable until all essential workers have been vaccinated, just based on #'s and vulnerability to severe illness

Talbot: We are continuing to evaluate the idea.

Ballard: We plan to reconvene in February/March unless there is an emergency need to meet sooner.

Talbot: Sincere thanks to SDMAC members and other participants on the call today. We will continue to offer the science as it becomes available.

Ballard: Anne Edwards, can this meeting be adjourned?

Edwards: Dr. Ballard, you can adjourn the meeting.

Ballard. This meeting is adjourned.

Conference Call ended at 1:40 p.m.

Respectfully submitted by: Joan Widmer and Carole Totzkay