

**Conference Call Convened at 1:00 p.m. Eastern Daylight Time**

✓ **Present:**

- ✓ Jonathan Ballard, MD, MPH, MPhil – NH Department of Health and Human Services, Chief Medical Officer (accompanied by Director Jennifer Harper and Fallon Reed at NH DOS HSEM)
- ✓ Kathy A. Bizarro-Thunberg, MBA, FACHE – Executive Vice President / Federal Relations, New Hampshire Hospital Association (in a car husband is driving)
- ✓ Charles P. Burney, MD – Resident, General Surgery and Leadership Preventive Medicine (on headphone)
- ✓ Michael Calderwood, MD – Infectious Disease and International Health, Dartmouth Hitchcock Medical Center (in office alone)
- ✓ Rep. Polly Campion, MS, RN – New Hampshire House of Representatives (in home office alone)

Patricia E. Clancy, MD – Pleasant St. Family Medicine, Chair, Concord Hospital Ethics Committee

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 (work 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 (alone; did not vote on adjourn)
- ✓ Jeff Dickenson – Advocacy Director, Granite State Independent Living (alone)
- ✓ Paul Drager, JD – MedEthics Consulting (home office alone)
- ✓ Anne Edwards, Esq. – Associate Attorney General, NH Department of Justice (office alone)
- ✓ John E. Friberg, Jr. Esq. – Chief Legal Officer, Manchester and Nashua SolutionHealth (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 (alone)
- ✓ Sally Kraft, MD, MPH, VP of Population Health at Dartmouth-Hitchcock (home alone)

Richard Levitan, MD – Emergency Medicine, Littleton Regional Hospital

- ✓ John McAllister, President, Professional Fire Fighters of NH (home alone)
- ✓ Kenneth Norton LICSW – Executive Director, National Alliance of Mental Illness, New Hampshire Chapter (Gilford, Maine with family, alone)
- ✓ Debra Pendergast – New Hampshire Department of Safety, Director of the Division of Fire Standards and Training and Emergency Medical Services (home office, alone)
- ✓ James G. Potter – Executive Vice President/CEO, New Hampshire Medical Society (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

- ✓ Kate Riddell, MD – Anesthesiologist, Southern New Hampshire Medical Center (alone)

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

- ✓ Luanne Rogers, RN – Administrator, St. Theresa's Rehabilitation and Nursing Center
- ✓ Justin Romello – New Hampshire Department of Safety, Bureau Chief, Division of Fire Standards and Training and EMS (home office alone)
- ✓ David Ross, Administrator – Hillsborough County Nursing Home (office alone)
- ✓ Michael Sitar, Jr. Chief, Tilton Northfield Fire and EMS (home office alone)

- ✓ Luanne Rogers, RN – Administrator, St. Theresa’s Rehabilitation and Nursing Center (alone)
- ✓ Sedden R. Savage, MD, MS – Addiction Medicine and Pain Medicine Clinician, Advisor to Dartmouth Hitchcock Substance Use and Mental Health Initiative (home office alone)
- ✓ Sen. Tom Sherman – New Hampshire Senate (home alone)
- ✓ Steve Surgenor, MD – Anesthesiologist, Dartmouth Hitchcock Medical Center (wife in car then will be on my own)

Elizabeth Talbot, MD – New Hampshire Department of Health and Human Services, Deputy State Epidemiologist, Dartmouth Hitchcock Medical Center, Infectious Disease Clinician

- ✓ Robert Theriault, Jr., BSP Pharm, MB, RPh – Director of Pharmacy Services, Wentworth-Douglass Hospital (work office alone)
- ✓ Joan C. Widmer, MS, MSBA, RN, CEN – Nurse Executive Director, New Hampshire Nurses Association (home office alone)
- ✓ Tom Wold, DO – Chief Medical Officer, Portsmouth Regional Hospital

NH Department of Health and Human Services participating on the call:

- ✓ Carole Totzkay, MS, CHES® - New Hampshire Department of Health and Human Services, Committee Facilitator
- ✓ Colleen Haggerty, RN, DHHS, Division of Public Health Services – NH Immunization Section
- ✓ LCDR Torane (TW) Hull, RN, MSN, MPA – Centers for Disease Control and Prevention

---

Meeting opened by Dr. Jonathan Ballard reading an official public access meeting statement. Roll call was performed. SDMAC members received in advance of the meeting the following public-accessible references:

- National Academies of Sciences, Engineering, and Medicine (NAM) 2020. *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25914>.
- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations. Version 1.0. September 16, 2020. [https://media.defense.gov/2020/Sep/16/2002498510/-1/-1/1/COVID19\\_VACCINATION\\_PROGRAM\\_PLAYBOOK.PDF](https://media.defense.gov/2020/Sep/16/2002498510/-1/-1/1/COVID19_VACCINATION_PROGRAM_PLAYBOOK.PDF)

**Calderwood:** Currently 40 COVID-19 vaccines under study around the world; 2 (Moderna and Pfizer) in phase 3 trials in the US, these need a second dose. These are both RNA vaccines, fast to develop. Worldwide 12 genetic vaccines. None of these have been used before in humans, can't be used in a single dose, and can't be made in high volume at least initially. 11 viral vector vaccines, class that Astra Zeneca is in; 18 protein-based, none of these in clinical trials; 3 inactivated/attenuated vaccines, slowest to develop, in emergency use. Moderna and Pfizer show promising results for immune response to date, no pregnant women or children in trials. No severe adverse effects. Phase 3 trials must protect at least 50% of subjects and must be large enough to determine safety. Moderna has 30,000 participants; vaccine must be stored at minus 20 degrees C; \$1M award for scale up production. Pfizer trial 43,000 participants; \$1.5M award; must be stored at minus 70 degrees C; stable for 24 hours at 2-8 degrees C.

**Ballard:** Governor Sununu has issued Emergency Order #69. It establishes the SDMAC to serve as an Ethics Committee to advise the DHHS Commissioner and DHHS on ethical matters related to the vaccine and its distribution. The SDMAC membership has expanded to include broader participation from groups involved in these matters. Recognized LT Commander TW Hull who has been working with the DHHS Immunization Program for several months.

**Hull:** The Regional Public Health Networks (PHNs) have been preparing for this type of vaccine distribution over a number of years. They have conducted a wider review of H1N1 and other pandemic responses to look at lessons learned. Have point of distribution (POD) plans, conducting flu tabletop exercises over the past few years. This will be a public and private partnership in delivering this vaccine. Challenges include storage and handling, multiple doses required for vaccination, and documentation.

**Ballard:** NY Times has created a vaccine tracker available at

<https://www.nytimes.com/interactive/2020/science/coronavirus-vaccine-tracker.html>

We currently do not have an Emergency Use Authorization (EUA) vaccine in the U.S. No vaccine approved by the CDC Advisory Committee on Immunization Practices (ACIP), which is the group that formally recommends vaccine schedules. Recognize that any new vaccine has an initial period of limited supply. The NAM document has four phases with recommendations as to who vaccine should be considered for vaccination. The CDC Playbook looks at health care workers with direct exposure as one of the highest risk groups. Then older adults and individuals with co-morbid conditions and then people living in congregate settings. The Regional PHN have been looking at the actual numbers in many of these groups. We have a few targeted questions (Q#) to discuss and then open the line to the public.

**Q1.** *Should we specifically look at NH epidemiology (highest incidence and prevalence across the state) for disbursement to healthcare workers within specific Counties – Hillsborough and Rockingham – as the first recipients of vaccine? Is this reasonable?*

**Ross:** Yes. That is a reasonable approach provided we have enough vaccine.

**Q2.** *How should we define healthcare workers within healthcare facilities that treat or are around patients with COVID-19? i.e., clinical and environmental care workers, only staff who work in specific units such as emergency departments, ICUs, or COVID-19 units?*

**Burney:** Yes. I agree with Ross. Yes. It makes sense to prioritize within healthcare facilities, especially staff with the highest risk of exposure.

**Calderwood:** I agree on both questions. Some groups more likely to respond to a vaccine, for instance elderly may not respond as well. We should try to find balance between young and old persons at risk.

**Romanello:** From public safety and hospital setting, we should consider rural counties as the number of public safety and hospital personnel is smaller and potentially more at risk because fewer staff to respond to an incident.

**Sherman:** The greatest impact is in nursing homes. Look at most vulnerable—LTC in the counties most impacted then look at hospitals and public safety.

**Q3.** *If a limited amount of vaccine would be available, should we vaccinate a whole priority group first or based on epidemiology?*

**Kraft:** Hospitals are important, but also look at where the infections are occurring. For instance ambulatory/respiratory clinics located around the state.

**Hodder:** I support looking at the epidemiology within the county where highest rates are. How likely will the supply we get be based on the population size of our state?

**Ballard:** According to the CDC, nothing has been formalized yet regarding the vaccine amount each state and territory will receive. Several principals: all states will receive vaccine, but not clear if distribution will be based on population or disease burden.

**Calderwood:** Focus on nursing homes. Both patients and staff would likely have a robust response. The other group not mentioned is teachers especially as more schools are open. Children are another group to consider vaccinating.

**Q4.** *First responders are another highly impacted group. Approximately 20% of NYC police department personnel were affected and 40 officers died. How should the National Framework look for this group in NH? Are there higher risk groups within first responders?*

**Reed:** In NH, there are just under 12,000 first responders that receive hazard pay compensation.

**Hoebeke:** Depends on the size of the agency and the procedures they have in place.

**McAllister:** Every time they respond to a call of any nature they are potentially exposed.

**Romanello:** I echo both Hoebeke and McAllister. There are 5,500 EMS in the state are actively affiliated with an EMS facility. All have equal potential for exposure. About 500 (age 60-80 mean age is 71) of these responders are older adults.

**Ballard:** Within the NAM document, the following foundational principles were identified that are consonant with many and grounded in U.S. social values and cultural discourse: 1) maximization of benefits; 2) Equal regard; Mitigation of health inequities; 3) fairness; 4) Evidence-based; and 5) Transparency.

**Q5.** *Should NH adopt these foundational principles?*

**Q6.** *Also, how should the national framework and phased allocation for persons residing in LTC facilities be implemented?*

**Calderwood:** We need to think about how easy it is to control an environment and mitigate the risk. Hospitals are a much more controlled environment than locations within the community.

**Campion:** The NAM report mentions the use of Social Vulnerability Index (SVI). To what extent can we use this for first responders? Also, it supports focus on LTC facilities.

**Widmer:** I concur with Sherman and Campion on focus on LTC. Look at maximum benefit for limited resources: consider staff at LTC (clinical, environmental, food service, etc.), as well as community based responders (home care nurses, EMS, etc.) and possibly ED's as screening not always possible in emergent situations.

**Sherman:** Will this protocol be in conjunction with antibody level testing?

**Ballard:** We have not received guidance on antibody testing within the two documents. The World Health Organization has stated that positive test results from antibody testing is not an immunity passport because of limited data on reinfection. However, this may change with more scientific evidence.

**Dickinson:** LTC facilities are valid as a priority. We should include home and community-based care providers working in the home.

**Savage:** Use a broad definition of facilities, especially those with congregate living, recovery centers, community mental health congregate living, homes for brain injury patients, etc. Not sure how to gather this data.

**Ballard:** Getting this data can be challenging in some cases, however the Department is working with regional public health networks to obtain.

**Q7.** *If person has a number of comorbidities, should that person be higher on the list?*

**Norton:** Echoes Dickenson and Savage's points. Look more broadly at LTC, include NHH and correctional facilities. Also, include mental health mobile crisis teams, who go into homes.

**Sitar:** We need to reiterate the educational aspects of maintaining social distancing, etc. while supplies remain low.

**Hiller:** Need to look at elderly with co-morbid conditions and look at the definition of essential workers. Also, consider teachers. What about individual choice relative to vaccine, early receipt vs. delayed receipt? Wearing masks should continue in addition to limited vaccine.

**Campion:** We should make vaccine available at no cost.

**Bizarro-Thunberg:** We may develop a different plan than another state within the Northeast region. How will that be communicated? How will we communicate this to the public?

**Ballard:** There is some Northeast coordination at play currently.

**Carole:** Has been in discussions with MA. Plan to look at what each NE state is doing and trying to be on same page as much as possible. All the states are looking at populations that are at the most risk. The epidemiology might be slightly different but that should be expected based on each states' populations, risks, and SVI amongst other benchmarks.

**Calderwood:** Need to look at the operations side and not make things too complex. Hard to get down to the individual level.

**Kraft:** Need a statewide registry on who has been vaccinated and it would be helpful if this could be standardized across states.

**Widmer:** Registry important to be able to track who has received the first dose, but has failed to get the second dose. Failure to get second dose can lead to incomplete and/or partial immunity.

**Drager:** Will there be enough vaccines for first tier for both first and second dose of the vaccines? Plus, what about personal responsibility of individuals to receive the vaccine?

**Calderwood:** One lesson learned is the fragility of the supply chain and allotments can change quickly. Efficacy is with second dose of the same vaccine. Need to save enough for second dose for those who receive the first dose. This vaccine is coming to market in record time, and may be authorized under an Emergency Use Authorization (EUA), so then cannot mandate it.

**Riddle:** Is it worth changing our thinking about protecting the most vulnerable if staff is not choosing to take the vaccine. Give to elderly, even if immune response is not as robust.

**Widmer:** The storage and handling of the two vaccines farthest along are quite challenging; assuming that DHHS is looking into best ways to address these issues, but this could impact access for defined priority populations.

**Ballard:** Yes.

**Reed:** PHNs have great experience with the logistics of community-based vaccinations.

**Friberg:** SNHMC and Elliot Hospital – they would like to see more community outreach regarding crisis standards of care. More public discourse broadly.

**Hiller:** Given the recent outbreaks in university populations, distribute the vaccine through the university's health services.

**Campion:** Is it understood that the state will not have control over the amount of vaccine available to the state initially?

**Ballard:** Yes this is true. Each state is required to submit a plan to the CDC for vaccine distribution, this is the state's locus of control.

**Kraft:** From an operational perspective, I've seen a wide variation in the success of school-based flu clinics. Examine these programs for lessons learned relative to how to make the program successful. Also, don't forget the ancillary supplies to go along with the vaccine plan.

**LINE OPEN to the PUBLIC for COMMENTS:**

**Stephanie Patrick (Disability Rights Center):** Thank you for the discussion. Point out a few things, important to provide clear information relative to risk of the vaccine. Allow for ability to opt out of vaccine distribution, particularly for individuals in congregate living. It is important not to discriminate against individuals with disabilities when considering priorities. Also consider impacts of social isolation, will be starting to see more impacts from this. Any plan will not be easy to implement, but will be more well received if it is transparent.

**Donald J. Pfundstein, Esq., Gallagher, Callahan & Gartrell for American Health Insurance Plans (AHIP):** Found the discussion very important and believe AHIP can be useful in this process. Will debrief with medical directors and operations chiefs from the plans. Will come back with some ideas and recommendations on how they contribute.

**No further public feedback.**

Motion to adjourn by Calderwood and second by Potter. Individual roll call vote unanimous to adjourn.

**Conference Call ended at 3:50 p.m.**

*Respectfully submitted by: Joan Widmer and Carole Totzkay*