Conference Call Convened at 9:00 a.m. Eastern Daylight Time

✓ **Present:**

✓ Jonathan Ballard, MD, MPH, MPhil – NH Department of Health and Human Services, Chief Medical Officer (accompanied by 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 Surgeoner, 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., BSPharm, 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 state agencies participating on the call:

- ✓ Carole Totzkay, MS, CHES® - New Hampshire Department of Health and Human Services, Committee Facilitator
- ✓ Katja Fox MHCDS, MPA - Director, NH DHHS Division for Behavioral Health
- ✓ Colleen Haggerty, RN, DHHS, Division of Public Health Services – NH Immunization Section
- ✓ Deb Scheetz - Division Director, Division of Long Term Supports and Services
- ✓ LCDR Torane (TW) Hull, RN, MSN, MPA – Centers for Disease Control and Prevention
- ✓ Jennifer Harper – Director, NH Homeland Security and Emergency Management
- ✓ Helen Hanks – Commissioner, Department of Corrections
- ✓ Christen Lavers – NH Department of Justice
- ✓ Tyler Brannen – NH Insurance Department
- ✓ Dr. Jeffery Fedder – New Hampshire Hospital

Ballard: Meeting opened by Dr. Jonathan Ballard reading an official public access meeting statement. Roll call was performed. Last meeting minutes were approved with no changes. Introduced topics on agenda, distributed in advance of the meeting. He provided an overview of the NH Coronavirus Disease 2019 Vaccination Plan, distributed in advance of the meeting.

NH Cases to date: 12,699 NH cases, 489 deaths (4% rate), 2,057 with current active infection, 5K individuals being monitored. 56 persons hospitalized currently, 794 hospitalized overall, (6% rate). Hillsborough & Rockingham counties have the highest number of cases, but all counties showing widespread community transmission.

Vaccine update: 38 vaccines in Phase I trials, 14 in Phase II trials, 11 in Phase III trials, none currently approved for use in the US.

Pfizer Vaccine: Recently shared Phase III trial information, vaccine is about 90% effective. This was very surprising and welcomed. This vaccine is an mRNA vaccine. Phase III trial has 43,000 enrollees in Germany, Brazil, Argentina and US, with a wide range of racial groups, but not tested in children or pregnant women. Vaccine will need to be stored at -80 degrees C. Pfizer looking to submit for emergency use authorization within next 2 weeks.

Moderna Vaccine: Also in Phase III trials, another mRNA vaccine; enrolled 30,000 participants in the trial, of which 7,000 are in older populations. Expect trial results to be released by end of year. Plan for 21M doses by then.

Other Vaccines: J&J-Beth Israel vaccine, an adeno virus vaccine; this is a one dose vaccine. Had an initial pause in trial, now resumed; anticipated early 2021. Also Oxford vaccine, in Phase III trials, also adeno virus/one dose vaccine. Novovax, viral protein model, but this is further down the road.

New Hampshire priority populations were mostly consistent with the framework recommendations developed by the National Academies of Sciences, Engineering & Medicine, with exception of elderly individuals living in congregate settings (we moved them to phase 1a). Individual working in direct patient care with COVID-19 patients have had a higher infection rate than general population; supports their priority placement for vaccine. With only 20M doses immediately available nationally, we may need to add further priority levels. How do we further narrow vaccination needs within healthcare workforce?

Desrosiers: 4 to 1 deaths of individuals relative to other populations; prioritize those who work in long term care. This will reduce severe morbidity and mortality in this high risk patient population. This priority should exceed the priority of individuals working in hospitals.

Ballard: If initial vaccine is released under EUA, confirmed we cannot mandate its use.

Wold: Virus has changed, need to appreciate differences in first and second waves. The second wave is hitting a different population and is more rural. This wave may behave differently. More of general population will be getting sick and seek medical care; consequently impacting hospital-based healthcare workers. Hospitals had good capacity in first wave, not the case at this time.

Ballard: Four criteria from National Academies of Science, Engineering & Medicine: risk of acquiring infection, risk of severe mortality and morbidity, reducing societal impact, reducing transmission to others. Should these criteria be weighted differently in NH?

Sherman: Seeing different infection pattern, more widespread community transmission, but still seeing LTC cases increasing. Workers need to be prioritized. We may need to prolong visitation restrictions in LTC settings. Another cohort to be considered includes teachers in the public school system; this can limit ability to keep schools open.

Ballard: Teachers are currently in Phase II of the distribution plan, along with individuals with co-morbid conditions, those in DOC system and all other older adults. Phase III is everyone else.

Wold: Agrees with Sherman and Desrosiers.

Ballard: Vaccine distribution plan to go to highest risk counties first, then broaden based on dose availability. But if epidemiology changes and infection is more widespread, how do we change the plan?

Widmer: Shares opinion of Desrosiers & Sherman. Prioritizing direct care healthcare workers, meets all criteria established by the National Academies of Sciences, Engineering & Medicine. Also will address existing and looming healthcare staffing shortages.

Hanks: Appreciates the Phase 1b priority for DOC population. Wants to make sure this population maintains a priority position. They have no choice regarding their living situation. Staff is working with this population 24-7.

Reeves: Hospitals in the state have various sizes. DHMC is designating care areas for COVID-19 patients. Look at maybe segregating hospital works to prioritize their most at risk staff (COVID-19 units and ED and EMS).

Ballard: How would you stratify those with the highest risk? If you received an allocation that does not meet your needs what would you do?

Reeves: DHMC works through NHHA to determine how best to stratify allocation schemes.

Ross: Could move residents of LTC facilities to Phase II and give healthcare workers/staff a higher priority.

Desrosiers: Acute care and LTC settings both equally important; but most of the deaths in LTC. In both these settings, there is little that can be done to reduce exposure. Are there other

mitigation efforts that can be undertaken to limit transmission until vaccine more widely available, e.g. remote learning, telehealth visits, etc.?

Hillar: Since vaccine will likely not be required, if individuals refuse the vaccine, can we assign them to areas away from COVID-19 patients to reduce exposure?

Bizzaro-Thunberg: Spoke to the prioritization within hospitals; worked with E. Talbot to fine tune data collection on this topic and worked with hospital HR staff to prioritize staff into three levels. NHHA also looked at ambulatory surgery and physician staff. Data collected and shared with DHHS. Can fine tune this more when we know the available vaccine doses.

Wold: Looked at point-people in the hospital, and also high risk staff such as respiratory therapy staff. But they need guidance . Changing staffing decisions based on choice to not vaccinate is a slippery slope and could result in acute staffing issues.

Drager: Confused as to what the goals are for prioritizing immediate allocation of vaccine: containment, spread, saving lives, morbidity, etc.? Most of the mortality is in long term care; need to remember that elderly adults in LTC settings do not have the ability to self-mitigate their risks. Need to establish the goals before you can determine priorities.

Ballard: Priorities are not established in the document. How can we prioritize them?

Drager: Look at it from a utilitarian standpoint, look at which priorities will save the most lives.

Sitar: What is the amount of does that will be available? It doesn't seem like many doses will be available initially. It will come down to the available number of doses.

Ballard: Is it the recommendation of the SDMAC to adopt the seven recommendations in the Framework for Equitable Allocation of COVID-19 Vaccine (document provided prior to meeting for review)? Read the seven recommendations.

Norton: NH Hospital should be considered for a higher priority because of the growing mental health crisis (43 individuals waiting for placement in EDs across the state).

Clancy: Recommendations as written are acceptable based on principals, but seem a bit thin on how to implement the recommendations. She agrees with Norton.

Fedder: NHH does have a COVID-19 unit at this time. Does have an elder unit.

Potter: Echoes comments of Desrosiers with prioritizing LTC staff and direct care staff in acute care settings. Wondering if we should differentiate between EMS and Fire, have different

exposure risks. Need some universal guidance for employees who choose not to vaccinate, such as PPE requirements, etc.

Romanello: In NH, it is difficult to distinguish between EMS & Fire personnel. Both have risk of exposure.

LINE OPEN to the PUBLIC for COMMENTS:

Stephanie Patrick (NH Disability Rights Center): Need to also consider workers providing direct care to individuals in the home environment, they are in and out of multiple homes every day. Remember that there are younger adults in long-term care facilities. She also encouraged as much transparency as possible when communicating with the public; make information as accessible as possible.

Ballard: Critical supplies and infrastructure update: Considerable amount of resources still available in NH including ventilators, portable ventilators, anesthesia machines, Bipap machines, CPAP, and patient beds including ICU beds.

Wold: Hospitals worked together to leverage available resources as best as possible during the first wave. Most hospitals can flex to 200% over regular capacity before reaching crisis stage. When need to go beyond this, then would reach out to the State Emergency Operations Center to request activation of the Crisis Standards of Care Plan.

Clancy: Are there other standards that can be used to determine when CSC needs to be activated?

Drager: The Governor said he expects somewhere an increase in cases daily in NH; currently at around 200/day. What impact will this increase have on hospitalizations?

Ballard: Not sure at this time due to changing demographics of the impacted populations but general increases in community transmission of disease has resulted in increased hospitalizations across the country.

Bizzaro Thunberg: Hospitals looking a hospital risk assessment daily: including all beds, ICU beds, equipment, supplies, personnel and medications; also stratifying these as normal, low and critical levels. This was developed as an early warning sign of determining when approaching critical levels. Hospitals will continue to look at these daily risk assessments.

Desrosiers: During this second wave, hospitals are fuller than during first wave due to the suspension of non-emergent procedures that occurred during the first wave. Hoping that hospitals can continue work together to avoid need to invoke a statewide crisis plans. We will need to monitor this as hospitalization rates increase.

Hodder: Agree we are in a new phase, hospitals can work together to address issues as they arise. She agrees that De-escalation and Recovery Subcommittee does need to continue to function.

Ballard: Let him know if anyone wants to be a member of the Community & Healthcare Engagement Subcommittee.

LINE OPEN to the PUBLIC for COMMENTS:

Stephanie Patrick (NH Disability Rights Center): Looking for some clarification: question regarding activation of the CSC, have final guidelines been established?

Ballard: The Commissioner of DHHS is the one to decide if the CSC guidelines are to be activated per the written plan on the state Crisis Standards of Care website. The clinical guidelines are in draft form on the website, and the department is in the process of finalizing them to ensure they are ready in the event Crisis Standards of Care are activated. SDMAC will likely have another meeting of the SDMAC in about one month.

No further public feedback.

Motion to adjourn by Clancy and second by Edwards. Voted unanimous to adjourn.

Conference Call ended at 10:50 a.m.
Respectfully submitted by: Joan Widmer and Carole Totzkay