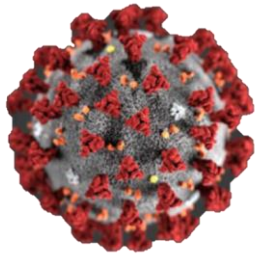


New Hampshire Coronavirus Disease 2019 Weekly Partner Call

September 23, 2021

Ben Chan
Jonathan Ballard
Elizabeth Talbot
Beth Daly
Lindsay Pierce

Thursday noon-time partner calls will focus on science, medical, and vaccine updates with time for Q&A

NH DIVISION OF Public Health Services
Department of Health and Human Services

Healthcare Provider & Public Health Partner Calls

- 2nd and 4th Thursday of each month from 12:00-1:00 pm (next call will be Thursday, October 14th)

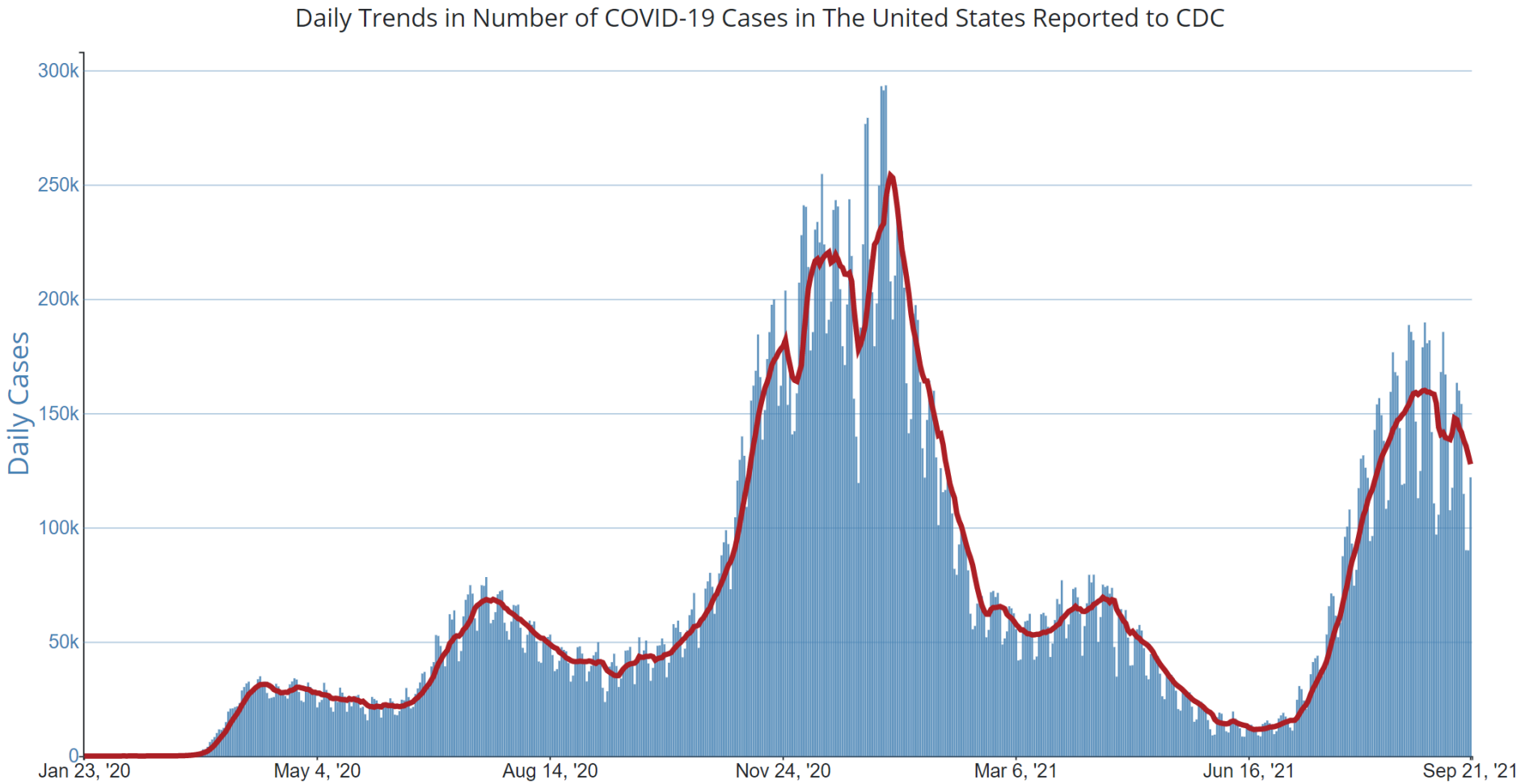
- Webinar/call information:
  - Zoom link: https://nh-dhhs.zoom.us/s/94059287404
  - Webinar ID: 940 5928 7404
  - Passcode: 353809
  - Telephone: 646-558-8656

Agenda

- Epidemiology Update
- HAN Update #45: Monoclonal antibodies
- FDA & ACIP Updates: Vaccine Boosters
- Studies on Vaccine Effectiveness (VE)
- Other Public Health Updates
- Questions & Answers (Q&A)

Epidemiology Update

U.S. National Daily Incidence of COVID-19



https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases

NH DIVISION OF Public Health Services
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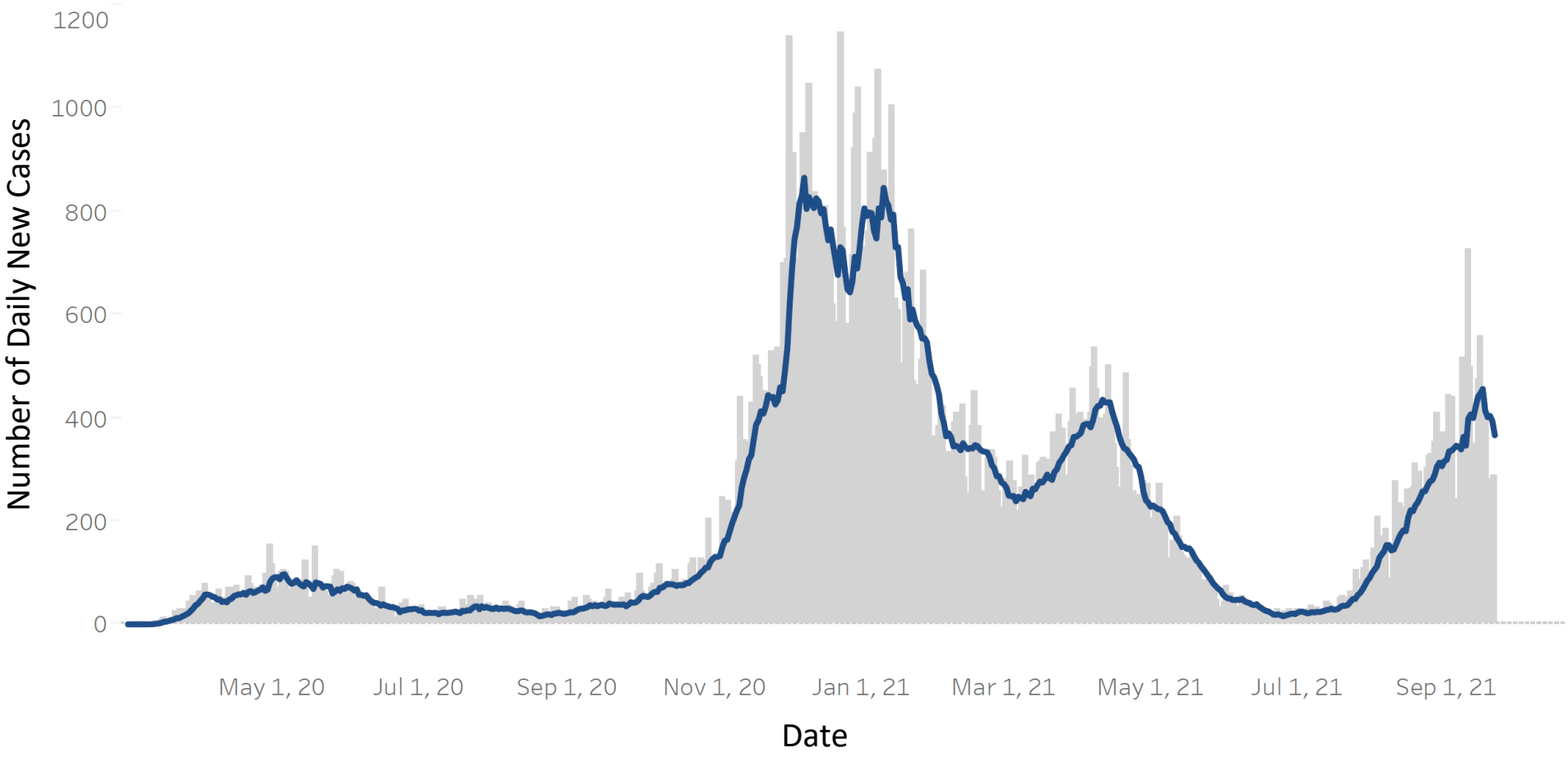
Number of New COVID-19 Cases per Day in NH



https://www.nh.gov/covid19/dashboard/overview.htm#dash

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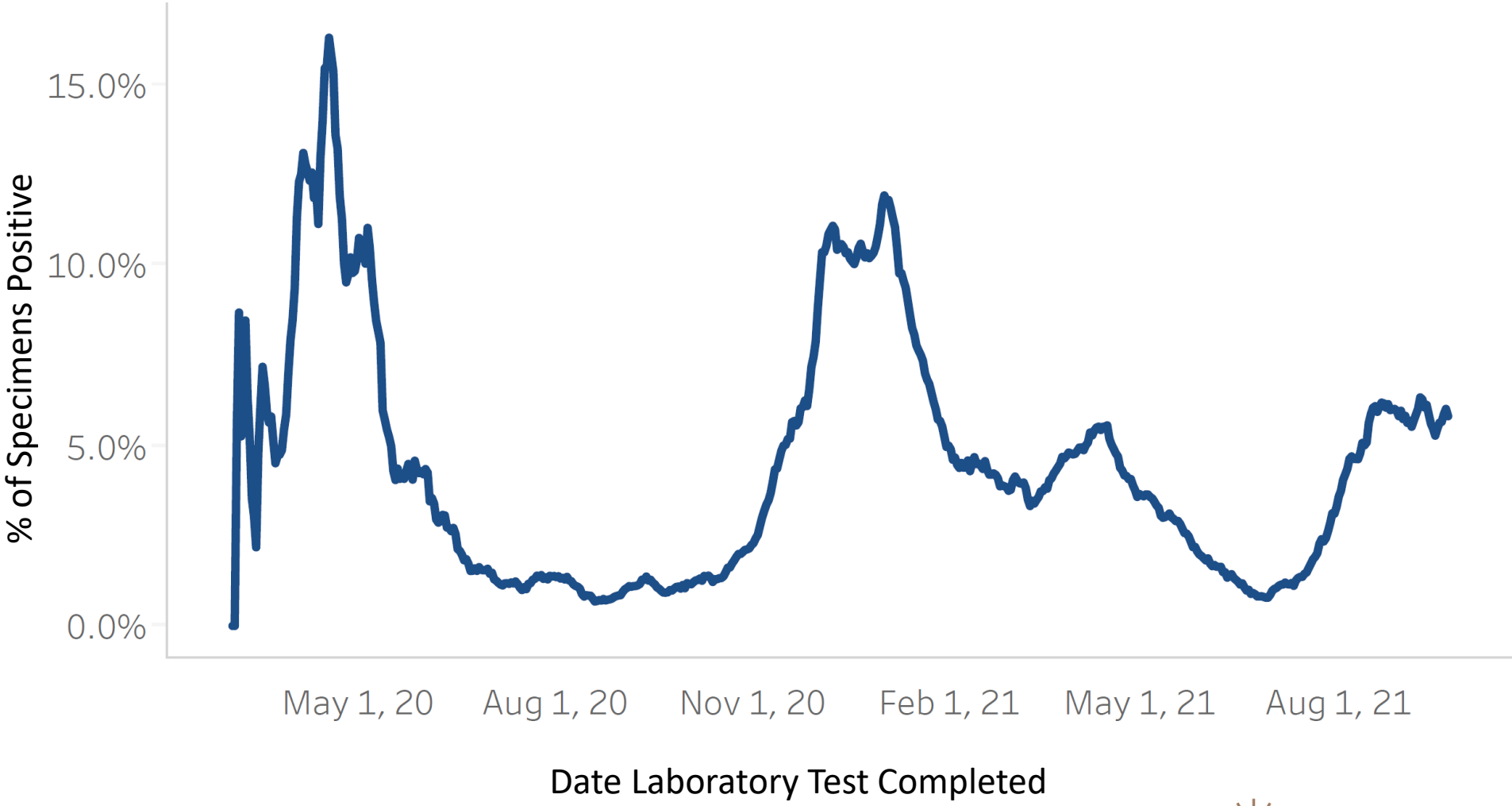
Department of Health and Human Services

% of Tests (Antigen and PCR) Positive for COVID-19 (7-Day Average)



https://www.nh.gov/covid19/dashboard/overview.htm#dash

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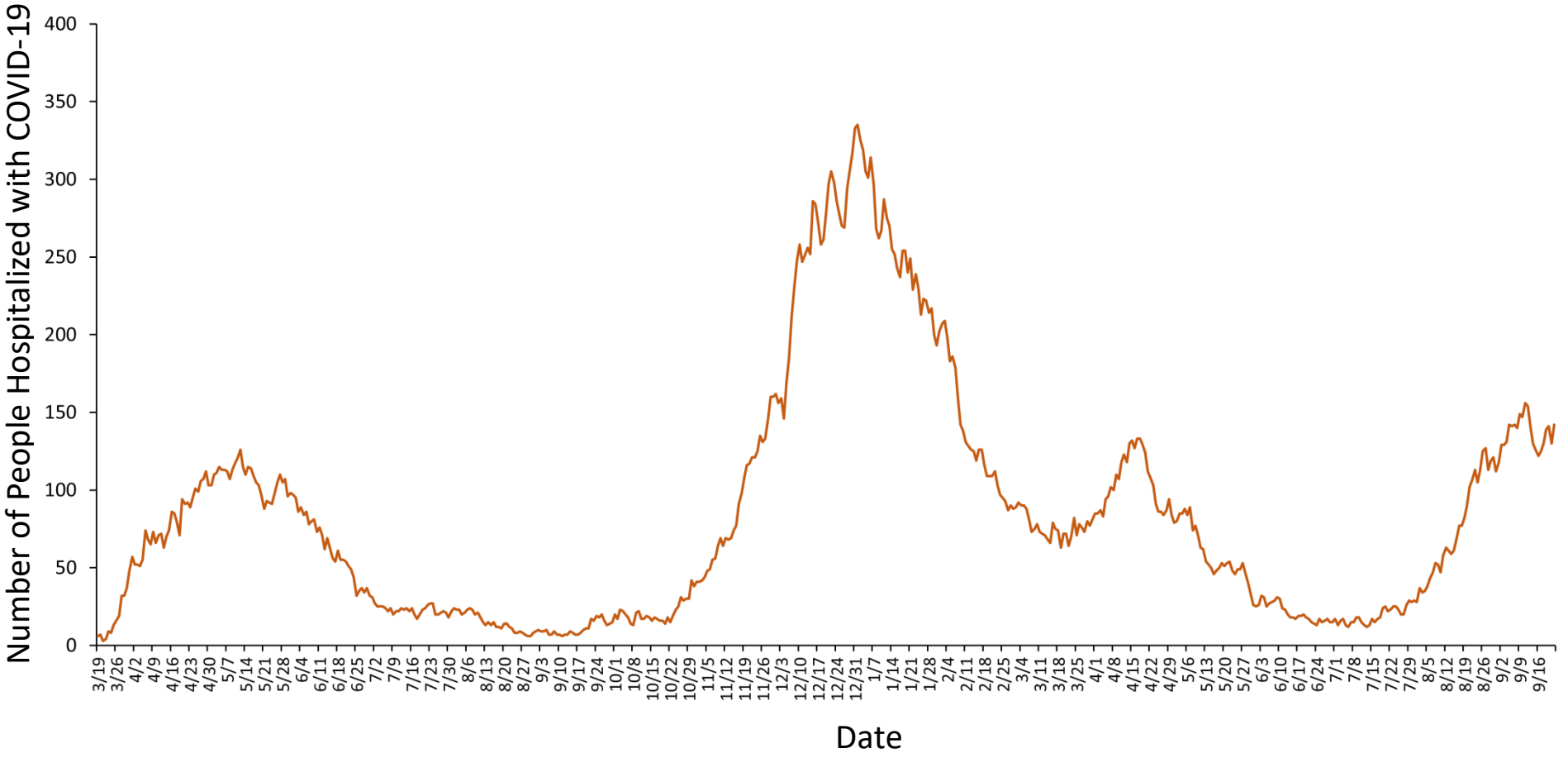
Number of People Hospitalized with COVID-19 Each Day in NH (Hospital Census)



https://www.nh.gov/covid19/dashboard/overview.htm#dash

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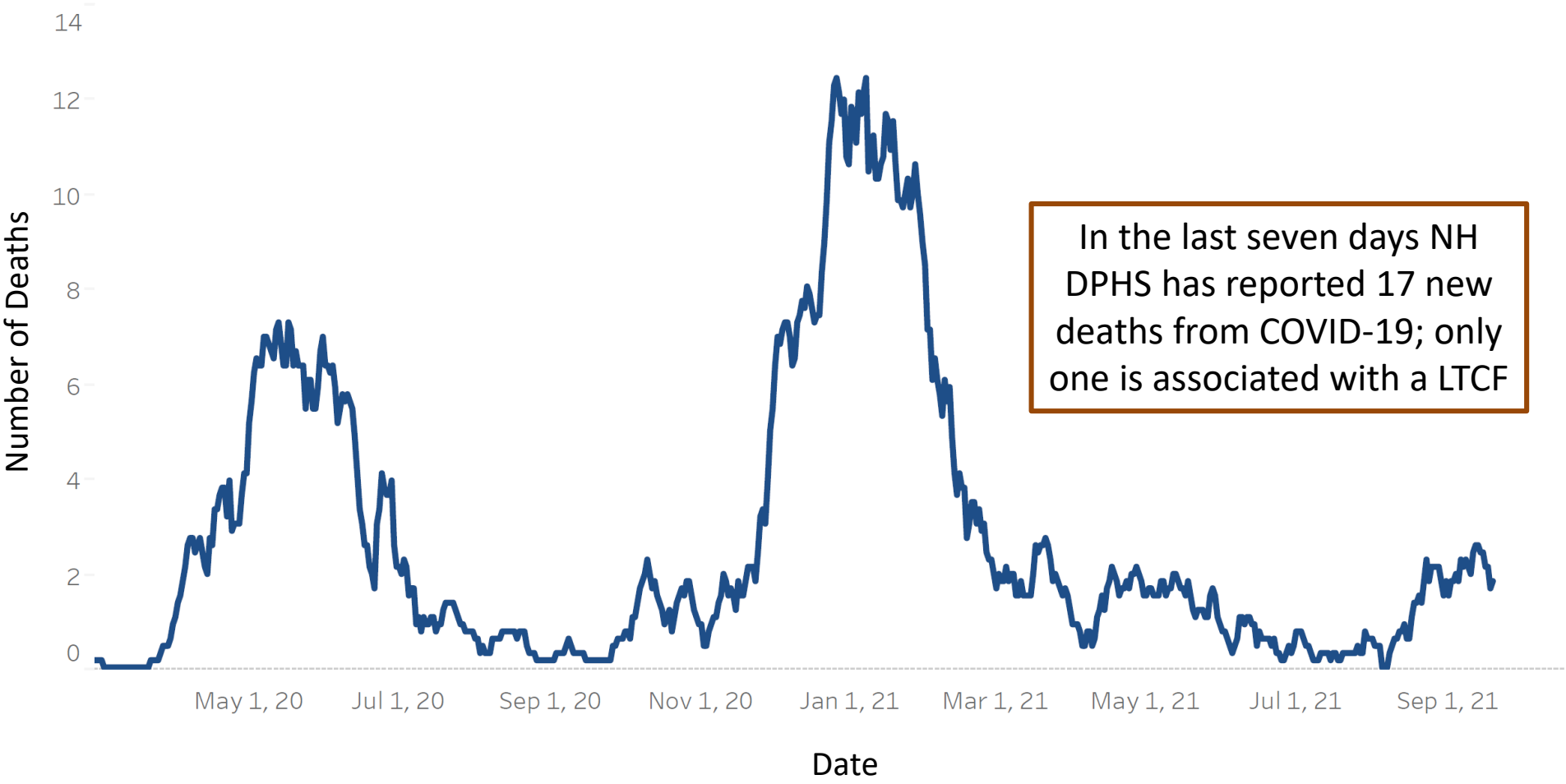
Average Number of COVID-19 Deaths per Day in NH (Based on Date of Death)



In the last seven days NH DPHS has reported 17 new deaths from COVID-19; only one is associated with a LTCF

https://www.nh.gov/covid19/dashboard/overview.htm#dash

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COVID-19 HAN Update # 45:

Anti-SARS-CoV-2 Monoclonal Antibodies

(Dr. Jonathan Ballard)

https://www.dhhs.nh.gov/dphs/cdcs/alerts/documents/covid-19-update45.pdf

NH DIVISION OF
Public Health Services
Department of Health and Human Services

Monoclonal Antibodies for the Treatment of COVID-19

Jonathan Ballard MD, MPH, MPhil

Chief Medical Officer
Department of Health and Human Services
State of New Hampshire

Healthcare and Public Health Partners Call
September 23rd, 2021

Disclaimer

Please use original source recommendations/guidelines as well as individual health practitioner clinical assessment for patient care. This presentation is not meant to be all-encompassing and more recent clinical guidelines may exist at the time of your review of this presentation. References cited in this presentation were accessed on 9/15/2021.

Health Alert Network (HAN) from 9/17/2021

THIS IS AN OFFICIAL NH DHHS HEALTH ALERT

Distributed by the NH Health Alert Network
DHHS.Health.Alert@dhhs.nh.gov
September 17 Time 1600 (4:00 PM EDT)
NH-HAN 20210917

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all
Department of Health and Human Services

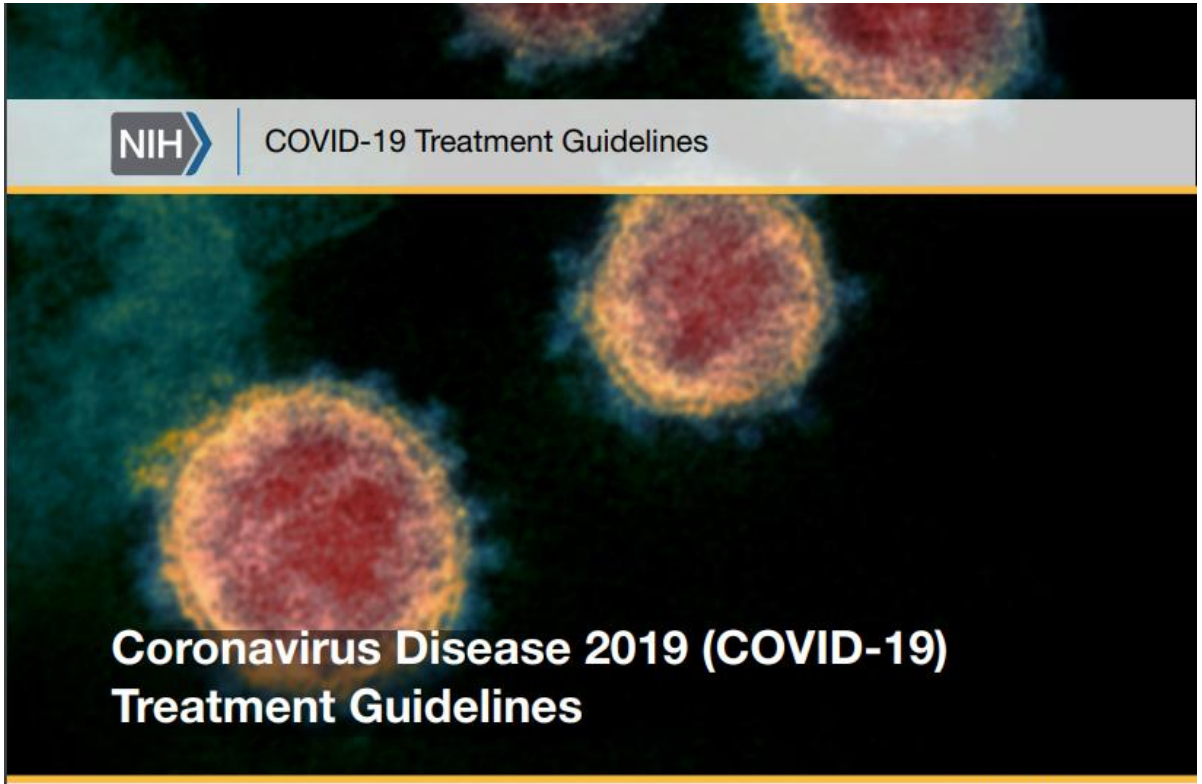
COVID-19 Pandemic, Update # 45

SARS-CoV-2 Monoclonal Antibody Therapy Updates
Resumption of Healthcare Provider & Public Health Partner Webinars

Key Points and Recommendations:

- Management of patients with COVID-19 vary by setting and severity of illness; providers should familiarize themselves with COVID-19 treatment guidelines from both the National Institutes of Health (NIH) and the Infectious Disease Society of America (IDSA)
  - Note the NIH has updated their guidance on use of bamlanivimab plus etesevimab but this not yet been incorporated into their guidance summary
  - Review the recent CDC HAN advising against the use of ivermectin, which has not been shown to be effective at treating or preventing COVID-19
- Three SARS-CoV-2 monoclonal antibody products are available for use under a U.S. Food and Drug Administration (FDA) Emergency Use Authorization (EUA), including bamlanivimab plus etesevimab, casirivimab plus imdevimab, and sotrovimab
  - Use these therapies for patients with mild to moderate confirmed COVID-19 infection and who are not hospitalized (unless hospitalized for a reason other than COVID-19) but are at high risk for progressing to severe disease and/or hospitalization

Treatment for COVID-19



General Principles of Treatment for COVID-19

Treatments are based upon the general pathogenesis of COVID-19

- In the early clinical course, the disease is driven by replication of SARS-CoV-2 virus.
  - Therapies that directly target the virus may have greatest effect.
- Later in the clinical course, the disease is driven by dysregulation of the immune and inflammatory response to SARS-CoV-2 virus that leads to tissue damage.
  - Immunosuppressive/anti-inflammatory therapies may be more beneficial in later states of disease.

https://files.covid19treatmentguidelines.nih.gov/guidelines/section/section_121.pdf

Hospitalized Adult Treatment for COVID-19

NIH | COVID-19 Treatment Guidelines

Search

About the Guidelines | Overview | Management | Therapies | Special Populations

Home / Management / Clinical Management / Hospitalized Adults: Therapeutic Management

- Management
  - Clinical Management
    - Clinical Management Summary
    - Nonhospitalized Patients: General Management
    - Nonhospitalized Adults: Therapeutic Management
    - **Hospitalized Adults: Therapeutic Management**
  - Critical Care

Guideline PDFs

Section Only (PDF | 5 MB)

Full Guideline (PDF | 5 MB)

Sign Up For Updates

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example@domain.com

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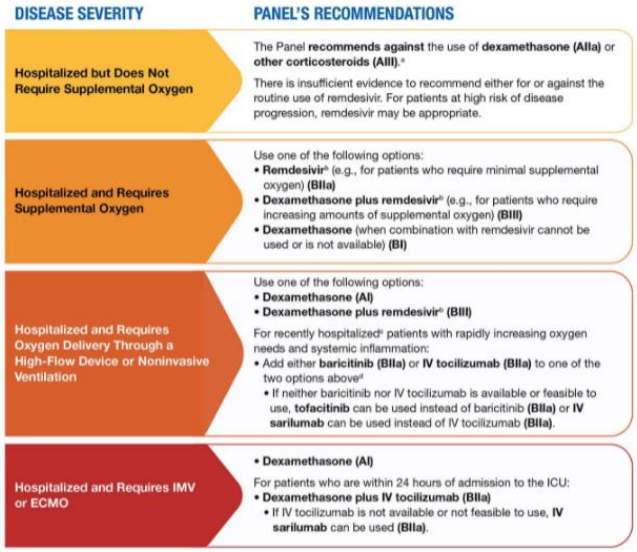
Therapeutic Management of Hospitalized Adults With COVID-19

Last Updated: August 25, 2021

Figure 2. Therapeutic Management of Hospitalized Adults With COVID-19 Based on Disease Severity



https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/hospitalized-adults--therapeutic-management/

Non-Hospitalized Adult Treatment for COVID-19

Figure 1. Therapeutic Management of NonHospitalized Adults with COVID-19

All outpatients with COVID-19 who enter the health care system should have in-person or telehealth follow-up visits. Symptomatic treatments, including hydration, antipyretics, analgesics, and antitussives, can be initiated as needed.

Patients should be counseled about symptoms that warrant re-evaluation by a health care provider (e.g., new onset dyspnea, worsening dyspnea [particularly dyspnea that occurs while the patient is resting or that interferes with daily activities], mental status changes). Home resources should be assessed before patients are discharged from a clinic, urgent care center, ED, or hospital; outpatients should have access to housing, proper nutrition, a caregiver, and a device that is suitable for telehealth. If patients are discharged while they are still receiving oxygen supplementation, they should receive oximetry monitoring and close follow-up soon after discharge.

PATIENT DISPOSITION	PANEL'S RECOMMENDATIONS
Not Requiring Hospitalization or Supplemental Oxygen, As Determined by a Health Care Provider in ED or an In-Person or Telehealth Visit	Anti-SARS-CoV-2 monoclonal antibody products are recommended for outpatients with mild to moderate COVID-19 who are at high risk of disease progression, as defined by the EUA criteria (treatments are listed in alphabetical order):[a] • **Casirivimab plus imdevimab**; *or* • **Sotrovimab** At this time, the Panel **recommends against** the use of **bamlanivimab plus etesevimab** in these patients due to an increase in the proportion of potentially resistant variants **(AIII)**.[a] See text for details. The Panel **recommends against** the use of **dexamethasone** or **other systemic glucocorticoids** in the absence of another indication **(AIII)**.[b]
Discharged From Hospital Inpatient Setting in Stable Condition and Does Not Require Supplemental Oxygen	The Panel **recommends against** continuing the use of **remdesivir (AIIa)**, **dexamethasone (AIIa)**, or **baricitinib (AIIa)** after hospital discharge.
Discharged From Hospital Inpatient Setting and Requires Supplemental Oxygen *For those who are stable enough for discharge but who still require oxygen*[c]	There is insufficient evidence to recommend either for or against the continued use of remdesivir, dexamethasone, and/or baricitinib. Review the text below when considering the use of any of these agents after hospital discharge.
Discharged From ED Despite New or Increasing Need for Supplemental Oxygen *When hospital resources are limited, inpatient admission is not possible, and close follow-up is ensured*[d]	The Panel recommends using **dexamethasone** 6 mg PO once daily for the duration of supplemental oxygen (dexamethasone use should not exceed 10 days) with careful monitoring for adverse events **(BIII)**. There is insufficient evidence to recommend either for or against the use of remdesivir. When considering the use of remdesivir, review the text below for further discussion. The Panel **recommends against** the use of **baricitinib** in this setting, except in a clinical trial **(AIII)**.

Rating of Recommendations: A = Strong; B = Moderate; C = Optional
Rating of Evidence: I = One or more randomized trials without major limitations; IIa = Other randomized trials or subgroup analyses of randomized trials; IIb = Nonrandomized trials or observational cohort studies; III = Expert opinion

https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/nonhospitalized-adults--therapeutic-management/

What are Monoclonal Antibodies?

- They are similar to antibodies that your body makes to fight viruses, however are made in labs of pharmaceutical companies.
- Unlike polyclonal antibodies that target multiple antigens, monoclonal antibodies are copies of antibodies that target specific proteins.
- Monoclonal antibodies used to treat COVID-19 bind to the spike protein, and block the virus from entering the body's cells.
- When the virus cannot enter cells, they cannot make copies of themselves and limits the further spread of the virus within the body.
- If a person is already sick, it means monoclonal antibodies can help prevent severe symptoms that result in hospitalization and death.

https://www.webmd.com/vaccines/covid-19-vaccine/news/20210826/monoclonal-antibodies-vs-vaccines-vs-covid-19

FDA Emergency Use Authorization for Regen-COV (casirivimab and imdevimab)

U.S. FOOD & DRUG ADMINISTRATION

September 9, 2021

Regeneron Pharmaceuticals, Inc.
Attention: Yunji Kim, PharmD
Director, Regulatory Affairs
777 Old Saw Mill River Road
Tarrytown, NY 10591

RE: Emergency Use Authorization 091

Dear Dr. Kim:

On February 4, 2020, pursuant to Section 564(b)(1)(C) of the Act, the Secretary of the Department of Health and Human Services (HHS) determined that there is a public health emergency that has a significant potential to affect national security or the health and security of United States citizens living abroad, and that involves the virus that causes coronavirus disease 2019 (COVID-19).[1] On the basis of such determination, the Secretary of HHS on March 27, 2020, declared that circumstances exist justifying the authorization of emergency use of drugs and biological products during the COVID-19 pandemic, pursuant to Section 564 of the Federal Food, Drug, and Cosmetic Act (the Act) (21 U.S.C. 360bbb-3), subject to terms of any authorization issued under that section.[2]

On November 21, 2020, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for emergency use of REGEN-COV (casirivimab and imdevimab, administered together)[3] for the treatment of mild to moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progressing to severe COVID-19 and/or hospitalization. Casirivimab and imdevimab are recombinant human IgG1 monoclonal antibodies that target the receptor binding domain of the spike protein of SARS-CoV-2. They are investigational drugs and are not approved for any indication.

https://www.fda.gov/media/145610/download

FDA Emergency Use Authorization for Regen-COV (casirivimab and imdevimab)

- **Treatment** of Mild to Moderate COVID-19 in adults and children (12 years of age and older with weight of at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, who are at High Risk for progression to severe COVID-19, including hospitalization or death

OR

- **Post-Exposure Prophylaxis** of COVID-19 for individuals who are at risk for progression to severe COVID-19, including hospitalization or death.
  - Persons not fully vaccinated or who are not expected to mount an adequate immune response
  - Exposed to individual with COVID-19 consistent with CDC criteria for close contact or are at high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other individuals in the same **institutional setting**.

https://www.fda.gov/media/145610/download

- Method of administration may be through:

IV Administration

or

Subcutaneous Injection

https://www.fda.gov/media/145610/download

FDA Emergency Use Authorization for Regen-COV (casirivimab and imdevimab)

Criteria for Identifying High Risk Individuals

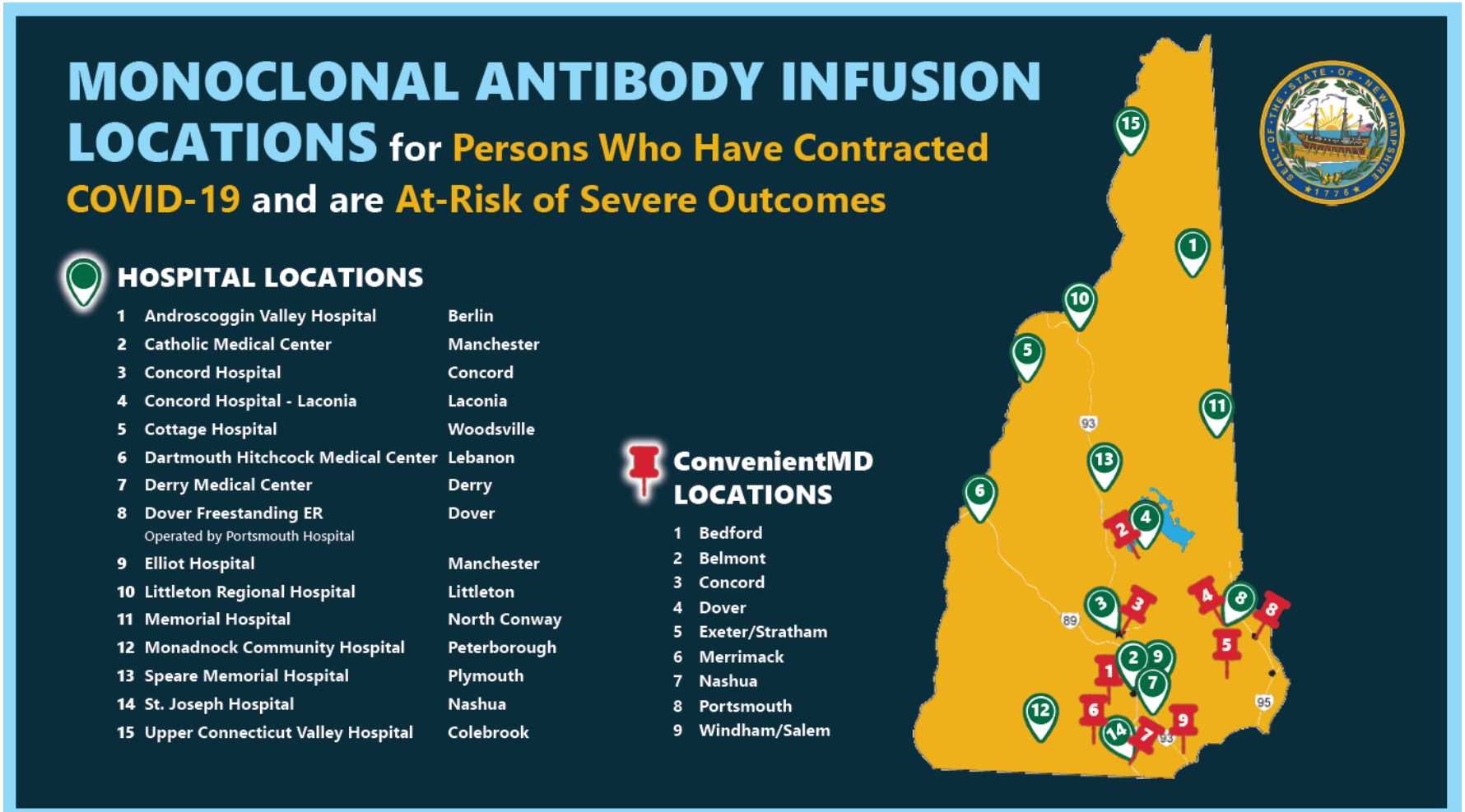
The following medical conditions or other factors may place adults and pediatric patients (age 12-17 years and weighing at least 40 kg) at higher risk for progression to severe COVID-19:

- Older age (for example, age ≥65 years of age)
- Obesity or being overweight (for example, BMI >25 kg/m^2, or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)
- Pregnancy
- Chronic kidney disease
- Diabetes
- Immunosuppressive disease or immunosuppressive treatment
- Cardiovascular disease (including congenital heart disease) or hypertension
- Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- Sickle cell disease
- Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
- Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19))

Other medical conditions or factors (for example, race or ethnicity) may also place individual patients at high risk for progression to severe COVID-19 and authorization of REGEN-COV under the EUA is not limited to the medical conditions or factors listed above. For additional information on medical conditions and factors associated with increased risk for progression to severe COVID, see the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html. Healthcare providers should consider the benefit-risk for an individual patient.

https://www.fda.gov/media/145610/download

Outpatient Locations for Monoclonal Antibodies



https://www.dhhs.nh.gov/dphs/cdcs/covid19/documents/monoclonal-antibody-map.pdf

Pharmacies with mAB that service Skilled Nursing Facilities

Omnicare of New Hampshire
Health Direct
Northeast Pharmacy Services
Pharmerica

Ordering Monoclonal Antibodies

- United States DHHS has resumed weekly distribution amounts for states based on statewide incidence of new infections, hospitalizations, and product utilization
- NH DPHS allocates to NH facilities based on their requests and utilization, and the product directly ships from AmerisourceBergen
- To request supplies of monoclonal antibodies, email COVID19mAbDistribtuion@dhhs.nh.gov or call 603-271-4463

Thank you for all of your work and service!

FDA & ACIP Updates: Vaccine Boosters

(Dr. Elizabeth Talbot)

Boosters

When: relative to an individual's completed series, after everyone else gets primary, and/or with global consideration? Variant responsive?

Who: medically vulnerable to COVID or all? Regionally per variant?

With what: heterologous or homogenous or a new booster formulation?

How? Only after safety, immunogenicity and public health need analyzed

Pfizer–BioNTech Current Regulatory Summary

- COMIRNATY® made by Pfizer for BioNTech
- Approved as 2-dose series for prevention of COVID-19 in individuals ≥16y
- Authorized under EUA to be administered for emergency use to:
  - Prevent COVID-19 in individuals 12-15y, and
  - Provide 3rd dose to individuals ≥12y who have been determined to have certain kinds of immunocompromise

Pfizer–BioNTech Booster: VRBPAC

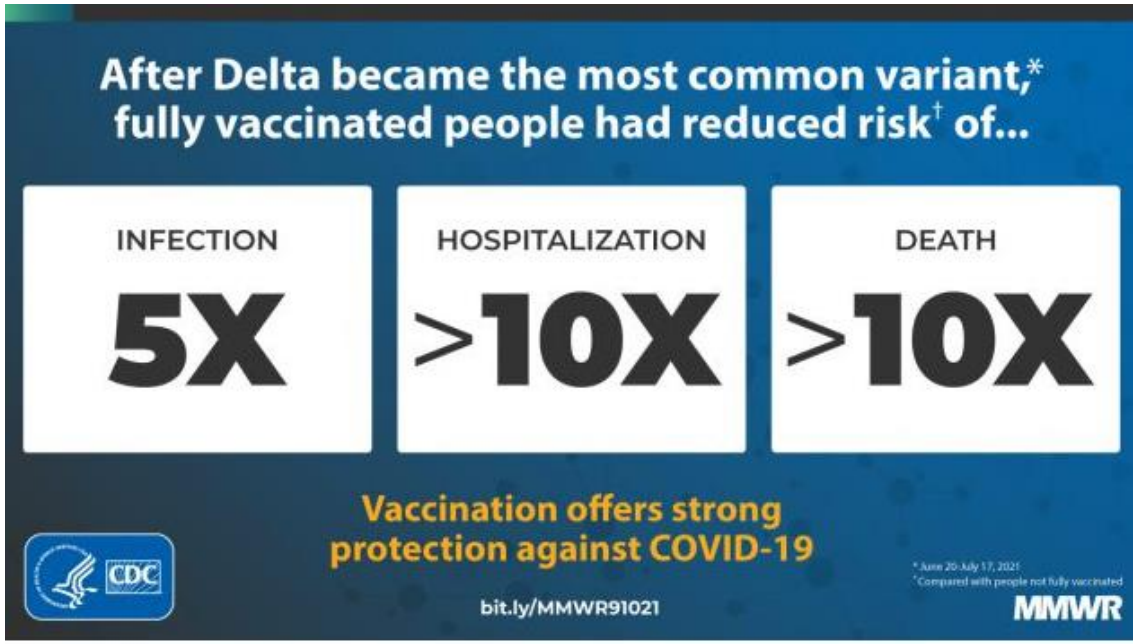
Sept 17: VRBPAC voted to recommend to FDA that a booster dose of Pfizer vaccine, given ≥6m after completion of primary series, may be used for persons

- ≥ 65 years;
- At high risk of severe COVID-19; and
- Frontline healthcare workers

VRBPAC and Lancet Commentary: Pros

Discussions at VRBPAC meeting and a commentary summarized challenges to decisions around booster recommendations. Notably, some of the literature around VE and effectiveness are observational and not peer-reviewed, but:

- VE is greater against severe disease than against any infection
- Vaccination remains substantially protective against severe disease from all VOCs [VBMs]
- VE of most vaccines against symptomatic disease is less for delta than alpha
- VE against both symptomatic and severe disease due to delta remains high


After Delta became the most common variant,* fully vaccinated people had reduced risk† of...
INFECTION
5X
HOSPITALIZATION
>10X
DEATH
>10X
Vaccination offers strong protection against COVID-19
bit.ly/MMWR91021
MMWR

[CDC MMWR]

VRBPAC and Lancet Commentary: Cons

Potential downsides to a booster dose:

- A premature third dose with an ancestral-strain vaccine may serve to over imprint the immune system and dampen responses to future delta-lineage boosters; waiting for a delta-specific vaccine is preferred
- If boosters that can have immune-mediated side effects (e.g., myocarditis after mRNA or GBS with Janssen/J&J) are widely introduced too soon or too frequently, vaccine acceptance may be adversely affected in the future
- A threshold for true waning in VE needs to be established, otherwise a poor precedent is set to boost q6m for mild waning
- Booster data from Israel provides info only on short-term advantage (7-12 days)

Pfizer – BioNTech Booster: FDA

Sept 22: FDA said it would amend the EUA for single booster dose, to be administered ≥ 6m after completion of primary series in:

- Individuals ≥ 65 years;
- Individuals 18 - 64 years of age at high risk of severe COVID-19; and
- Individuals 18 - 64 years of age whose frequent institutional or occupational exposure to SARS-CoV-2 puts them at high risk of serious complications of COVID-19 including severe COVID-19
  - Healthcare workers, teachers and day care staff, grocery workers, those in homeless shelters or prisons, among others

Booster Next Steps

Sept 22-23: ACIP voting on Pfizer booster recommendations

Data on the advisability of booster doses of the Moderna and Janssen/J&J vaccines are pending

Sept 20: Pfizer/BioNTech for 5-11yo

Phase 1/2/3 trial enrolling 4,500 6m-11yo without evidence of previous COVID in US, Finland, Poland, Spain in >90 sites

- 2,268 are 5-11yo

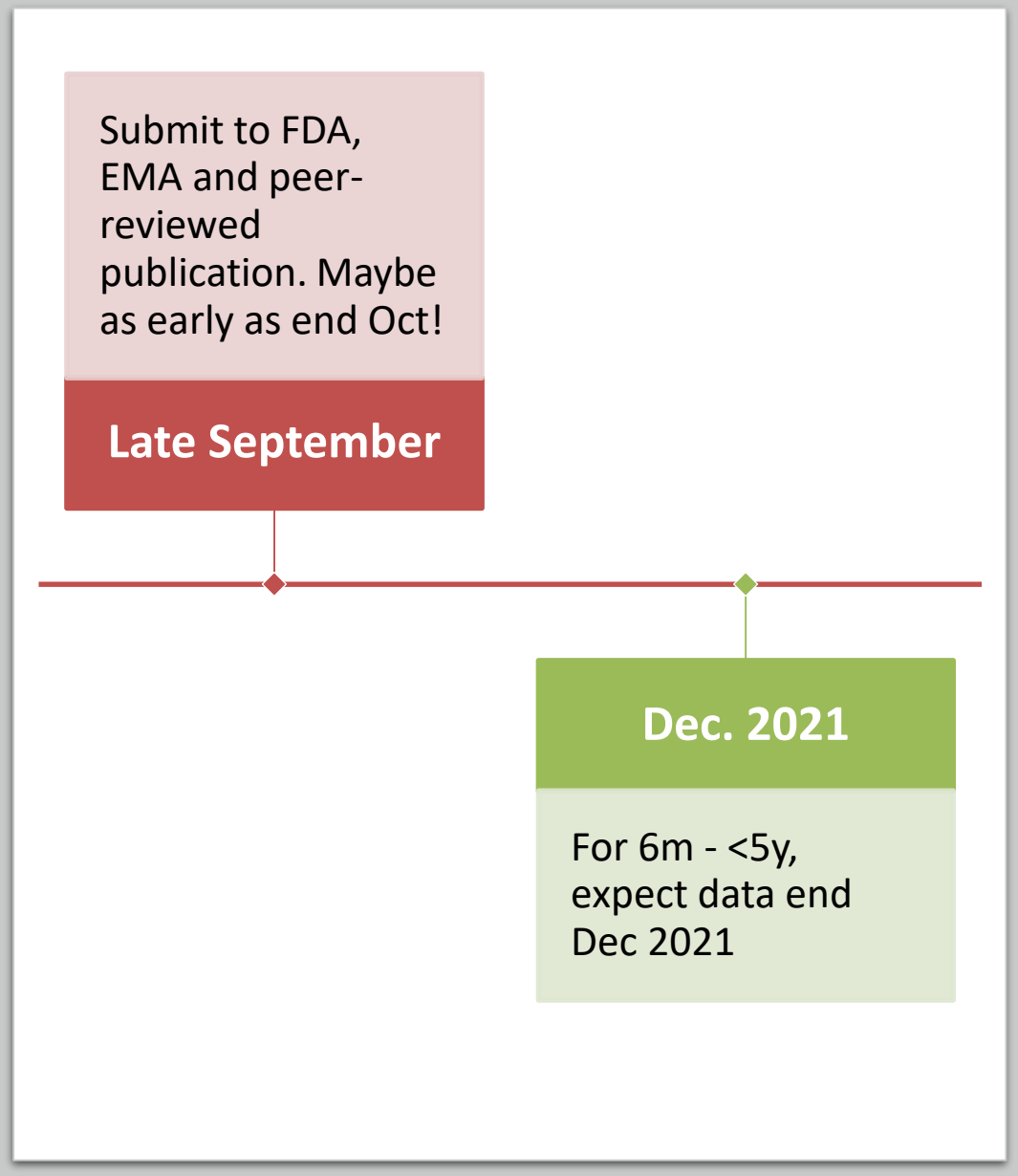
Phase 1 determined that 5-11yo receive 10ug/dose and <5yo 3ug/dose in 2-dose regimen 21d apart

1m following 2nd, NA geometric mean titer (GMT) was 1,197.6 (95% CI 1,106.1-1,296.6)

- Compares with GMT 16-25yo 1,146.5 (95% CI 1,045.5-1257.2)

Comparable safety profile c/w placebo recipients same age

Pfizer/BioNTech: Next Steps for Children



14.8M Americans have received J&J

9/20 J&J Janssen Ensemble 1

- Among 30k participants ≥18yo in multi-country study of one-dose,
  - Overall VE 66% (72% in US population)
  - 85% against severe disease
  - 100% against hospitalizations
  - 16 cases vs 64 in placebo arm

J&J Vaccine Effectiveness in US

- Effectiveness study preprint
- Health insurance record analysis through July (nb Delta variant emerged)
- Among 390,517 J&J vaccinees c/w 1.52M unvaccinated people matched on age, sex, time, ZIP code, risk factors, one-dose J&J vaccine
  - 79% protection against COVID-19 infection
    - Lower in high Delta incidence states
  - 81% protection against hospitalizations
    - 86% for participants < 60y
    - 78% for those ≥ 60y

9/20 J&J Janssen Ensemble 2

- Among 30k participants in multi-country study, 2nd dose at 56d increased VE against mod/severe infection to 75%
  - 14 cases in vaccinees vs 52 placebo
- In US, VE 94% VE against mod/severe disease
  - 1 vaccinated vs 14 placebo resulting in wide confidence interval 58-100%
- 100% against severe disease

Is 56 Days Apart Right Interval?

- People given a booster shot ≥6m after their first dose had a 12-fold increase in antibodies
  - Compared to a four-fold increase for people who got a second dose at 2m, when measured at 4w after second dose
  - Protection should be stronger if people get boosters later
- Expected to extend duration of protection
- Submitted to FDA

Studies on Vaccine Effectiveness (VE)

(Dr. Benjamin Chan)

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 70
September 10, 2021

Monitoring Incidence of COVID-19 Cases, Hospitalizations, and Deaths, by Vaccination Status — 13 U.S. Jurisdictions, April 4–July 17, 2021

- Two surveillance measures to track vaccine effectiveness:
  - % of people with COVID-19 (% cases) who are fully vaccinated (% will naturally increase with increasing levels of population vaccination)
  - Incidence rate ratio (IRR) comparing rate of infection in unvaccinated vs. fully vaccinated persons
- Compared two time periods:
  - Pre-Delta: April 4th – June 19th
  - Delta Predominant: June 20th – July 17th

https://www.cdc.gov/mmwr/volumes/70/wr/mm7037e1.htm

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Comparing Infection, Hospitalization, and Death in Unvaccinated vs. Fully Vaccinated (IRR: Incidence Rate Ratio)

Time Period	IRR Comparing Unvaccinated to Fully Vaccinated Persons		
	Infection	Hospitalization	Death
Pre-Delta	11.1	13.3	16.6
Delta Predominant	4.6	10.4	11.3

- Pre-Delta people who were not fully vaccinated were at 11x higher risk of infection, 13x higher risk of hospitalization, and 16x higher risk of death compared to people fully vaccinated
- During Delta predominance, people who were not fully vaccinated were at 5x higher risk of infection, 10x higher risk of hospitalization, and 11x higher risk of death compared to people fully vaccinated

https://www.cdc.gov/mmwr/volumes/70/wr/mm7037e1.htm

Comparing Infection, Hospitalization, and Death in Unvaccinated vs. Fully Vaccinated (IRR: Incidence Rate Ratio)

Time Period	IRR Comparing Unvaccinated to Fully Vaccinated Persons		
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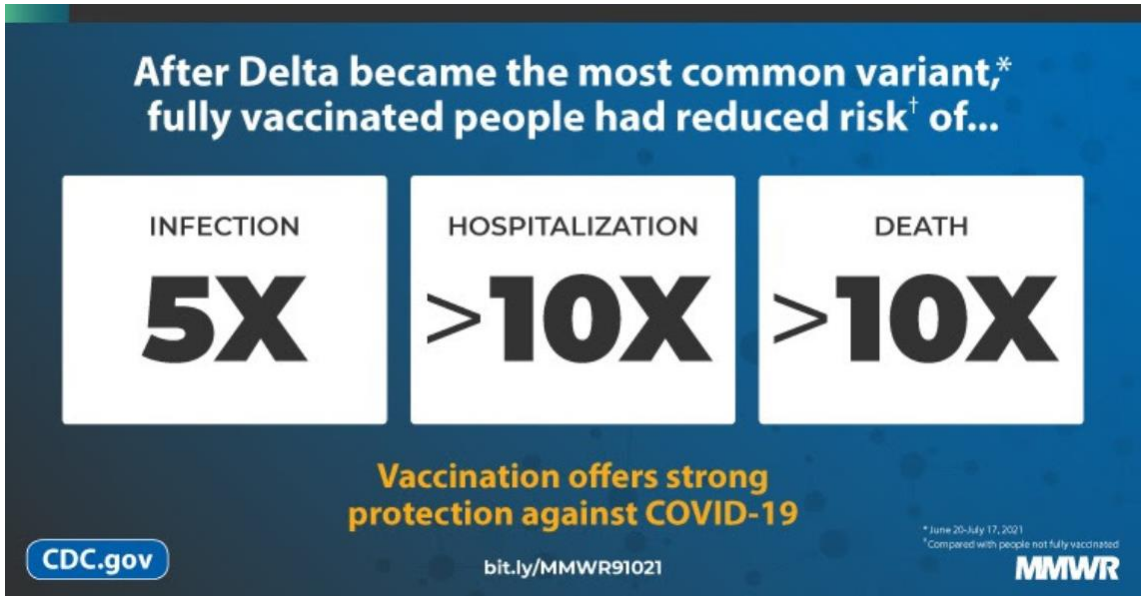
Pre-Delta	11.1	13.3	16.6
Delta Predominant	4.6	10.4	11.3



https://www.cdc.gov/mmwr/volumes/70/wr/mm7037e1.htm

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Department of Health and Human Services

Changes in Vaccine Effectiveness (VE)

- Changes in IRR between time periods represented a change in VE from:
  - 91% to 78% (infection)
  - 92% to 90% (hospitalization)
  - 94% to 91% (death)
- People 65+ years of age had larger declines in VE against hospitalization and death compared to younger ages
- Other recent studies have also shown greater declines in VE against hospitalizations for older adults 75+ years of age (*Grannis et al. MMWR; Sept 10*), and veterans 65+ years of age (*Bajema et al. MMWR; Sept 10*)

https://www.cdc.gov/mmwr/volumes/70/wr/mm7037e1.htm

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Protection of BNT162b2 Vaccine Booster against Covid-19 in Israel

- Israel approved "booster" doses of the Pfizer-BioNTech COVID-19 vaccine for persons 60 years of age and older (July 30, 2021)
  - Based on studies showing a booster dose increased antibody neutralization levels (compared to after 2nd dose)

- This study reports on vaccine effectiveness (VE) of a booster (3rd dose) of the vaccine at preventing confirmed infection and severe illness in persons 60+ years of age (compared to those who received only 2 vaccine doses)
  - Study period: July 30th – August 31st

https://www.nejm.org/doi/full/10.1056/NEJMoa2114255

Table 2. Primary Outcomes of Confirmed Infection and Severe Illness.*

Outcome	Nonbooster Group	Booster Group	Adjusted Rate Ratio (95% CI)†
Confirmed infection			11.3 (10.4 to 12.3)
No. of cases	4439	934	
No. of person-days at risk	5,193,825	10,603,410	
Severe illness			19.5 (12.9 to 29.5)
No. of cases	294	29	
No. of person-days at risk	4,574,439	6,265,361	

https://www.nejm.org/doi/full/10.1056/NEJMoa2114255

Other Public Health Updates

(Lindsay Pierce)

COVID-19 Case Reporting

New Hampshire is a dual reporting state:

- *NH RSA 141-C and He-P301 mandate reporting of suspect and confirmed cases by healthcare providers and laboratories*

Healthcare Providers:

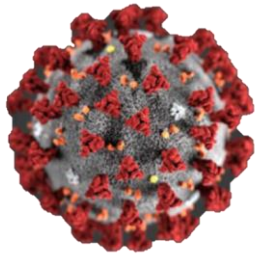
- Please submit complete COVID-19 Case Report Form by fax (603-271-0545)
- Report positive PCR/antigen tests, hospitalizations, and deaths
- Case report forms are not needed for negative or invalid tests

Questions & Answers (Q&A)

Healthcare Provider & Public Health Partner Calls

- 2nd and 4th Thursday of each month from 12:00-1:00 pm (next call will be Thursday, October 14th)

- Webinar/call information:
  - Zoom link: https://nh-dhhs.zoom.us/s/94059287404
  - Webinar ID: 940 5928 7404
  - Passcode: 353809
  - Telephone: 646-558-8656



New Hampshire Coronavirus Disease 2019 Weekly Partner Call

September 23, 2021

Ben Chan
Jonathan Ballard
Elizabeth Talbot
Beth Daly
Lindsay Pierce

Thursday noon-time partner calls will focus on science, medical, and vaccine updates with time for Q&A

NH DIVISION OF
Public Health Services
Department of Health and Human Services