

**NEW HAMPSHIRE  
CORONAVIRUS DISEASE 2019  
VACCINATION PLAN**

October 30, 2020

*New Hampshire Department of Health and Human Services*

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**RECORD OF CHANGES**

Date of original version: 10/16/2020

<b>Date Reviewed</b>	<b>Change Number</b>	<b>Date of Change</b>	<b>Description of Change</b>	<b>Name of Author</b>
10/30/2020	1	10/30/2020	Added Executive Summary	C Haggerty, E Daly

DRAFT

**ABBREVIATIONS USED IN THIS DOCUMENT**

CDC	Centers for Disease Control and Prevention
ESU	Emergency Services Unit
FEMA	Federal Emergency Management Agency
HCP	Healthcare Personnel
IMT	Incident Management Team
IIS	Immunization Information System
LTCF	Long-term Care Facility
MRC	Medical Reserve Corp
NH DHHS	New Hampshire Department of Health and Human Services
NHIP	New Hampshire Immunization Program
NH DPHS	New Hampshire Division of Public Health Services
PPE	Personal protective equipment
RPHNs	Regional Public Health Networks
SDMAC	State Disaster Medical Advisory Committee
VAMS	Vaccine Administration Management System
VTrcks	Vaccine Tracking System

## ABOUT THIS DOCUMENT

This plan was developed by the New Hampshire (NH) Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS), Bureau of Infectious Disease Control, Immunization Program. The planning process to develop this plan included a variety of internal and external stakeholders. Content included in this plan was adapted, in part, from the Centers for Disease Control and Prevention's *Vaccination Program Interim Playbook for Jurisdiction Operations*, prior pandemic and outbreak event experience in New Hampshire, preparedness plans, and other resources. The format and content of this plan is in accordance with the specific elements required to be addressed by the Centers for Disease Control and Prevention. The COVID-19 vaccine planning process has required flexibility as guidance and planning assumptions continue to evolve. This plan is intended to represent current plans and strategies as of the date of the document; however, DPHS will adapt its approach as appropriate based on new science or national best practices and guidelines throughout the vaccination initiative.

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## EXECUTIVE SUMMARY

The Coronavirus Disease 2019 (COVID-19) pandemic has caused substantial morbidity and mortality, and significant economic and social disruption. Through current mitigation efforts, and in anticipation of a COVID-19 vaccine, New Hampshire's (NH) goal is to decrease disease burden and ensure NH citizens remain healthy and free from disease in every stage of life. This plan was developed by the NH Department of Health and Human Services (DHHS), Immunization Program (NHIP) and informed by the Centers for Disease Control and Prevention's *Vaccination Program Interim Playbook for Jurisdiction Operations*, prior pandemic and outbreak experience in NH, preparedness plans, and the National Academies for Science, Engineering, and Medicine's [\*Framework for Equitable Allocation of Vaccine for the Novel Coronavirus\*](#). This plan represents current plans and strategies. NH's approach will be adapted as appropriate based on new science or national best practices and guidelines throughout the vaccination initiative. Key components of NH's plan are summarized here.

**SECTION 3: PHASED APPROACH TO COVID-19 VACCINATION:** NH's vaccination program is structured around the concept of a phased response, whereby vaccine may initially be limited. A Vaccine Allocation Strategy Branch will inform strategies related to equitable dose distribution. The current distribution plan includes starting each phase of vaccination in geographic areas with the highest COVID-19 disease case count. Ensuring equitable access to COVID-19 is central to NH's vaccine planning efforts. NH's initial plan includes vaccination of the following groups under Phase 1a: High-risk workers in health care facilities, first responders, and older adults in residential care settings

**SECTION 4: CRITICAL POPULATIONS:** Some populations have been disproportionately impacted by COVID-19 and are at increased risk for infection, severe illness, and death. Data is being gathered from multiple sources to determine accurate numbers for distribution planning. NH's definition of critical infrastructure workforce is currently being determined by the Vaccine Allocation Strategy Branch, building off of the Pandemic Influenza critical workforce guidance to include critical infrastructure not traditionally considered. Sub populations will likely be determined by co-morbidity and will require vetting through medical homes. The Vaccine Operations Section's Communication Branch is developing an initial, comprehensive communication plan that clearly delineates methods for communication with various entities, including the general public and partners that serve critical populations.

**SECTION 5: COVID-19 PROVIDER RECRUITMENT AND ENROLLMENT:** NH is a universal childhood vaccine purchase state, with many providers currently enrolled in NHIP. A Government/Non-government partnership of distribution will be implemented. Providers identified as vaccinators in the first phase will be prioritized for enrollment. Recruitment will be based on utilization in the next phases, as well as creating depth of vaccine providers and decreasing barriers towards immunization. Additionally, 13 fixed sites on the government side of the response will be established to supplement these individual vaccine providers. Pharmacies will also be recruited to provide additional vaccination services. Vaccine providers will be verified through the established, Vaccine Provider Agreement process; provider enrollment data will be submitted via CDC's Vaccine Tracking System (VTrckS) and sent to CDC. Ensuring equitable access to COVID-19 vaccine is central to planning efforts, with oversight by the Vaccine Allocation Strategy Branch, and solicitation of

feedback from the State Disaster Medical Advisory Committee and the DHHS Office of Health Equity. Key documents leveraged for this work include NH's COVID-19 Equity Response Team [report](#), CDC's COVID-19 Response Health Equity [Strategy](#), and the National Academies for Science, Engineering, and Medicine's A [Framework for Equitable Allocation of Vaccine for the Novel Coronavirus](#). All pharmacy distribution plans will be approved by the NHIP and Vaccine Operations Section to ensure equitable and fair distribution.

**SECTION 8: COVID-19 VACCINE STORAGE AND HANDLING:** Prior to the receipt of COVID-19 vaccine, new vaccine providers will be required to complete vaccine storage and handling training. The training will be conducted via an independent, on-line education portal (CDC TRAIN), webinars, an established Help Line that will include clinical and vaccine management subject-matter experts, and various job aids. COVID-19 vaccine storage and handling capabilities will be evaluated via the COVID-19 specific, CDC Vaccine Provider Agreement and Profile.

**SECTION 10: COVID-19 VACCINATION SECOND-DOSE REMINDERS:** Individuals will be notified when they are eligible for their second dose of COVID-19 vaccine via the NH Immunization Information System's reminder/recall feature, through CDC "shot cards" provided upon initial vaccine receipt, through their medical home's reminder/recall process, or text messaging. State-wide documentation will be leveraged to ensure the second dose of a vaccine presentation is the same as the first, observing recommended intervals between vaccine doses.

**SECTION 12: COVID-19 VACCINATION PROGRAM COMMUNICATION:** NH's COVID-19 vaccination communication plan will be continuously updated to include addressing communications with key audiences, identification of effective communication channels, and partner activation for each phase of the COVID-19 Vaccination Program. NH DHHS has established processes for providing crisis and emergency risk communications in an expedited manner. This includes leveraging NH's Joint Information Center and the Health Alert Network (HAN). A member of the Department's Public Information Office leads the vaccine planning Communication Branch.

**SECTION 14: COVID-19 VACCINE SAFETY MONITORING:** Through the vaccine provider enrollment process, NH will ensure enrolled vaccination providers understand the requirements and process for reporting adverse events to the Vaccine Adverse Event Reporting System. Information will also be made available through NHIP's website, social media platforms, and quarterly NHIP conference calls.

**SECTION 15: COVID-19 VACCINATION PROGRAM MONITORING:** NH will implement methods and procedures for monitoring progress in the COVID-19 Vaccination Program implementation. Vaccine ordering and distribution will be approved at the state level and vaccine wastage will be monitored through standard, established procedures. Methods and procedures for monitoring resources are in place, including monitoring the budget, staffing, and supplies. Reception of public communication messages will be monitored through the public information office, media inquiries, and social media. Program metrics to be monitored include vaccination provider enrollment, doses distributed, doses administered, and vaccination coverage. Bi-directional communication pathways are being formulated and leveraged to provide real-time feedback to inform NH's COVID-19 vaccine response efforts.

## **SECTION 1: COVID-19 VACCINATION PREPAREDNESS PLANNING**

### ***A. Vaccine Planning Process***

Public health and healthcare organizations in New Hampshire have been planning for pandemic vaccine distribution for nearly two decades. There are a number of plans in place to support vaccination during a pandemic. We also have the experience of distributing vaccine during the H1N1 pandemic and other public health emergencies. NH DHHS will leverage these plans, our existing strong partnerships, and our prior experience in order to mount a comprehensive vaccination program in response to COVID-19. For COVID-19 specifically, NH DHHS has been planning since June for the eventual availability of a safe and effective COVID-19 vaccine. This planning has been accomplished through formation of a structured planning team with feedback from partners.

### ***B. Continuous Quality Improvement***

Maintaining a flexible approach and willingness to adapt vaccination initiative strategies throughout the response will be important to problem solving and ensuring an effective program. Continuous quality improvement is conducted through established strategic planning, participation in roundtables, preparedness exercises, including annual school-based flu vaccine clinics and after-action meetings, and regular engagement with internal and external partners. This approach will continue throughout the COVID-19 response efforts, following traditional incident command structure. The following historical events have also contributed to the overall planning process:

- Key findings from the 2009 Influenza A H1N1 pandemic vaccination initiative
- Key findings from the 2019 Crimson Contagion high-threat infectious disease national exercise
- Federal Vaccine Tabletop Exercise, 09/17/2020 (Partners: FEMA, NH DHHS/DPHS, ESU)
- Annual School-Based Flu Clinics held annually for the last ten years via Regional Public Health Networks (RPHNs)
- Immunization Program weekly planning sessions, commencing July 7, 2020

## **SECTION 2: COVID-19 ORGANIZATIONAL STRUCTURE AND PARTNER INVOLVEMENT**

### ***A. Organizational Structure***

New Hampshire's COVID-19 Vaccination Plan requires cooperation between government and non-government entities in order to ensure a successful distribution methodology. This includes hospital organizations, medical homes (primary care providers, prisons, Veteran's Association, Home Health, etc.), Emergency Medical Services, Long-Term Care and Assisted Living Facilities; organizations supporting individuals experiencing housing insecurity. It is expected that New Hampshire's distribution will include vaccinating approximately 75% of the population through external stakeholders and 25% via government response. Communication pathways are established through a formalized communication branch to delineate messages between general public and external vaccinators and government vaccinators.

### ***B. Internal COVID-19 Vaccination Planning Structure***

The organizational structure follows the DPHS' Incident Management Team (IMT) ([Appendix 1](#)), with the Vaccine Operations Section coming under the Incident Commander ([Appendix 2](#)). The Vaccine Operations Section includes six branches:

- 1) Vaccine Allocation Strategy
- 2) Communication
- 3) Logistics
- 4) Vaccine Accountability
- 5) Vaccine Documentation
- 6) Medical Direction

### ***C. Committee of Key Internal Leaders and External Partners***

Initial COVID-19 vaccine planning included the Immunization Program team ([Appendix 3](#)); and expanded to include representation from:

- CDC Public Health Associate Program
- Chief Medical Officer
- Chief, Bureau of Housing Support
- Chief, Bureau of Infectious Disease Control
- Contracted Epidemiologists
- NH Homeland Security
- NH Hospital Association
- NH Medical Society
- NH National Guard
- NH State Epidemiologist

- Chief, Fire Standards & Training/  
Emergency Medical Services
- Deputy Public Health Director
- DHHS Emergency Services Unit
- DPHS Incident Management Team
- Governor’s COVID Equity Response Team
- Granite State Health Care Coalition
- NH Health Care Coalition
- NH Deputy State Epidemiologist
- Office of Medicaid
- Office of Professional Licensure
- Public Health Director / State Health Official
- Public Health Emergency Preparedness Director
- Public Health Information Office
- Regional Public Health Network Coordinators
- State Disaster Medical Advisory Council

### ***D. Additional Relevant Expertise***

The NH Crisis Standards of Care Committee was formed to provide input on the equitable distribution of durable medical equipment, medications and other scarce medical resources during the COVID-19 pandemic. This expanded into the development of the State Disaster Medical Advisory Committee (SDMAC) group, and has assumed advisory capacity for COVID-19 vaccine allocation related response efforts ([Appendix 4](#)).

### ***E. Local Coordination***

New Hampshire has a centralized public health structure with disease control authority resting with the DHHS Commissioner. There are two local health departments in the state’s largest cities, Manchester and Nashua. In order to provide local public health response capacity, there are 13 regional [Public Health Networks](#) (RPHNs), that plan, train for, and respond to public health emergencies based on CDC’s 15 Preparedness Capabilities. Their role is to improve the overall preparedness and resiliency of communities, while also developing specific emergency response capabilities across the public health, health care, and behavioral health systems, which includes extensive planning and exercising for mass vaccination initiatives. During COVID-19 response efforts, the RPHNs will conduct COVID-19 vaccination clinics within their regions. Their response effort participation will be coordinated through the state ICS structure. The RPHNs have plans in place to communicate with key stakeholders and local officials within their regions and with the State of New Hampshire during emergency response and mass vaccination campaigns.

***F. Tribal Coordination***

New Hampshire does not have state or federally recognized Native American tribes.

***G. Key Partners for Critical Populations***

Pharmacies, correctional facilities, FQHCs and additional external partners that represent homebound seniors, group homes and minority populations, will be incorporated into New Hampshire's COVID-19 Vaccination Plan through formalized vaccine provider agreements. Once the provider meets the requirements of the agreement and submits it to the NH Immunization Program (NHIP), these providers will be created in the Immunization Information System, provide training on how to order and document vaccination as well as creating facilities and end user profiles in New Hampshire's Immunization Information System (IIS). These processes will allow for the ordering and documenting of COVID-19 vaccine by pharmacies and correctional facilities. Homeless shelters, assisted living facilities and other populations that have barriers to care, such as those with substance use disorder, will be an RPHN focal area. RPHNs will bring vaccine and vaccinators to these locations and have experiencing reaching vulnerable populations from our recent 2019 statewide hepatitis A vaccination campaign.

## SECTION 3: PHASED APPROACH TO COVID-19 VACCINATION

### A. *Vaccination Program Strategy*

New Hampshire's vaccination program is structured around the concept of a phased response, whereby vaccine may be available as follows:

Phase 1: Potentially Limited Doses Available

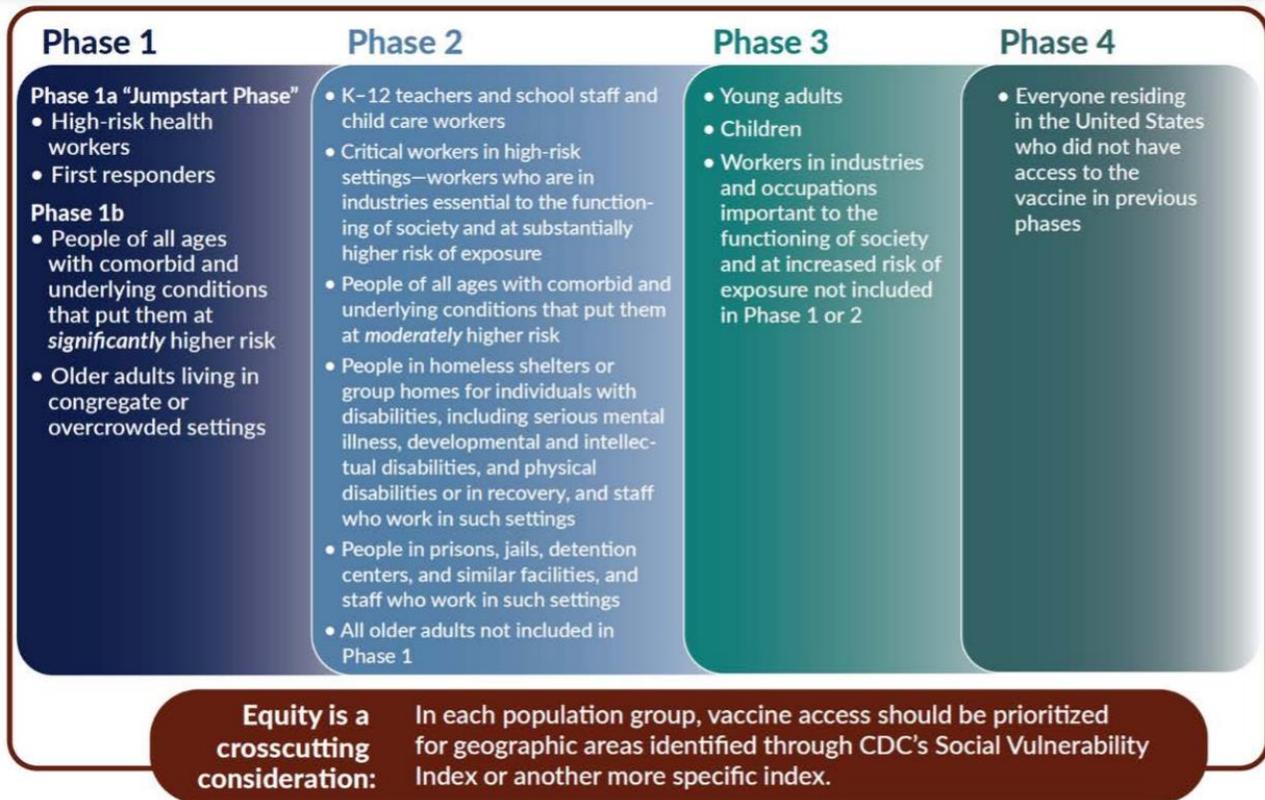
Phase 2: Large Number of Doses Available, Supply Likely to Meet Demand

Phase 3: Likely Sufficient Supply, Slowing Demand

A Vaccine Allocation Strategy Branch was developed to inform strategies related to equitable dose distribution. This branch coordinates with the aforementioned SDMAC group for external perspective and recommendations. The final approval of vaccine distribution will be informed by recommendations from the Centers Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), the New Hampshire Vaccine Allocation Strategy and Medical Direction Branches, NH DHHS Commissioner and the Governor's Office. The current distribution plan includes starting each phase of vaccination in geographic areas with the highest COVID-19 disease case count. This is to serve as a starting point vs. a containment strategy. Allocations will be distributed utilizing a combination of fixed and mobile government distribution sites, as well as leveraging medical home providers and pharmacies.

Ensuring equitable access to COVID-19 is central to New Hampshire's vaccine planning efforts and decisions will be guided by federal guidance with adaptations made based on local conditions and vulnerable populations. Our initial planning efforts have been guided by the National Academies for Science, Engineering, and Medicine's A [Framework for Equitable Allocation of Vaccine for the Novel Coronavirus](#) and will be updated as needed based on any additional federal guidance that may be issued. The phased approach outlined in this framework is depicted in the figure below.

Figure: A Phased Approach to Vaccine Allocation for COVID-19



Source: Adapted from the National Academies for Science, Engineering, and Medicine's A [Framework for Equitable Allocation of Vaccine for the Novel Coronavirus](#)

For Phase 1a, New Hampshire will include older adults living in residential care settings (e.g. nursing homes and assisted living facilities). Other older adults in congregate settings (e.g. senior living complexes, etc.) will be included in Phase 1b. New Hampshire's Phase 1a vaccination allocation strategy is outlined in [Appendix 5](#) and is the initial focus of planning. The Vaccine Allocation Strategy Branch gathered data from hospital organizations, long-term care and assisted living facilities, first responders (to include Fire, EMS, and Police), and the DHHS Bureau of Housing Support (to include external partners affiliated with health equity in the two most populous New Hampshire cities). Data provided initial estimates for each of the Phase 1a population groups. This coincided with rough estimates for New Hampshire's COVID-19 vaccine distribution over the initial 2-3 months. Decisions regarding allocation of vaccine for phases beyond 1a have not yet been firmly established, however, these decisions will be informed by the national guidance and the general approach outlined in the figure above, with some modifications for local circumstances. The Vaccine Allocation Strategy Branch is currently evaluating national recommendations and state-wide epidemiologic patterns to determine prioritization of populations for Phase 2 & 3.

## SECTION 4: CRITICAL POPULATIONS

### **A. Critical Population Identification**

Some populations (“critical populations”) have been disproportionately impacted by COVID-19 and are at increased risk for infection, severe illness, and death. The expected allocation of vaccines to these populations is outlined in the table above. Critical population groups may include:

- Healthcare personnel
- Other essential workers
- Long-term care facility residents (e.g., nursing home and assisted living facility residents)
- People with [underlying medical conditions](#) that are risk factors for severe COVID-19 illness
- People 65 years of age and older
- People from racial and ethnic minority groups
- People who are incarcerated/detained in correctional facilities
- People experiencing homelessness/living in shelters
- People attending colleges/universities
- People living and working in other congregate settings
- People living in rural communities
- People with disabilities
- People who are under- or uninsured

### **B. Critical Population Estimation**

On an on-going basis, a combination of internal and external stakeholders are meeting and, where possible, comparing data from multiple sources to determine accurate numbers for distribution planning. Medical homes are currently being identified and will be used as the primary methodology to vaccinate those individuals with co-morbidities. For those individuals with identified co-morbidities without a medical home, vaccination will occur through state-government response efforts and pharmacies. See Section (above, 1A).

### **C. Identification of Additional Critical Populations**

New Hampshire’s definition of critical infrastructure workforce is currently being determined by the Vaccine Allocation Strategy Branch. This branch is building off of the Pandemic Influenza critical workforce guidance to include critical infrastructure not traditionally considered. (i.e., grocery workers). As these groups are identified, population numbers are determined through a discussion

with subject-matter experts. Sub populations will likely be determined by co-morbidity and will requiring vetting through medical homes. For sub population in critical infrastructure, a prioritization list will be developed by the Vaccine Allocation Strategy Branch, using the aforementioned strategy.

***D. Communication Coordination for Critical Populations***

Weekly calls between the Incident Management Team and internal and external stakeholders, began in September 2020. This provided opportunities to communicate high-level planning details as the Vaccine Operations Section was being developed. The Vaccine Operations Section's Communication Branch is developing an initial, comprehensive communication plan that clearly delineates methods for communication with various entities, including the general public and partners that serve critical populations.

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## SECTION 5: COVID-19 PROVIDER RECRUITMENT AND ENROLLMENT

### ***A. Vaccination Provider Recruitment and Enrollment***

Significant planning has been carried out around recruiting and enrolling COVID-19 vaccination providers, including the specific types of settings vaccine is expected to be distributed in for each phase of the initiative. As a universal state for childhood vaccines, New Hampshire already has many providers enrolled in the immunization program. Enrollment will need to be significantly expanded, and will be driven based on the phased vaccine allocation strategy.

### ***B. Provider Types and Settings***

A Government/Non-government partnership of distribution will be implemented. This is due to resource limitations on both sides. By distributing the work between both, we can utilize current, established methods of distribution, such as hospital organizations, nursing homes, etc. This enables the public side, for those that are unable to have medical direction or skilled personnel, to administer vaccine.

#### Government response:

- Using the state's two local health departments and 13 Regional Public Health Networks (RPHNs) to disseminate vaccines through closed point of dispensing (POD) agreements. The RPHNs already have closed POD plans in place in each region and have been encouraged to increase the number of closed POD agreements. RPHNs will work in concert with EMS/Fire to vaccinate first responders.
- Local health departments and RPHNs will conduct open PODs for vulnerable areas of the population that will have difficulty accessing vaccine through other efforts.

#### Non-Government response:

- Partnerships to deliver vaccine to hospital networks to vaccinate their workforce
- Pharmacists and/or other primary vaccination providers to vaccinate vulnerable populations
- Medical Homes
  - For persons with medical co-morbidities, it is preferred to vaccinate in the medical home
  - If an individual does not have a medical home (i.e. persons experiencing homelessness), they should they be directed to:
    - Local health departments and RPHNs
    - Community Health Centers

**C. Provider Enrollment Data Collection**

Provider enrollment data will be submitted via CDC's Vaccine Tracking System (VTrckS) and sent to CDC. Vaccine providers will be verified through the established, Vaccine Provider Agreement process, a process that is conducted on an annual basis for all New Hampshire vaccine providers.

**D. Provider Credential Verification**

Planning efforts currently underway includes work to establish processes to verify that providers are credentialed with active, valid licenses to possess and administer vaccine. This includes working with the existing volunteer registration and credentialing systems in place in New Hampshire for emergency response as well as working with professional boards to access licensing databases.

**E. Provider Training**

Training will be accomplished via interactive, on-line, independent learning. CDC TRAIN will be leveraged to provide specific course work for the following topics: PPE; Vaccine Storage & Handling; Clinical Operations (Just-In-Time training); COVID-19 safety measures related to social distancing, and mobile clinics.

**F. Vaccine Redistribution**

Vaccine orders in quantities < 100 doses will be delivered to NH DHHS for redistribution to smaller entities. Vaccine Accountability staff will facilitate the receipt, packaging and redistribution of these vaccine doses, observing all relevant cold-chain requirements for individual vaccine presentations.

**G. Equitable Vaccine Allocation**

Ensuring equitable access to COVID-19 vaccine is central to New Hampshire's vaccine planning efforts. Through established communication methods in previous efforts, continuous external stakeholder feedback, along with current expert planning, will assure equitable distribution of COVID-19 vaccine. The Vaccine Allocation Strategy Branch will oversee the allocation plan. This includes soliciting feedback from the SDMAC and feedback from the DHHS Office of Health Equity and the DPHS Equity subject matter expert who sits on the COVID-19 Incident Management Team. Key documents leveraged for this work include New Hampshire's COVID-19 Equity Response Team [report](#), CDC's COVID-19 Response Health Equity [Strategy](#), and the National Academies for Science, Engineering, and Medicine's A [Framework](#) for Equitable Allocation of Vaccine for the Novel Coronavirus.

***H. Pharmacy Participation***

All pharmacy distribution plans will be approved by the NH Immunization Program/Vaccine Operations Section to ensure equitable and fair distribution, based on the Vaccine Allocation Strategy Branch recommendations. Recruitment will be through associations, external partners and direct contact to both the commercial retail, private, and independent retail pharmacies. Hospital pharmacies will be coordinated through hospital organizations.

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## **SECTION 6: COVID-19 VACCINE ADMINISTRATION CAPACITY**

### ***A. Estimated Vaccine Administration Capacity***

Capacity plans are currently being expanded from previous pod exercise experience. Specifically, school-based flu vaccine clinics, recent Hepatitis A vaccine clinics and H1N1 vaccine clinics. Efforts to expand capacity focus on a model of approximately 25-30% of administered vaccine being distributed through the thirteen Regional Public Health Networks (RPHNs). The RPHNs will have one fixed site and one mobile site capability. Current plans call for a volunteer branch to be implemented to coordinate state-wide volunteers. This branch will come under Planning in the IMT Section. Additional efforts to expand capacity include leveraging Emergency Medical Services, a centralized system in New Hampshire, local National Guard, and working with professional medical, nursing, and pharmacy licensing boards and schools to provide vaccinators. This will be built off the foundation of the Medical Reserve Corp. (MRC) and established RPHN vaccinators.

### ***B. Provider Recruitment Plans***

The recruitment plan for vaccinators will be informed by the Vaccine Allocation Strategy Branch's final recommendations on phases of vaccine implementation. It is generally recognized that the most amount of vaccine providers will be utilized in Phases 2 and forward. The goal is to create vaccine through-put of approximately 100 vaccinations per hour at each of the thirteen fixed locations, while simultaneously providing mobile vaccination clinics to smaller, vulnerable populations that may have more difficulty accessing fixed sites.

## **SECTION 7: COVID-19 VACCINE ALLOCATION, ORDERING, DISTRIBUTION, AND INVENTORY MANAGEMENT**

### ***A. Allocation Method and Plan***

Current state-wide epidemiology trends will inform distribution patterns for priority populations. For example, the strategy is to vaccinate in geographic regions experiencing the highest incidence of COVID-19 disease. Based on current assumptions, the goal is to vaccinate an entire phase of the population throughout the state, prior to proceeding with vaccination of the next phase. Exceptions to this general rule will be when a specified amount of vaccine, deemed by the Vaccine Allocation Strategy Branch, is below the threshold to transport to another region.

The vaccine allocation amount, and guarantee of second-dose distribution of the same vaccine presentation for the first phase group, will inform New Hampshire's strategy of how far initial doses of COVID-19 vaccine can be distributed. For example, if 100 doses of Vaccine Presentation A cannot be guaranteed for a second dose within the recommended timeframe, New Hampshire will completely vaccinate 50 people (50 doses will be held for the second dose after the recommended interval between doses).

### ***B. Cold Chain Capability***

Once final storage and handling requirements are released, additional strategies will need to be explored to provide adequate freezer and deep freezer vaccine storage. Federal supplemental funding has allowed for the purchase of thirteen refrigerators and fourteen freezers. Further funding would be leveraged to assist in purchasing additional needed equipment. Prioritization of this equipment will be based off geographic and population size.

Additional state capacity includes five refrigerators and one freezer. Federal supplemental funding has allowed for the purchase of a pharmacy-grade freezer, one ultra-cold freezer, and forty-two portable refrigerators/freezers (can be used in either capacity).

Building upon the knowledge gained as a Universal Vaccine Purchase state, current capacities are measured and reported for the majority of pediatric and family practice clinics. The capacity among these clinics is currently stronger in refrigeration vs freezing capability. A survey of these practices will be conducted to assess their access to additional cold-storage (freezers).

**C. Vaccine Ordering**

Vaccine Allocation will occur through vaccine provider agreements under the direction of the NHIP, following the Vaccine Allocation Strategy Branch phases. Depending on the COVID-19 vaccine distribution initial release, the NH Immunization Information System (IIS) will be used to order vaccine. The IIS is currently being implemented after the vendor contract (Envision) was approved in mid-June 2020. If vaccine is released before the IIS is implemented, an alternate system for vaccine ordering will be used. Redundancies have been explored to ensure efficient vaccine ordering and distribution processes. Dependent on the CDC requirements, NH DHHS would consider leveraging CDC's Vaccine Administration Management System (VAMS). In the event VAMS and the IIS cannot be used, existing alternate solutions already available to New Hampshire will be leveraged with final data residing in the IIS, once the IIS is fully implemented.

**D. Vaccine Repositioning**

It is expected that vaccine doses will be packaged for shipment from the federal distributor with a minimum quantity requirement (e.g. 100 doses). To accommodate smaller orders, NH DHHS will receive some shipments of vaccine that can be broken down into smaller allotments and shipped to organizations ordering fewer doses of vaccine. Redistribution of COVID-19 vaccine will be completed under the direction of the Vaccine Distribution Branch, under the Vaccine Operations Section. Strike teams of trained vaccine storage and handling personnel will be leveraged in the event redistribution of vaccine is required.

**E. Vaccine Wastage and Inventory Monitoring**

Historically, New Hampshire vaccine wastage is well below CDC's target (<5%) for jurisdictions receiving federally supplied vaccine. Vaccine wastage and inventory reports for COVID-19 vaccine will follow established processes for other federally-supplied vaccines, including providing a monthly report. Vaccine wastage and inventory levels will be monitored through the IIS. In the event vaccine is distributed prior to the IIS implementation, monitoring of wastage and inventory will be conducted through an alternate system. Redundancies have been explored to ensure capability for inventory monitoring. Dependent on the CDC requirements, NH DHHS would consider leveraging CDC's Vaccine Administration Management System (VAMS). In the event VAMS and the IIS cannot be used, existing alternate solutions already available to New Hampshire will be leveraged with final data residing in the IIS, once the IIS is fully implemented.

## **SECTION 8: COVID-19 VACCINE STORAGE AND HANDLING**

### ***A. Monitoring Adherence to Vaccine Storage and Handling Requirements***

As a Universal Vaccine Purchase state, a large number of our Family Practice providers are enrolled with the NHIP. On an annual basis, these practices receive vaccine management training and education. Prior to the receipt of COVID-19 vaccine, new vaccine providers will be required to complete vaccine storage and handling training. This training will include mobile clinic vaccine management, in addition to other clinical operation instruction (PPE, COVID-19 screening, drive through clinic considerations and documentation). The training will be conducted via an independent, on-line education portal (CDC TRAIN) and will be followed up with webinars, an established Help Line to include clinical and vaccine management subject-matter experts, and various job aids.

### ***B. Assessing provider/redistribution depot COVID-19 vaccine storage and temperature monitoring capabilities***

COVID-19 vaccine storage and handling capabilities will be evaluated via the COVID-19 specific, CDC Vaccine Provider Agreement and Profile. Monthly, temperature logs will be submitted from all enrolled vaccine providers, and reviewed by NHIP Vaccine Accountability staff following established NHIP processes.

## **SECTION 9: VACCINE ADMINISTRATION DOCUMENTATION AND REPORTING**

### ***A. Vaccine Doses Administered Data Collection***

Depending on the COVID-19 vaccine distribution initial release, the NH Immunization Information System (IIS) will be used to collect data on vaccine doses administered. If vaccine is released before the IIS is implemented, an alternate system for tracking vaccine doses administered will be used. Redundancies have been explored to ensure efficient tracking of vaccine doses administered. Dependent on the CDC requirements, NH DHHS would consider leveraging CDC's Vaccine Administration Management System (VAMS). In the event VAMS and the IIS cannot be used, an alternate solution will be used with final data residing in the IIS, once the IIS is fully implemented.

### ***B. Submission Vaccine Administration Data to the Immunization (IZ) Gateway.***

The [IZ Gateway](#) is a federal mechanism for connecting IISs or other documentation systems to CDC to share authorized vaccination information. Submission of data to the IZ Gateway will be dependent upon CDC's final determination regarding required data element fields. Currently, New Hampshire is scheduled in the fifth phase of an IZ Gateway connection. It is unclear if this connection will be made prior to receipt of COVID-19 vaccine. In the event the IZ Gateway cannot be utilized to provide data to federal partners, New Hampshire is currently discussing potential solutions with the IIS vendor, Envision.

### ***C. Ensuring COVID-19 Vaccination Provider Readiness for Data Reporting***

To ensure real-time documentation and reporting of COVID-19 vaccine administration data from healthcare provider settings, a state-wide system will be deployed (described above: IIS, VAMS, or state solution), to provide data to the NHIP. Every effort will be made to submit data concurrent with state law, in a timely fashion. Clarification by CDC related to required data element fields will determine whether or not New Hampshire can meet the 24-hour reporting requirement.

### ***D. Ensuring COVID-19 Vaccination Clinic Readiness for Data Reporting***

To ensure real-time documentation and reporting of COVID-19 vaccine administration data from satellite, temporary, or off-site clinic settings, a state-wide system will be deployed (described above: IIS, VAMS, or state solution), to provide data to the NHIP. Every effort will be made to submit data concurrent with state law in a timely fashion.

***E. Provider-level Data Monitoring***

To monitor provider-level vaccination data to ensure each dose of COVID-19 vaccine administered is fully documented and reported every 24 hours, a state-wide system will be deployed (described above: IIS, VAMS, or state solution), to provide data to the NHIP. Every effort will be made to submit data concurrent with state law in a timely fashion. NHIP will follow up with vaccine providers that do not adhere to vaccine documentation and reporting requirements.

***F. COVID-19 Vaccination Coverage Reports***

COVID-19 vaccination coverage reports will be generated via the IIS. The reports will be used to identify gaps in vaccine coverage, and potential barriers to receipt of vaccine, throughout the state. The current strategy calls for leveraging the NH IIS as the primary strategy for documentation. As this program is currently being implemented, a back-up plan of allowing vaccine providers to document in their Electronic Health Records (EHRs) and upload them via “flat file” directly into the IIS will prevent double documentation by facilities that have this capability. This process would require the “flat file” to be uploaded quickly enough to meet the reporting requirements of both the State of New Hampshire and Centers for Disease Control and Prevention. The advantage of this strategy would be that vaccinators would not need to be trained in an additional system. However, it increases the amount of personnel needed to be assigned to NHIP to monitor and track data quality.

## **SECTION 10: COVID-19 VACCINATION SECOND-DOSE REMINDERS**

### ***A. Methods for Second-Dose Reminders***

It is expected that COVID-19 vaccine recipients will need to be reminded of the need for a second dose, should a second dose be required for the eventual vaccine formulation(s) that is distributed. Individuals will be notified when they are eligible for their second dose of COVID-19 vaccine via the IIS's reminder/recall feature; through CDC "shot cards" provided upon initial vaccine receipt; or through their medical home's reminder/recall process. Additional options are being explored for second dose reminders to individual patients, for example, reminders via text messaging.

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## **SECTION 11: COVID-19 REQUIREMENTS FOR IISs OR OTHER EXTERNAL SYSTEMS**

### ***A. Vaccine Documentation for High-Volume or Temporary Settings***

For mobile and off-site vaccine clinics (closed PODs), vaccine administration will be documented via technology solutions that include Mobile WebIZ (a standalone documentation system, part of the IIS), direct data entry into the IIS and redundancies explained below. Vaccinators will utilize tablets, laptops and portable internet connections. Options are currently being explored to capture patient demographic data prior to clinic start to improve the throughput of patients.

Depending on the COVID-19 vaccine distribution initial release, either VTrckS or the NH IIS will be utilized. If vaccine is released after December 7, 2020, our current plan will allow for utilization of the IIS. The IIS is currently being implemented after the vendor contract (Envision) approval in mid-June 2020.

Contingency planning for network outages or other access issues is underway. Redundancies have been explored to ensure efficient documentation of vaccine administration. Dependent on the Centers for Disease Control and Prevention (CDC) data element requirements, NH DHHS would consider utilizing the Vaccine Administration Management System (VAMS). In the event VAMS and the IIS cannot be utilized, an established internal solution will be leveraged with final data residing in the IIS, once the IIS is fully implemented.

### ***B. Data Collection Elements***

It will be important to capture information for persons who will receive COVID-19 vaccine in order to monitor equitable vaccine distribution and progress towards the vaccination plan's goals. Patient data elements to be collected will include: Name, DOB, address, race/ethnicity, allergies/contraindications/precautions, required vaccine information, insurance status. The IIS does not have functionality that provides for the documentation of co-morbidities.

### ***C. Data Exchange***

Currently, our IIS does not accept HL7 messages. If a data use agreement can be established between IZ Gateway and NH's IIS, that HL7 messaging pathway will be prioritized. Additional HL7 onboarding will commence over the first four months of 2021.

### ***D. Enrollment in the IIS***

Planning is underway to rapidly enroll and onboard to the IIS those vaccination provider facilities and settings expected to serve healthcare personnel (e.g., paid and unpaid personnel working in

healthcare settings, including vaccinators, pharmacy staff, and ancillary staff) and other essential workers. Two solutions are currently being explored. The first solution is to onboard Phase 1 vaccine providers and will rely on more human resources, rather than a technology solution. This process involves completion of the CDC fillable pdf and submission to NHIP via email; data will then be entered manually into the IIS or VTrckS. The second solution will involve a technology-based solution to streamline vaccine provider enrollment. When the IIS is implemented, an online vaccine provider enrollment module will be leveraged for the same process.

### ***E. Use of IZ Gateway Connect***

The [IZ Gateway](#) is a federal mechanism for connecting IISs or other documentation systems to CDC to share authorized vaccination information. The IZ Gateway contributes to a coordinated COVID-19 vaccination response by streamlining these connections and ensuring more up-to-date exchange of immunization data. IZ Gateway connections with New Hampshire are currently being explored. Data use agreement approval will be dependent upon CDC clarification related to data element requirements, as well as CDC's prioritization of New Hampshire's connection to the IZ Gateway.

## **SECTION 12: COVID-19 VACCINATION PROGRAM COMMUNICATION**

### ***A. COVID-19 Vaccination Communication Plan***

New Hampshire's COVID-19 vaccination communication plan is in place and will continuously be updated to include addressing communications with key audiences, identification of effective communication channels, and partner activation for each of the phases of the COVID-19 Vaccination Program. A Communication Branch was formed as one of six branches in the Vaccine Operations Section, part of New Hampshire's public health response Incident Management Team. Implementation of the communications plan is ongoing; it will include the identification and active engagement of internal partners and external stakeholders in the planning process. Key internal partners include subject-matter experts in infectious disease/epidemiology, vaccine management, communications, representation from housing, equity groups, Emergency Medical Services and Emergency Services Unit. External partners include long-term care and assisted living facilities, hospital organizations (which also represent a large number of health care practices), schools, retail, private and hospital pharmacies, health care coalitions and associations, and professional medical societies.

### ***B. Crisis and Emergency Risk Communication***

NH DHHS has established processes for providing crisis and emergency risk communications in an expedited manner. This includes leveraging the State of New Hampshire's Joint Information Center. For clinical or partner messaging, subject-matter experts are consulted in the development of communications, which are provided through the Health Alert Network (HAN) and which reach >14,000 healthcare providers and other public health partners in New Hampshire. For public messaging, a variety of platforms are used to push information to the public. A member of the Department's Public Information Office leads the vaccine planning Communication Branch, which allows for flow of information and consistent messaging across the COVID-19 response.

## **SECTION 13: REGULATORY CONSIDERATIONS FOR COVID-19 VACCINATION**

### ***A. Emergency Use Authorization and Vaccine Information Statement Provider Education***

Ensuring enrolled COVID-19 vaccination providers are aware of, know where to locate, and understand the information in any Emergency Use Authorization (EUA) fact sheets for providers and vaccine recipients or vaccine information statements (VISs), as applicable, will be important. If New Hampshire proceeds with the distribution of COVID-19 vaccine under the Emergency Use Authorization (EUA), the Communication Branch will provide EUA fact sheets and Vaccine Information Statements (VISs) for vaccine providers and vaccine recipients through the Immunization Program website, social media platforms, links to the CDC website and direct email to enrolled providers. Consideration will be given towards information being provided via the Health Alert Network (HAN).

### ***B. Emergency Use Authorization and Vaccine Information Statement Distribution***

New Hampshire will follow guidelines and recommendations provided through the CDC as it relates to the distribution of fact sheets and COVID-19 vaccine VISs under a EUA.

## **SECTION 14: COVID-19 VACCINE SAFETY MONITORING**

### ***A. Reporting of Adverse Events to the Vaccine Adverse Event Reporting System (VAERS)***

New Hampshire will ensure enrolled COVID-19 vaccination providers understand the requirement and process for reporting adverse events following vaccination to VAERS. Through the vaccine provider enrollment process, COVID-19 vaccine providers will receive information related to the requirement and process for reporting adverse events to VAERS. Information will also be made available through the Immunization Program website, social media platforms and quarterly Immunization program conference calls.

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## **SECTION 15: COVID-19 VACCINATION PROGRAM MONITORING**

### ***A. Program Progress Reporting:***

New Hampshire will implement methods and procedures for monitoring progress in COVID-19 Vaccination Program implementation, including monitoring:

- Provider enrollment
- Access to COVID-19 vaccination services by population in all phases of implementation
- IIS or other designated system performance
- Data reporting to CDC
- Provider-level data reporting
- Vaccine ordering and distribution
- 1- and 2-dose COVID-19 vaccination coverage

Vaccine Agreements will be executed using the following methodology. Providers identified as vaccinators in the first phase will be prioritized for enrollment. After enrolling these vaccine providers, additional providers will be recruited. Recruitment will be based on utilization in the next phases, as well as creating depth of vaccine providers and decreasing barriers towards immunization. This will be achieved by reviewing geographic and population base data for the state. Providers unable to vaccinate will be assessed on an individual basis, and opportunities to provide vaccination in their area will be explored. Additionally, 13 fixed sites stood up on the government side of the response will be established to back up these individual vaccine providers. Pharmacies will also be recruited to provide additional vaccination services.

Vaccine providers will be required to document COVID-19 vaccine in the final COVID-19 documentation system. Those unwilling to comply will not be shipped additional vaccine and additional attempts will be made to establish new vaccine providers in this area. Recognizing the burden of documentation (entry into their own EMR and in the state's documentation system) NHIP is making every effort to explore all options for large data migrations from existing electronic health record systems, compliant with state regulations. Vaccine ordering and distribution will be approved at the state level and vaccine wastage will be monitored through standard, established procedures. State-wide documentation will be leveraged to ensure the second dose of a vaccine presentation is the same as the first, observing recommended intervals between vaccine doses.

### ***B. Resource Monitoring***

Methods and procedures for monitoring resources are in place, including monitoring the budget, staffing, and supplies. All resource management for COVID-19 vaccine distribution, is currently being managed by NHIP as part of the Vaccine Operations Section. This same methodology will be applied to future methods and procedures for monitoring resources. The Vaccine Operations Section will also leverage resources within the larger Incident Management Team structure, which includes Finance and Logistics sections.

### ***C. Communication Monitoring***

The Communication Branch, established under the Vaccine Operations Section, utilizes communication subject-matter experts to create, inform and standardize communication pathways. Future plans will address implementing communication strategy evaluation methods, to include monitoring the success of message delivery and message reception among target audiences. Currently, communication has been broken out into sub categories: RPHNs, external health care provider entities/organizations and general population. Current planning to include national, corporate vaccine providers, contracted through the CDC, is under consideration. Reception of partner communication messages will be monitored through bidirectional communication with stakeholder groups. Reception of public communication messages will be monitored through the public information office, media inquiries, and social media monitoring.

### ***D. Local-level Situational Awareness Monitoring***

Bi-directional communication pathways are currently being formulated and leveraged to provide real-time feedback and inform New Hampshire's COVID-19 Vaccine response efforts. Some examples of this include, Chief Information Officers of large hospital organizations; professional medical societies in New Hampshire, Granite State Health Care Coalition, NH Hospital Association, RPHNs.

### ***E. Vaccination Program Metrics***

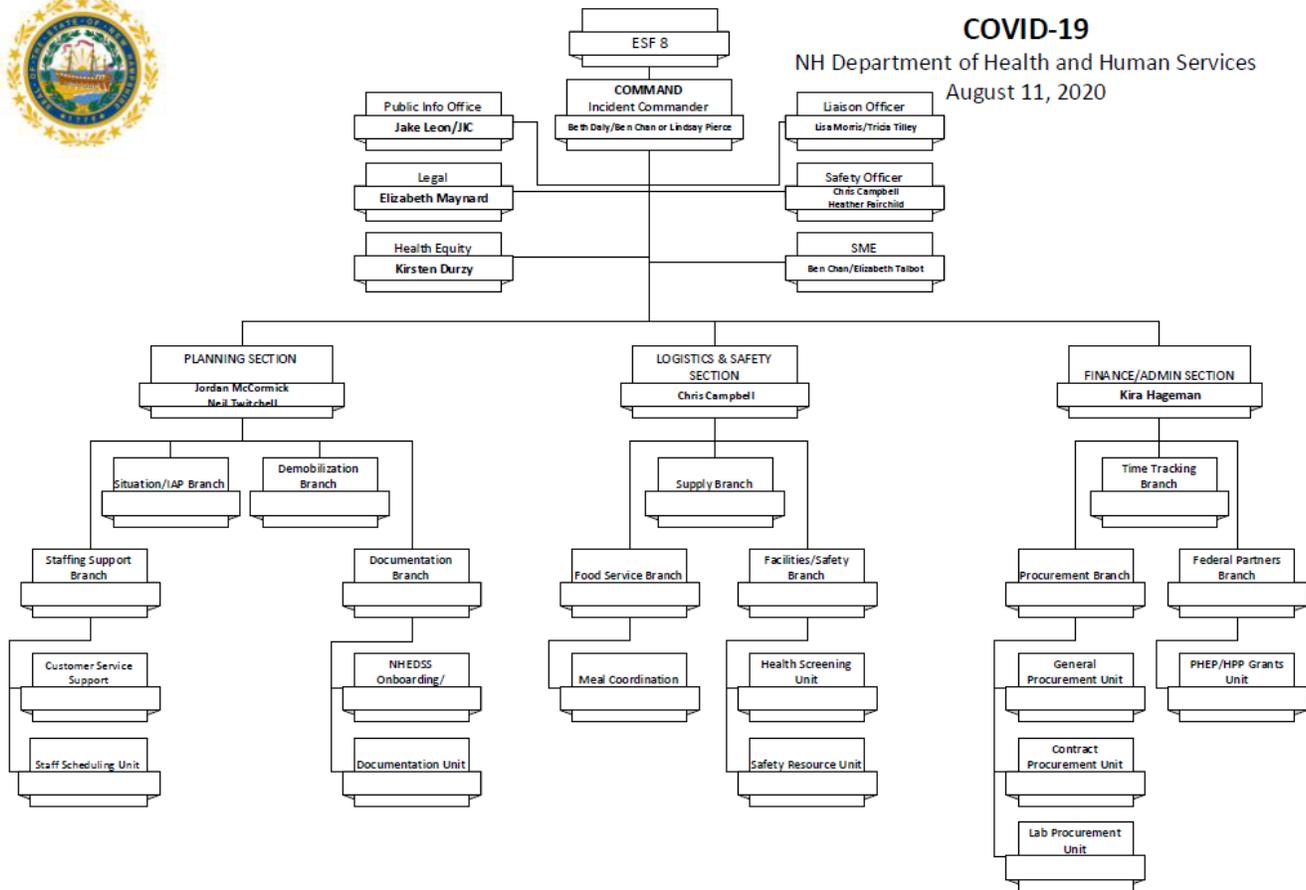
Program metrics to be monitored include vaccination provider enrollment, doses distributed, doses administered, and vaccination coverage. Additional metrics may be developed. Plans are underway to incorporate relevant COVID-19 vaccine data into the Department's existing New Hampshire COVID-19 dashboard to provide vaccine-specific information and resources to the general public and state and local officials. Further reporting will be generated as needed.

## APPENDIX 1: INCIDENT MANAGEMENT TEAM STRUCTURE

This organizational chart reflects the COVID-19 public health response organizational structure. There are three Operations Sections that report to the Incident Commander and not depicted in this chart. These three Operations Sections are the primary operational units in the public health response and include: 1.) Case Investigation, Contact Tracing, and Epidemiology and Surveillance, 2.) Testing, and 3.) Vaccine Planning.



**COVID-19**  
NH Department of Health and Human Services  
August 11, 2020



**APPENDIX 2: VACCINE OPERATIONS SECTION**

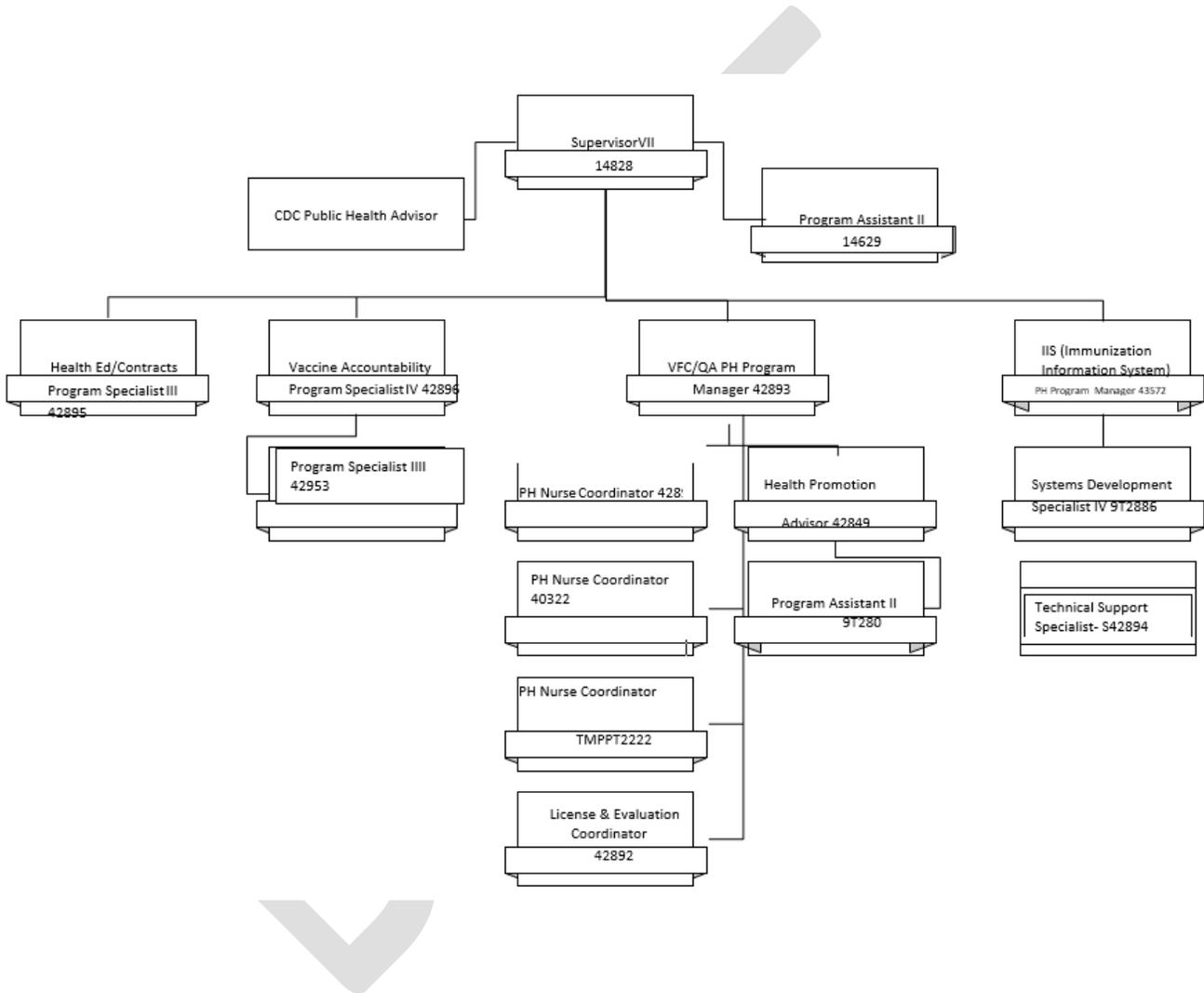
This organizational chart reflects the COVID-19 vaccine planning organizational structure.

Incident Commander: Dr. Beth Daly					
Vaccine Operations Section Chief: LCDR Torane Hull, Deputy: Colleen Haggerty, Support: Elinor Fenton					
Vaccine Allocation Strategy Branch Director: Dr. Elizabeth Talbot Deputy: TBD SDMAC* Liaison: Dr. Jonathan Ballard	Communications Branch Director: Laura Montenegro, PIO Deputy: TBD	Vaccine Storage and Handling Branch Director: Lena Boulanger Deputy: Rachel Moon	Logistics Branch Director: Craig Beaulac Deputy: Sean Heichlinger	Documentation Branch Director: Alok Patra Deputy: Jackie Ramirez	Medical Direction Branch Director: Dr. Ben Chan Deputy: Janice Houston
<ul style="list-style-type: none"> <li>Develop vaccine allocation strategy with regard to clinical, ethics, and equity considerations</li> <li>Estimate phase group populations</li> </ul>	<p><u>External Partners</u></p> <ul style="list-style-type: none"> <li>RPHNs</li> <li>Healthcare (e.g. LTCFs, hospitals, provider practices, EMS, etc.)</li> </ul> <p><u>General Population</u></p> <ul style="list-style-type: none"> <li>Communicate strategy</li> <li>General Inquiries</li> <li>Information on where to get vaccinated</li> <li>Why should people get vaccinated</li> </ul>	<ul style="list-style-type: none"> <li>Order and Distribution Approval</li> <li>Shipping/Number gathering</li> <li>Vaccine storage and handling training:                             <ul style="list-style-type: none"> <li>RPHNs</li> <li>Healthcare Providers</li> </ul> </li> <li>Vaccine storage and handling at Depot</li> <li>Repackaging for orders under 100</li> <li>Vaccine redistribution</li> <li>Vaccine agreement- for participating HCP</li> </ul>	<ul style="list-style-type: none"> <li>Non-vaccine storage and inventory</li> <li>Healthcare Provider Equipment distribution as able</li> <li>RPHN equipment and supply allocation</li> </ul>	<p><u>Documentation /Ordering Training</u></p> <ul style="list-style-type: none"> <li>IIS Training:                             <ul style="list-style-type: none"> <li>General Providers</li> <li>RPHN-Mobile Web IZ</li> </ul> </li> <li><u>Backup documentation methods</u></li> <li>VAMs</li> <li>State created solution</li> <li><u>Documentation Support</u></li> <li>Helpdesk</li> <li>Educational webinars</li> </ul>	<ul style="list-style-type: none"> <li>SOP and Clinical Direction Creation</li> <li>Nurse RPHN Liaison                             <ul style="list-style-type: none"> <li>1:2 support**</li> <li>Vaccination questions and support</li> </ul> </li> <li>RPHN Medical Direction Training:                             <ul style="list-style-type: none"> <li>Just In Time Training</li> <li>PPE training</li> <li>COVID Screening Training</li> <li>Alternate Clinic site training</li> </ul> </li> </ul>
<p>Staffing</p> <ul style="list-style-type: none"> <li>Carole Totzkay</li> <li>Christophe Courtine</li> <li>Katie Owens-Bonner</li> </ul>	<p>Staffing</p> <ul style="list-style-type: none"> <li>Nia Smart</li> <li>Danielle Morse</li> <li>Stephanie Locke</li> <li>Neil Twitchell</li> <li>Megan Denubila</li> <li>Taylor Selembo</li> <li>211</li> <li>GSHCC</li> <li>CHI / JSI Contract</li> </ul>	<p>Staffing</p> <ul style="list-style-type: none"> <li>Lori Johnson</li> <li>Kelly Jones (Education)</li> <li>3-5 additional FTEs needed (temporary until all provider agreements complete).</li> <li>1 National Guard (long-term asset)</li> </ul>	<p>Staffing</p> <ul style="list-style-type: none"> <li>Will leverage existing resources such as National Guard assets and teams to distribute PPE and possibly monitor vaccine at closed PODs, under discussion.</li> </ul>	<p>Staffing</p> <ul style="list-style-type: none"> <li>IIS Position – In Recruitment</li> <li>3-6 additional FTEs needed</li> </ul>	<p>Staffing</p> <ul style="list-style-type: none"> <li>Suzanne Allison</li> <li>Anne Lucey</li> <li>Xan Gallup</li> <li>Kelly Jones</li> <li>Taylor Selembo</li> <li>**Immunization PHNs + 2 additional FTEs</li> <li>1 additional staff needed for training</li> </ul>
<p><u>Vaccine Allocation Strategy Participants:</u> Dr. Elizabeth Talbot, Dr. Jonathan Ballard, Maj. Lyndsey Fleming, Incident Commander, Vaccine Operations Section Chief and Deputy, Branch Leads, HSEM, Dr. Ben Chan, Kirsten Durzy, Tricia Tilley, Lisa Morris, Neil Twitchell, Stephanie Locke, Melissa Hatfield, *The State Disaster Medical Advisory Committee will be consulted in an advisory capacity.</p>					

### APPENDIX 3: IMMUNIZATION PROGRAM SECTION

This organizational chart reflects the day-to-day organizational structure of the Immunization Program Section irrespective of COVID-19 planning.

New Hampshire Department of Health and Human Services  
 Division of Public Health Services  
 Bureau of Infectious Disease Control  
 Immunization Program Section



#### **APPENDIX 4: STATE DISASTER MEDICAL ADVISORY COMMITTEE (SDMAC)**

- Jonathan Ballard, MD, MPH, MPhil – NH Department of Health and Human Services, Chief Medical Officer
- Kathy A. Bizarro-Thunberg, MBA, FACHE – Executive Vice President / Federal Relations, New Hampshire Hospital Association
- Charles P. Burney, MD – Resident, General Surgery and Leadership Preventive Medicine
- Michael Calderwood, MD – Infectious Disease and International Health, Dartmouth Hitchcock Medical Center
- Rep. Polly Campion, MS, RN – New Hampshire House of Representatives
- 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
- James Culhane – President and CEO, Home Care Hospice & Palliative Care Alliance
- 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
- Jeff Dickenson – Advocacy Director, Granite State Independent Living
- Paul Drager, JD – MedEthics Consulting
- Anne Edwards, Esq. – Associate Attorney General, NH Department of Justice
- John E. Friberg, Jr. Esq. – Chief Legal Officer, Manchester and Nashua SolutionHealth
- Marc D. Hiller, MPH, DrPH – Associate Professor, Department of Health Management and Policy, College of Health and Human Services, University of New Hampshire
- 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
- Joseph Hoebeke, Chief, Hollis Police Department
- Sally Kraft, MD, MPH, VP of Population Health at Dartmouth-Hitchcock
- Richard Levitan, MD – Emergency Medicine, Littleton Regional Hospital
- John McAllister, President, Professional Fire Fighters of NH
- Kenneth Norton LICSW – Executive Director, National Alliance of Mental Illness, New Hampshire Chapter
- 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

## New Hampshire COVID-19 Vaccination Plan

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- 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
- 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
- David Ross, Administrator – Hillsborough County Nursing Home
- Michael Sitar, Jr. Chief, Tilton Northfield Fire and EMS
- Luanne Rogers, RN – Administrator, St. Theresa’s Rehabilitation and Nursing Center
- Sedden R. Savage, MD, MS – Addiction Medicine and Pain Medicine Clinician, Advisor to Dartmouth Hitchcock Substance Use and Mental Health Initiative
- Sen. Tom Sherman – New Hampshire Senate
- Steve Surgenor, MD – Anesthesiologist, Dartmouth Hitchcock Medical Center
- Elizabeth Talbot, MD – New Hampshire Department of Health and Human Services, Deputy State Epidemiologist, Dartmouth Hitchcock Medical Center, Infectious Disease Clinician
- Robert Theriault, Jr., BPharm, MB, RPh – Director of Pharmacy Services, Wentworth-Douglass Hospital
- Joan C. Widmer, MS, MSBA, RN, CEN – Nurse Executive Director, New Hampshire Nurses Association
- Tom Wold, DO – Chief Medical Officer, Portsmouth Regional Hospital

## APPENDIX 5: VACCINE ALLOCATION STRATEGY

### Coronavirus Disease 2019 (COVID-19) Vaccine Allocation Strategy Considerations, Processes, Preliminary Data October 12, 2020

#### Background

Immunization with a safe and effective COVID-19 vaccine will be a critical component of the New Hampshire (NH) strategy to reduce COVID-19-related illnesses, hospitalizations, and deaths and to help restore societal functioning. When vaccine becomes available, there may be limited supply and, therefore, the NH Department of Health and Human Services (DHHS) Division of Public Health Services (DPHS) has created a vaccine allocation strategy to focus initial vaccine access for those critical to the response, who provide direct clinical care, and who maintain societal function, as well as those at highest risk for developing severe illness from COVID-19.

#### Framework to Develop the NH COVID-19 Vaccine Allocation Strategy

The New Hampshire Immunization Program assembled in the earliest months of the pandemic in order to begin planning for the eventual development of a COVID-19 vaccine. The Vaccine Operations Section was formally created within the DPHS Incident Management Team in order to support information sharing and to leverage resources across the public health response. Within this Section, the Vaccine Allocation Strategy Branch (VASB) was established in order to

1. Develop the New Hampshire vaccine allocation strategy with regards to clinical, ethics, and equity considerations
2. Estimate tier group populations

The VASB is made up of units with focus on:

1. Ethics/Equity, with liaison to the NH State Disaster Medical Advisory Committee
2. Clinical Issues
3. Special Populations
4. Data Strike Team

We are planning in terms of three phases:

1. Potentially limited supply of COVID-19 vaccine doses available
2. Large number of vaccine doses available
3. Sufficient supply of vaccine doses for entire population (surplus of doses)

There are four core resources for the development of the allocation strategy:

1. NH DHHS High Threat Infectious Diseases Plan
2. Crimson Contagion National Drill
3. [National Academy of Sciences \(NAS\) Framework for Equitable Allocation of Vaccine for the Novel Coronavirus](#)
4. [COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations](#)

### Adopted Framework

The group has formally adopted the NAS Framework for Equitable Allocation of a Vaccine for the Novel Coronavirus. This framework is built on the ethical principles of maximum benefit, equal concern, and mitigation of health inequities, and the procedural principles of fairness, transparency, and a basis in evidence. The plan provides detailed vaccination phases, including groups and subgroups that comprise each phase. The allocation criteria considered when determining vaccination phase are risk of:

- Acquiring infection
- Severe morbidity and mortality
- Negative societal impact
- Transmitting infection to others

While we adopt the NAS framework and recommendations, we have also made changes to accommodate New Hampshire-specific features of the pandemic. Due to the high morbidity and mortality in residents of long-term care facilities (including skilled nursing and assisted living facilities) in New Hampshire, we have elected to move this group from Phase 1b to phase 1a.

### Preliminary Population Estimates

Note that this table showing vaccination candidate populations is preliminary and these numbers and estimates have not yet been well-vetted and reviewed. The last column is 'Scenario 2', the situation during which initial vaccine supply is inadequate to even reach this critical at-risk population. In this scenario we suggest beginning vaccination in the regional public health networks (RPHNs) with the highest community transmission (Greater Manchester, Greater Nashua, South Central, and South Central). We have elected to use RPHNs as our unit of distribution because these units are frequently used for vaccine administration and distribution, thus leveraging existing relationships. These preliminary numbers for the RPHNs included in Scenario 2 are estimated from data for the two counties

## New Hampshire COVID-19 Vaccination Plan

that make up the majority of these areas (Hillsborough and Rockingham). We are currently refining these estimates to the RPHNs of interest.

Group	Subgroup	NH Total	Scenario 2
<b>High-risk workers in health care facilities</b>	Direct health care providers whose primary work location is emergency department, urgent care, intensive care unit, dedicated inpatient COVID unit, and estimated staff that frequent but are not housed at those settings (e.g., subspecialists, respiratory therapists)	11,714	6,255
	All on-campus hospital staff (excluding above direct care providers) such as dietary, environmental, clerical, security staff	31,344	16,738
	Direct and indirect staff in long-term care and skilled nursing facilities	11,730	6,264
	Direct and indirect staff in assisted living facilities	4,730	2,526
	VNA, hospice	NA*	NA*
<b>First responders</b>	Fire and EMS (public, private, and volunteer)	8,462	2,962
	Law enforcement	4,374	1,815
	National Guard	160	85
<b>Older adults in residential care settings</b>	Residents in long-term care and skilled nursing facilities	8,911	4,758
	Residents in assisted living facilities	6,244	3,334
<b>TOTAL</b>		<b>87,669</b>	<b>44,738</b>

\*Note one important population that is currently excluded from these estimates are the home care, hospice and palliative care providers and active patients. These are not included due to inadequate data at the time of this writing. However, the NH Home Care, Hospice and Palliative Care Alliance of NH did survey their members (N=42) and to date we have received responses from 23 agencies:

- Total number of direct care staff, including per diem: 2,552
- Total number of non-direct care staff: 776
- Patient/client census (busiest day during week of Sept. 7): 9,289

Not all serving agencies are members of the Alliance.